Witness Name: Ann Sheridan

Statement No.: 2

Dated: 25.03.2025

Rule 9 reference: EPUT Rule 9(8) & Rule 9 (8) (a)

LAMPARD INQUIRY

SECOND WITNESS STATEMENT OF ANN SHERIDAN

I, Ann Sheridan, will say as follows: -

Introduction

1 I am the Executive Nurse within Essex Partnership University NHS Foundation Trust ('EPUT') and I have held this position since 9 February 2024.

2 I have been in employment with EPUT since 9 February 2024. I was not in EPUT's employment during the period in scope of 1 January 2000 to 31 December 2023. Prior to joining EPUT, I was employed by Central and North West London Foundation Trust where I was its Managing Director of Divisional Mental Health Services.

3 I report directly to the Chief Executive Officer ('CEO'), Paul Scott.

4 I am a registered mental health nurse, a registered general nurse, and a qualified social worker.

5 This statement is made in response to the request made by the Inquiry to EPUT on 9 January 2025, under Rule 9 of the Inquiry Rules 2006, with reference **'EPUT Rule 9(8).'** EPUT was asked in that letter to respond to a series of questions around ligature related deaths and serious incidents that occurred within EPUT and its predecessor organisations, from 1 January 2000 to 31 December 2023.

6 I would like to offer my sincere personal condolences to anyone who has lost loved ones while receiving care from mental health services in Essex. This statement aims to address questions from the Lampard Inquiry about safety at EPUT. No part of this statement is intended to diminish the impact that the tragic loss of life will have had on families, loved ones and the EPUT staff that cared for them.

7 In this corporate witness statement, I have provided answers to the Inquiry's questions on behalf of EPUT. Not all the matters related to the Trust are within my own personal knowledge, but I have relied on information and documents provided by colleagues and the contents of the statement are true to the best of my knowledge, information and belief. The statement also supplies information regarding the former Trusts (North Essex Partnership University NHS Foundation Trust or "'NEP", and South Essex University Partnership NHS Foundation Trust or "SEPT"). This information is sourced directly from the electronic information or documents held by EPUT, as described further below and I have relied on the accuracy of that information, together with the searches described below.

8 The Rule 9 (8) request asked the Trust to provide the information requested in under five weeks. The work involved has included identifying and speaking with those within the organisation who may have direct knowledge of the matters request, as well as examination of electronic and paper records held by EPUT. We have used our best endeavours in the limited time available to provide as much detail as possible and will seek to provide any updates to this statement that may be required if further information comes to light.

9 There were also aspects of Rule 9 (8) that we felt needed further clarification from the Lampard Inquiry before we could answer some requests appropriately. A request for clarification was sent via our Legal Advisors, Browne Jacobson, on 17 January 2025. Clarification was received from the Lampard Inquiry as part of Rule 9 (8) (a) on 13 March 2025.

10 Much of the information requested by the Inquiry relates to the period before the creation of EPUT, on 1 April 2017 and has required searches of the historic data bases relating to its predecessor organisation still held and accessible by EPUT (see paragraph 13 for a list of those databases). In addition, EPUT holds archive boxes containing paper incident forms for SEPT and NEP covering incidents between 2000 and 2010, which it has not been possible to search to date. In relation to matters which occurred before April 2017, this statement sets out a summary of the documentary information that is available via these written sources, and supporting exhibits.

11 On 14 March 2025, the Inquiry provided clarification that Learning Disability services would be within the scope of the Lampard Inquiry. In line with this new guidance, EPUT has used best endeavours to update the data in the provided template **[AS02-01: Ligature Template Accompanying Rule 9 (8)]** to include incidents from Learning Disability services within the time afforded to complete this statement.

12 My statement will be set out using the following structure:

a) Approach to Incident Data Collection

b) External Investigations and learning related to ligature incidents not resulting in death

c) Annual Programme of Audits and Annual Risk Assessment Audits

d) Ligature Training

e) Material and Documentation used by the Trust

Approach to Incident Data Collection

Identification of Ligature Incidents

13 Incident data has been collected from a variety of sources:

- EPUT's Datix (Risk Management) System covering incidents from April 2017 to present
- North Essex Partnership NHS Foundation Trust's (NEP's) Datix System covering incidents from April 2009 to April 2017
- Former South Essex Partnership University NHS Foundation Trust's (SEPT's) Datix System covering incidents from April 2010 to April 2017
- Former North Essex Partnership University NHS Foundation Trust's (NEP's) Respond Database (Risk Management System) covering incidents from January 2002 to September 2015 and complaints from August 2000 to October 2015 (the Trust will use best endeavours to provide this information by 2 June 2025 following completion of the manual searches required).
- SEPT's Ulysses (Risk Management System) covering incidents from September 2000 to March 2011 (the Trust will use best endeavours to provide this information in June 2025 following completion of the manual searches required).
- Archive boxes containing paper incident forms for SEPT and NEP covering incidents between 2000 and 2010 (the Trust will use best endeavours to provide this information in June 2025 following completion of the manual searches required).

14 There is an overlap in the usage of some of the systems outlined in paragraph 13 above. There was a phased rollout of Datix across the Trusts, meaning that some paper forms were still being produced at some locations after the initial introduction of Datix. Respond was used at NEP for managing the SI investigation for incidents while the incident would have been reported initially through paper forms and once introduced, Datix. Until further reviews are completed, it can't be confirmed that no incidents at NEP since June 2009 and SEPT since April 2010 wouldn't have been

recorded only on paper, Respond or Ulysses (without an incident also being raised on Datix).

15 Incident data was extracted directly from EPUT's live Datix system using the following search criteria:

- Type: Incident Affecting Patient
- Category: Self-Harm
- Sub Category: Ligature

16 Incident data was extracted from NEP's Datix database via the RichClient platform using the following search criteria:

- Type: Incident Affecting Patient
- Code: Ligature involved

17 Incident data was extracted from SEPT's Datix database via the RichClient platform using the following search criteria:

- Type: Incident Affecting Patient
- Category: Self-Harm
- Sub Category: Ligature

18 The Trust has been experiencing some issues with the RichClient platform so it is possible that some data could have been missing from the reports. Where data quality issues have been identified, reports have been re-run which appears to have addressed the problems.

19 It was identified that the "Ligature" sub-category had only been in use on SEPT's Datix form since 02/04/2011 and the "Ligature involved" code on NEP's Datix form since 16/03/2013. To address this issue, all incidents were then extracted from these databases between their implementation date and the date that the ligature sub-categories were introduced. This resulted in 10,779 incidents for SEPT and 17,751 incidents for NEP.

20 Initial search terms were then applied using the Incident Description, Action Taken and Lesson's Learned fields to look for key words related to ligature. The key words used were:

- "Ligature" (to capture ligature and ligatured)
- "Neck"
- "Throat"
- "Knot"
- "Tied"
- "Tying"
- "Ripping" (rip was tested but resulted in a significant number of false positives)
- "Tear" (to capture tear and tearing)
- "Wrap" (to capture wrap and wrapping)
- "Strangulat" (to capture strangulate, strangulation and strangulated)
- "Strangl" (to capture strangle, strangled and strangling)
- "Hang" (to capture hang, hanging and hanged)
- "Suspend" (to capture suspend, suspending and suspended)
- "Fixed"
- "Asphyxiat" (to capture asphyxiate, asphyxiated and asphyxiating)
- "Suffocat" (to capture suffocate, suffocated and suffocating
- "Choke" (to capture choke and choked)
- "Choking"

21 The keywords resulted in 1035 flagged incidents to be reviewed from SEPT and 2447 flagged incidents to be reviewed from NEP.

22 A manual review of all flagged incidents on the all incident reports for SEPT and NEP was then conducted to determine whether the incident was a ligature and was within scope. Incidents that were extracted from Datix using the ligature categories for each trust were also reviewed to validate their categorisation and ensure that they were in scope.

23 The request also asked for incidents to be separated by facility; this was achieved using the team base and description columns on Datix. Paper incident forms also identify the facility that an incident took place on. Where there has been uncertainty, a manual check of the patient's records has been conducted to confirm the location.

24 EPUT has taken a ligature incident to be any incident that involved material that was used or could have been used to bind or tie a person's neck. This would exclude instances where the pressure to the neck was applied using the patient's or another patient's hands. A ligature may involve the use of a fixed point, but often this is not the case.

25 As noted in paragraph 9 above EPUT requested further clarification from the Inquiry on whether to include all ligature incidents or just ligature incidents that made use of a fixed point. The Trust has included all ligature incidents in its response, this is in line with the clarification received in Rule 9 (8) (a).

26 The Datix system for EPUT and the predecessor Trusts contain fields indicating the degree of harm. Where the degree of harm indicated death, the incident has been reported on the provided template as having resulted in death **[AS02-01: Ligature Template Accompanying Rule 9(8)]**.

27 The definition of a near miss provided by the Inquiry is:

- an incident, act or omission in care that had the potential to result in harm, but did not, primarily due to chance or interception.

28 This could also include incidents where material that could potentially have been used by a patient to ligature was found, but a ligature had not yet occurred.

29 For incidents reported on Datix, the degree of harm field was used to determine if the incident was a near miss. If the incident was confirmed to be a ligature after a manual review, and the degree of harm was listed as "No Harm", the incident was taken to be a near miss and reported as such on the provided template **[AS02-01: Ligature Template Accompanying Rule 9(8)]**. It is worth noting that the level of harm

associated with an incident is up to the interpretation of the person reporting the incident and there is no easy way to validate the level of harm that the reporter assigned.

30 In line with additional clarification provided in Rule 9 (8) (a), for incidents reported on Datix, the degree of harm was used to populate the "Harm" column on the provided template **[AS02-01: Ligature Template Accompanying Rule 9 (8)]**. If degree of harm was indicated as Low Harm, Minor Harm, Moderate Harm or Severe Harm, then the incident was recorded in the harm column against the appropriate ward and year.

31 Datix incidents include the names of people involved in the incident; this has been used to identify repeat attempts by the same person. The people involved in incidents are set out on Datix in categories such as: “witness”, “alleged perpetrator”, “person affected”, “reporter”.

- Where incidents had a person affected listed, this has been taken as the person that was the victim of the ligature.
- Where incidents had only an alleged perpetrator listed, these have been reviewed to identify whether the alleged perpetrator performed the ligature on themselves, or on someone else.
- Where incidents had an alleged perpetrator and a person affected listed, these have been reviewed to identify who the victim of the ligature was.
- In some incidents, the victim has not been identified on Datix. Where this is the case, it has had to be assumed that the incident was not a repeated attempt. Identifying the person in these instances would require checking to see which patients were on the ward on the date of the incident and then a review of case notes for those patients around that time period, looking for reference to a recent ligature attempt – this has not been possible due to time and resource constraints.

32 To be recorded on the provided template as a repeated incident, it would have to be a repeat attempt by a person on the same ward in the same year.

33 The data provided regarding repeated incidents has been updated to include "harm" incidents, in line with the guidance received in Rule 9 (8) (a).

34 The Datix systems for EPUT and the predecessor Trusts contain fields indicating if an incident was subject to a Serious Incident or Patient Safety Incident Investigation. This

column was used to identify incidents subject to an internal investigation and where the degree of harm column listed an outcome other than death, the incident was reported on the provided template **[AS02-01: Ligature Template Accompanying Rule 9(8)]**. Manual searches were then conducted to locate the report from the investigation, this was then populated on the provided template. In some cases, the report could not be located; this has been marked as "report not found". The Trust will continue to search for these reports and using best endeavours an update will be provided in June 2025.

Completion of the provided template

35 The Inquiry acknowledged in Rule 9 (8) (a) that EPUT is unable to provide information about the height of ligature points identified. Now that this clarification has been received, the Trust will use best endeavours to populate audit columns (K and L) on the "Summary" tab of the template provided by the Inquiry **[AS02-01: Ligature Template Accompanying Rule 9(8)]** in June 2025. EPUT was also unable to complete the "Audit Data" tab on this template until further clarification was provided on whether "high-level" means physically high up or high in risk, we will now use best endeavours to provide this in the template in June 2025. We have however exhibited the raw audit data extracted from the Datix system (see paragraphs 73-78 below). Further manual reviews will need to be completed to look for pre-Datix audit data (to be provided in June 2025).

36 The further detail about improvement work requested in column M on the "Summary" tab of the provided template will be completed now that clarification has been received and the Trust will use best endeavours to provide this to the Inquiry in June 2025. This will include detailed actions from ligature audits (as described further below), changes to policies/process and environmental improvements.

External investigations and learning related to ligature incidents not resulting in death

37 The Trust may hold additional information about external investigations into incidents resulting in death but in this section, as per the Inquiry's request, only investigations not resulting in a death have been included.

Investigations by the Care Quality Commission

38 The Trust does not believe there have been any investigations carried out by the CQC due to ligature incidents that did not result in death. However, a review of reports

available to the Trust did identify three CQC inspections where concerns had been received about the environment, but it was not stated whether this was specifically in relation to ligature risk. A table of these inspections is shown below:

Inspection Date	Type and reason for inspection	Organisation
Sept / Oct 16	CQC focused inspection Monitoring highlighted a number of concerns inc. learning from incidents and ward environments	NEPT
Aug 17	CQC Focused Inspection Adult and PICU Concerns raised re staffing numbers, patients care, environment, discharge planning, unexpected death of patient on leave	EPUT
Nov 17	CQC unannounced inspection CAMHS inpt & Forensic inpt & LD Inpt CQC monitoring had highlighted concerns inc maintenance of ward environment and management of patients Adult and PICU & Long Stay/ Rehab MH CQC monitoring had highlighted concerns inc ward environment and treatment given to patients and staff response to incidents OP MH Inpt CQC monitoring highlighted concerns re falls incidents and ward environments	EPUT

39 It is worth noting that while there were no specific CQC inspections into ligature risks, all CQC inspections offer an opportunity for learning and the majority of inspections did make recommendations for improvements around ligature. Review of the inspection reports suggests that there has been a shift in the recommendations received. Whilst this is an observation based on those reports, it appears that there has been a shift from early inspections (2014-16) finding a range of potential ligature points and recommending improvements, to later inspections acknowledging the

reduced numbers of ligature points and focussing more on refinements to ligature safety (e.g. ensuring appropriate cutters are in the ligature response wallet).

40 A review of complaints to the CQC that the Trust has been made aware of was also conducted. EPUT data was sourced from Datix by searching for complaints with a link to the Care Quality Commission (CQC). These were identified by using the tick box criteria and also by searching CQC in the description and outcome fields.

41 All CQC complaints were then reviewed and any that made reference to a form of ligature were highlighted. The complaints we have recorded on the Trust's internal drives were also reviewed to identify outcomes and learning related to the data from Datix.

42 This work identified 11 complaints that were raised to the Trust by the CQC **[AS02-02: CQC and PHSO Complaints Data]**.

43 To find complaints that predate the introduction of Datix, a review of archive boxes is being conducted. The Trust expects to be able to provide the outcome of this work in June 2025.

Investigations by the Health and Safety Executive (HSE)

44 EPUT has undertaken a review of all known cases reported to the HSE. All documentation has been reviewed to identify any previous ligature incidents not resulting in death that may have resulted in an HSE investigation.

45 Searches were conducted on the Trust's internal drives and identified a case on Ardleigh Ward in 2013 that was included in a HSE investigation and subsequent prosecution of the Trust related to ligature incidents and deaths. [I/S] (HM Inspector of Health and Safety) provided a Witness statement as part of the HSE Prosecution that confirms this ligature related near miss on Ardleigh Ward being included within the investigation **[AS02-03: Witness statement of** [I/S] **dated 29.06.2020]**. The investigation into the incident that occurred on 18 April 2013 at Ardleigh ward was documented in detail in an exhibit provided to HSE. **[AS02-04: HSE – Exhibit DE-212]**. The report found that the collapsible shower rail that the ligature had been tied to did not collapse as it was designed to. This led to an audit across the trust to understand the problem better and ensure that all rails had been checked within two weeks of the incident. Further detail about this matter has been set out in response to the Inquiry's R9(14), which asked for details of HSE prosecutions.

46 A Risk Manager ([I/S]) from NEP provided a witness statement to HSE on 31 January 2019 **[AS02-05: Witness statement of** [I/S] **dated 31.01.2019]**. This statement went into detail about the risk management processes that were in place at the time, including environmental standards, regular audits and the approach to funding required improvements.

47 An Associate Practitioner [I/S]) from NEP, who had reported to Michelle Appleby, provided a witness statement to HSE on 18 January 2019 **[AS02-06: Witness statement of** [I/S] **dated 18.01.2019]**. This statement provided more detail about the ligature audit process and went into specifics about some of the identified risks that may have contributed to the incidents being investigated within the HSE investigation, including door closers, hinges, wardrobes and windows.

48 A Director from one of NEPs suppliers[I/S] provided a witness statement to HSE on 30 May 2019 **[AS02-07: Witness statement of** [I/S] **dated 30.05.2019]**. This statement gave additional information into the installation, design and testing required to ensure that the collapsible shower and curtain rails functioned as intended.

49 The Trust provided a response to HSE detailing some of the mitigating actions that were put in place over the years to address ligature risk **[AS02-08: Mitigating statement HSE]**. The statement documented the Trusts investment into environmental ligature reduction with a total spend of approximately 1.9 million between 2017 and 2021. Again, further details of these issues have been provided in the response to R9(14) which relates to the HSE prosecutions.

50 From 2019 onwards, EPUT made substantial investment into new windows/fittings with the aim of reducing ligature risk and absconsion risk. Polar windows were selected as the approved replacement where risk had been identified with a currently installed window. Pending replacement, interim steps were taken to deal with ligature risks on windows e.g. clinical risk assessment.

51 Work was also completed to ensure that all Trust inpatient mental health wards had shower rails and bedroom and bathroom curtain rails that were designed to collapse under the application of a predetermined load. The Trust identified the following two systems:

- A magnetic collapsible plastic hold connector system (Kestrel) in Adult Acute and Older Adult Functional wards

- A fixed anti-ligature rail system with bespoke glider system (JTrac) in CAMHs, PICU Adult Acute and Low and Medium Secure Wards

52 From January 2020, a Trust wide maintenance contract for all collapsible rails was commissioned using a contractor independent to the original supplier and fitter.

Investigations by the Health Services Safety Investigations Body (HSSIB)

53 The Trust's internal drives have been reviewed for investigations by the HSSIB, but no relevant documents have been located in relation to ligature incidents. Further searches will be completed by 2 June 2025 and an update will be provided if additional information is found.

Investigations by the Parliamentary and Health Service Ombudsman

54 EPUT data was sourced from Datix by searching for complaints with a link to the Parliamentary and Health Service Ombudsman (PHSO). These were identified by using the tick box criteria and also by searching PHSO in the description and outcome fields.

55 All PHSO complaints were then manually reviewed and any that made reference to a form of ligature were highlighted. The complaints that are recorded on the Trust's internal drives were also reviewed to identify outcomes and learning related to the data from Datix.

56 These complaints were also cross referenced with spreadsheets that we hold to identify any potential disparities between them and Datix.

57 This work identified three incidents that resulted in investigation by the PHSO **[AS02-02: CQC and PHSO Complaints Data]**.

East London Foundation Trust Peer Review

58 While not an external investigation directly related to an incident not resulting in harm, in 2021 the Trust engaged with East London NHS Foundation Trust ('ELFT') to conduct a peer review of ligature safety on EPUT wards. This review, which reported in July 2021, concluded that EPUT had a clear ligature process in place to manage environmental risks of ligature. ELFT felt that our ligature process was strengthened

by the multi-disciplinary approach with ligature risk assessment inspections being conducted with the ward manager, an estates and facilities officer and a health and safety advisor all present. There were recommendations for improvement in governance and working practice, environment, workforce, and training and learning **[AS02-09: ELFT Peer Review Report]**. To summarise;

- Governance and working practice – improvements could be made to support 'ward to board' monitoring of risk, the ligature audit template could be simplified, and the policy could be revised to support clinical staff better
- Environment – clearer processes for updating clinicians on timelines for estates improvements were recommended and improved processes for planning improvement work with triangulation between estates and clinical teams to best manage risk
- Workforce – looking to strengthen the system in place to ensure bank and agency staff are given the same orientation to risks as regular staff across all wards
- Training and Learning – to consider enhancing staff awareness of suicide prevention strategy and more specific training on the use of ligature cutters

59 This review resulted in an action plan which was completed by the Trust to address the recommendations raised by ELFT during the peer review **[AS02-10: ELFT Action Plan v11 updated 10.22]**.

Annual Programme of Audits and Annual Risk Assessment Audits: Current EPUT Practice

60 I set out below an account of the programme and policies that are applicable across the Trust to manage ligature and other environmental risks. As is apparent from the Exhibits, this section contains a summary of the relevant policies, etc. applicable across the estate.

61 Ligature inspections should be undertaken on an annual basis alongside a number of measures in place to support the management of ligature in the Trust to identify, assess and manage ligature environmental risks and are completed to support the reduction of ligature risk. Other measures include, but are not limited to:

- Ligature Wallets – containing tools and guidance on ligature risk

- CG29 Suicide Prevention Clinical Guideline **[AS02-11: CG29 - Suicide Prevention Clinical Guidelines]**

- DATIX – The Datix system is utilised by the Trust to disseminate published national Safety Alerts and any EPUT ligature new risks identified for shared learning. The system enables dissemination to all relevant wards/areas for confirmation of alert/actions/mitigations taken.

- Ward managers lead on ligature risk management for their wards including, ligature incident reporting, inductions for all staff including temporary, bank and agency which include highlighting ward ligature hotspots, ensuring that the Ligature wallet is accessible, maintained and updated and ensuring that ongoing identification of potential ligature risks is undertaken during daily environmental checks.

- Trust Estates Ligature Works Program

- Estates annual testing program of curtain suspension systems and planned preventative maintenance (ppm)

- Ligature Risk Reduction Group (LRRG) – setting Trust environmental standards, /approval of inspection/audit tools, oversight of ligature inspection programs, oversight of actions arising from inspections, monitoring of the Risk Stratification programme, lessons and training/educational requirements, LOSC - Learning Oversight Sub- Committee, responsibility for ensuring learning is reviewed and taken forward Trust-wide. This group is chaired by EPUT's Chief Operating Officer (Alexandra Green).

62 The Health and Safety and Violence Prevention & Reduction (VAPR) teams facilitate the annual environmental ligature risk inspection programme, seeking to ensure that this is carried out within the required timescales, and carrying out continual review/development of the ligature inspection tool, providing the outcome report to the ward and recording breaches of environmental standards on the Trust Datix system.

63 The Ligature Inspection Team comprises of a member of the Health & Safety and VAPR team, a member of Estates Team and a member of the ward operational staff all of whom are mandatory for the inspection to go ahead. The Inspection Team are jointly responsible for completing an inspection using the inspection tool which audits against the agreed environmental standards **[AS02-12: CP75 – Appendix 8 – EPUT Fixture Fittings Ligature Environmental & Garden Standards]**. The inspection

team should agree actions to be raised for any breaches of these standards/maintenance issues and where appropriate ensure actions are raised on the Estates management system. Where a physical change to the environmental is not possible or will take a period of time to complete, appropriate mitigations for the wards and staff are identified and recorded. Following an inspection an outcome report identifying these actions/mitigations is provided to the ward and a one page summary is shared at Ligature Risk Reduction Group.

64 The environmental standards **[AS02-12: CP75 – Appendix 8 – EPUT Fixture Fittings Ligature Environmental & Garden Standards]** have been developed using a range of national guidance and internal learning. Whilst the standards apply as a general rule consideration actions/mitigations are reviewed in consideration of the areas/levels of risk posed i.e. supervised/unsupervised – private room areas – these are identified in the inspection tool using a 'room rating' system identified as:

- RED - Patients have unsupervised access
- AMBER - Patients are supervised at all times when in use
- GREEN - Patients are not permitted access and the room is not accessible to patients

65 The inspection team meet at the ward and undertake the inspection jointly visually assessing each room against the inspection tool and recording breaches in standard/maintenance issues and any mitigations. If for any reason a room is not able to be accessed the ward manager has the responsibility of conducting a review at their earliest opportunity and adding their finding to the latest inspection report.

66 Following each annual inspection the Health & Safety and VAPR representative will discuss and feedback any high-risk actions with the ward manager (prior to leaving the ward) and the Estates representative will upload all tasks onto 3i (the Trust's CAFM system) and provide the task numbers to the Health & Safety and VAPR team to include in the report. The draft inspection report is circulated to the Ward Manager/Matron/ Relevant Associate Director of service/Estates and ward representatives who attended the inspection alongside a copy of the Hot Spot Gallery for inclusion in the wards Ligature Wallets (if requiring update from the last ligature inspection) within 10 working days for their review/comments/ updates/ agreement and signature The full final report should then be issued within 15 working days of the inspection to:

- Executive Chief Operating Officer
- Care Unit Leadership Team (Director, Deputy Director of Quality and Safety and Medical Lead)
- Associate Director of Clinical Service
- Service Manager
- Clinical Lead/Matron
- Ligature Co-ordinator
- Ward Manager
- Estates representative
- Director of Estates & Facilities
- Head of Estates and Facilities

67 Ward Managers, Senior Managers and Matrons are responsible for ensuring all actions identified at a ligature inspection are completed within timescales and that mitigations are in place until actions are completed.

68 A one-page summary report of the inspection is submitted to LRRG for their review and approval of any changes identified i.e. in room ratings; this gives an overview of the completed inspection and findings as per template attached. Additionally, a monthly report is provided to LRRG from the Health & Safety and VAPR team detailing overdue actions, their risk rating and the mitigations in place.

69 In addition to the annual inspections, all wards have a follow up support review visit (6 months after annual inspection) facilitated by the Health & Safety and VAPR team jointly with an Estates team member, Ward Manager (or representative) and a Senior Clinician. This is focussed on coaching, support and education of staff, following up on any outstanding actions from the annual ligature inspections, audit compliance with policy and appendices and is to address any gaps in process from the previous ligature inspection.

70 The Health and Safety and VAPR representative, Estates representative and Clinician will discuss and feedback any high-risk actions to the ward manager (prior to leaving

the ward). Actions identified from the support review in relation to Breaches of Standard are recorded on Datix by the Health & Safety and VAPR team following the review visit and should be monitored by Ward Managers, Senior managers and Matron until completion. Overdue actions would be detailed in the monthly reporting to LRRG as per annual inspection overdue actions.

71 There were some adjustments to the ligature inspection process during the COVID period. Ligature inspections were conducted in person until close of play on 25 March 2020, but from 26 March 2020 all ligature inspections were paused subsequent to the Government's announcement and guidance. Once guidance was received, ligature Inspections recommenced on 18 August 2020 and it was agreed that these would be completed in person (with representatives from Health & Safety, Estates and the Ward, as per the Trust's policy) however, they would be subject to a ward risk assessment, infection control measures and safety on the wards i.e. any ward which had a Covid-19 outbreak (more than 2 patients). If there was an outbreak on a ward when there was an inspection scheduled, a table-top / remote exercise was to be conducted rather than an in person visit, following the procure below:

- Process for a table-top/remote exercise: a ligature inspection report would be generated exactly the same as if in-person, a telephone-call would be arranged with the Ward Manager and during this exercise, the Ward Manager would confirm any identified risks on the ward, and these would be documented in the same way as if in person. The report would be circulated, actions would be raised on Datix and distributed in line with CP75 **[AS02-13: CP75 – Ligature Environmental Risk Assessment and Management Policy]**.

72 In May 2023, The World Health Organisation confirmed that Covid-19 no longer qualified as a Global Emergency and therefore unless there was an outbreak on the Ward, a physical inspection would take place. Should an outbreak be declared (communicated via the Emergency Preparedness Resilience and Response department) it is discretionary upon personal circumstances should the inspection be rescheduled. Table-top exercises have not taken place since May 2023.

Inspection Data Collection

73 Since February 2015, the SEPT Datix system has been used to raise and monitor the implementation of environmental and non-environmental actions from ligature inspections. In this section we will explain how we have collated this data and provide

the exhibits with actions from these audits. Manual reviews would need to be completed to document actions from before the adoption of Datix for ligature audits, which is planned to be completed and provided in June 2025.

EPUT Inspection Data

74 The EPUT Ligature Actions listing report **[AS02-14: EPUT Ligature Actions Listing]** contains information, extracted from the EPUT Datix database, of any action recorded that resulted from a Ligature inspection from the date of merger (01/04/2017) to December 2023. The report includes (but is not limited to) the following information:

- Location of inspection
- Action Start date; Due date and Done date
- Description of identified ligature risk
- Priority rating of ligature risk/action – All levels of risk included (Extreme; High; Medium; Low; Not recorded)

75 The report also includes a pivot table which breaks the data contained in the listing report down, to show the number of actions by the following:

- Start date of action (by year)
- Team base and Team name
- Priority rating of ligature risk/action

SEPT Inspection Data

76 The SEPT Ligature Actions listing report **[AS02-15: SEPT Ligature Actions Listing]** contains information, extracted from the legacy SEPT Datix RichClient database, of any action recorded that resulted from a Ligature inspection within the Risk module. V2 includes some additional data extracted from the system not included in v1. The earliest record on this system dates to July 2014 and runs until merger in 2017. The report includes (but is not limited to) the following information:

- Action Due date and Done date
- Team base and Team name

- Description of identified ligature risk
- Priority rating of ligature risk/action

77 The report also includes a pivot table which breaks the data contained in the listing report down, to show the number of actions by the following:

- Due date of action (by year)
- Team base and Team name
- Priority rating of ligature risk/action

NEP Inspection Data

78 The NEP Ligature Actions listing report **[AS02-16: NEP Ligature Actions Listing]** contains information extracted from the legacy NEP Datix RichClient database, under the Risk sub-type 'Ligature'. This data does not appear to relate to specific actions arising from ligature or patient safety inspections but is linked to the Risk Register. There are a total of 25 individual risks recorded, resulting in a sum total of 61 actions. The Trust has been unable to locate a database with actions from NEP ligature inspection; it is believed – on the basis of the documents interrogated - that the actions would have only been recorded on each inspections individual template. A manual review of all NEP files will need to be conducted to list the actions from NEP audits (using best endeavours to be completed by June 2025).

Continuous monitoring of environmental risks: current EPUT systems

79 While ligature audits should be completed on an annual basis with follow up audits after six months (as discussed above), ward staff are responsible for monitoring environmental risk on a daily basis. Ward safety is everybody's responsibility and to reinforce the importance a 'Security Nurse' is allocated on each shift to ensure oversight of ward-based security matters and environmental checks.

80 Where potential environmental risks are identified, these are escalated to the shift lead/ward manager and estates (if required). If the identified risk can be mitigated by ward staff, appropriate action will be taken. This may include temporary closure of the area where the risk is located, increased staffing presence and/or increasing observation.

81 If the risk required the attention of Estates, it would be raised on '3i' the Trust's Facilities Management System along with a corresponding Datix incident. Clinical mitigations would remain in place until a resolution could be achieved.

82 The Trust holds twice daily 'Safety Huddles' where patient safety incidents are reviewed and EPUT has invested in patient safety experts that will support oversight of all incidents that is then discussed at a weekly senior clinical huddle with the senior leadership team.

83 Ad-hoc visits are conducted by people from our Integrated Care Boards and Local Authorities as well as by patient partners, Executive Directors and members of the Trust Board. During these visits, they are looking at the environment from both a safety and therapeutic point of view. Concerns are then raised through the appropriate governance route, depending on the person that visited.

Ligature Training

84 The requirement for ligature related training is set out both in the Ligature Environmental Risk Policy **[AS02-13: CP75 – Ligature Environmental Risk Assessment and Management Policy]** under section 12 and the Trust Mandatory Training Policy **[AS02-17: HR21 – Induction and Mandatory Training Policy]**. In addition, there is a range of information provided to staff.

Ligature Policy Section 12 Training Requirements

85 Section 12.1: Preventing suicide by ligature training is provided as an eLearning training package and is integrated into other training such as clinical risk training and suicide prevention training. The ligature eLearning training must be completed by all inpatient and community Mental Health staff and all facilities staff annually.

86 Section 12.2: Practical Ligature Training is available to all clinical staff from Band 4 and above, to increase ligature risk awareness. The training is also available to non-clinical staff including Corporate H&S and Estates representatives who are part of Ligature Inspection Teams.

87 Section 12.3: Information is provided for staff in brief guides and posters where required:

- **[AS02-18: CP75 – Appendix 2 – Local Induction Checklist Signage Sheet]**.

- **[AS02-19: CP75 – Appendix 3 – Safe Suspension of Curtains]**.
- **[AS02-20: CP75 – Appendix 4 – Contents of Red Tabbed Wallet]**.
- **[AS02-21: CP75 – Appendix 5 – Procurement Storage Maintenance of Ligature Cutters]**.
- **[AS02-22: CP75 – Appendix 6 – Ligature Cutters Station A4 Poster]**.
- **[AS02-23: CP75 – Appendix 7 – Emergency Procedure A4 Poster]**.

88 Section 12.4: Understanding and awareness is checked during ward visits by Executive Directors, during inspections carried out by the Trust resuscitation team, and during Ligature Inspections and reviews.

Ligature policy training matrix

Training	Staff Category	Delivery Method	Update interval
Corporate induction Meet the CEO, Trust values and standards, Human factors, Infection prevention, Staff engagement, Parity of esteem, Fire, Equality and Inclusive Behaviours, Risk, OLM and IT workshop, Safeguarding level 1 and 2	All new staff	MS Teams	NA
Clinical Risk Non-registered Registered	All clinical staff in MH and LD	E-Learning	3 yearly
Preventing suicide by Ligature	All inpatient and community Mental Health	E-Learning	1 yearly

	staff (including facilities)		

Summary of Available Training Content

89 **Preventing Suicide by Ligature (online)**, provided by EPUT. Essential online training to all staff working in an inpatient setting (or if it is required as part of their role):

90 This course has run from 2017 to date. This course is renewed annually and is delivered online (OLM) via the learning management portal. This course is similar to the ligature awareness training, with the exception that it (a) is delivered online therefore has video demonstrations as appose to human interaction and (b) is shorter in its content. Its main focus is to provide a basic overview of what is a ligature risk, reporting and removing risks, use of ligature cutters etc.

91 **Ligature Awareness Training (classroom based)**, provided by EPUT. Mandatory training for all staff working in an inpatient setting (or if it is required as part of their role):

92 This course has run from May 2024 to the current date. The course is renewed annually and is delivered over 3.5hrs in a face to face classroom environment. It is broken down into three elements, the first of which looks at the preventative aspects of ligatures. This includes recognising and identifying ligature risks, how to report these risks etc. The second part looks at the immediate actions to take during a ligature incident. For example, how to use the ligature cutters, safe removal of the ligature item etc. The final aspect looks at the post incident care provided to the patient following a ligature attempt. This includes physical signs of detrition, emergency care, best practices and recording the incident correctly.

93 **Ligature Environmental Risk Assessment Training (online)**, provided by TIDAL Training LTD. For all staff who undertake ligature inspections as part of ligature inspection programme.

94 This training commissioned in 2021 and ran until 2024. It was provided as a single attendance and was not required to be renewed. From 2021 to 2022 this was aimed at staff at band 6 and above. However, from 2022 to 2024 this was expanded to include staff at band 4 and band 5. TIDAL training delivered a two-day course aimed at all

nursing staff, estates officers and Health and Safety inspectors. This two-day course was designed to enhance the understanding of ligature risk assessments and what to do in the event of an emergency. Following the course, staff will have an understanding regarding risk assessments, skills and knowledge to recognise ligature self-harm injuries, including how to safely remove someone from suspension using ligature cutters.

95 This has been replaced by the Ligature awareness training outlined in paragraphs 91 and 92 but is still purchased for key individuals within the Health and Safety and Estates Teams who undertake inspections as an independent training session.

96 **Corporate Induction (online)**, provided by EPUT. For all new staff.

97 Corporate induction includes a session from the Health and Safety team which gives a basic introduction to ligature environmental risks.

Completion of the provided template

98 The Trust has completed the "Training and Documentation" tab of the provided template to the extent possible in the time allocated. There will be ligature training delivered on the job that is not captured in this statement. It also has not been possible to break down the training delivered by ward and attendance rate. It would be possible to provide the current training compliance by team, but providing past data would require cross referencing employee training data against employment details to identify the ward the person was working on at the time they completed the training.

Material and documentation used by the Trust

99 Rule 9 (8) requested a comprehensive list of any material or documentation that is used by the Trust to record and/or monitor ligature data, including internal policies, protocols and risk assessment tools.

100 The Trust utilises a range of different material and documentation to aid the recording and monitoring of ligatures. Monitoring is undertaken across a ward to board governance structure. The table below outlines the key materials and documentation used by EPUT:

Material / Document	Purpose	Level

Ligature Environmental Risk Assessment and Management Policy and appendices **[AS02-12, AS02-13, AS02-18, AS02-19, AS02-20, AS02-21, AS02-22, AS02-23]** **[AS02-24: CP75 – Appendix 9 – Standard Operating Procedure]** **[AS02-25: CP75 – Appendix 10 – Ligature Inspection Tool (v22.1)]** **[AS02-26: CP75 – Appendix 11 – Support Visits Tool]**	Sets out the criteria for the identification, assessment, and management of ligature anchor points within the organisation so far as is reasonably practicable The policy recognised that it is not possible to completely eliminate ligatures within a ward environment. The purpose of the policy is to describe the Trust's approach to, and responsibilities for, ligature identification, assessment, and management. The policy is intended to ensure that processes are in place to support staff in discharging their duty of care to patients, and to provide consistency and assurance of processes for the Trust.	Trust wide
Ligature Policy at a Glance **[AS02-27: CP75 – Ligature Policy at a Glance]**	Material for staff to help shared requirements set out in ligature policy	Trust wide
Local Induction checklist for ligature risk (Ligature policy appendix 2) **[AS02-18: CP75 – Appendix 2 – Local Induction Checklist Signage Sheet]**	Sets out checklist of information to be shared with new staff	Trust wide
Adverse Incident Policy and relevant appendices **[AS02-28: CP3 – Adverse Incident Policy]**	Sets out incident reporting requirements and processes	Trust wide

[AS02-29: CP3 – Appendix 4 – Witness Report] **[AS02-30: CP3 – Appendix 8 – 3 Day Follow up RIDDOR Incident Report (Service User Affected)]** **[AS02-31: CP3 – Appendix 9 – 3 Day Follow up RIDDOR Incident Report (Staff Affected]** **[AS02-32: CP3 – Appendix 15 – Inpatient (Mental Health) management following the unexpected death of a patient]** **[AS02-33: CP3 – Appendix 16 – Community Mental Health Management following the unexpected death of a patient]**		
Clinical Risk Assessment and Safety Management Policy **[AS02-34: CLP28 – Clinical Risk Assessment and Safety Management Policy]**	Policy promotes the safety of patients, carers and the public in relation to a range of clinical risks to self and others (including, self-harm, suicide, neglect, vulnerability and violence) whilst maximising the patients independence, social inclusion, and recovery. The policy and associated guidelines identify key principles for assessing and managing clinical risk with patients: promoting open and honest communication between all patients and staff; treating	Trust wide

	each patient as an individual, promoting choice, collaborative risk assessment and safety management and positive risk taking.	
Individual patient clinical risk assessments on the patient record systems	Undertaken for all patients to understand the current risk for each patient including considering risk of self-harm/suicide	Ward
Estates task log (3i – our CAFM System) / Datix Incidents (no harm)	Any ligature points identified by ward staff are reported via the Trust Datix Incident system and if corrective work is required are reported onto the Estates task log (3i)	Ward
Ligature Wallets and Red Pouches	These are available on all wards and include ligature cutters and instructions for use, ward heat map, hot spots photo gallery, ligature inspection report, safety alerts for ligature, signage sheet	Ward
Ward heat map and hot spots gallery (in ligature wallets)	Ward heat map is a floor plan of the ward with key ligature points highlighted, this is accompanied by the hot spots gallery which are photos of current ligature points. This is available for all staff to ensure they understand the risks on their wards.	Ward
EPUT Fixture Fittings Ligature Environmental Standards (appendix 8 of the ligature policy) **[AS02-12]**	Sets out the Trusts environmental standards for wards. Where applicable each standard reference the standard source including national safety alerts. Ligature inspection tools are inspect against these standards	Trust wide
Ligature annual inspection **[AS02-25]**	Undertaken collaboratively between the ward, H&S and Estates teams to review each rooms/area within each ward that	Ward

	patients can access to consider ligature risks.	
Ligature follow up visit **[AS02-26]**	Undertaken 6 months after annual inspection, collaboratively between the ward, H&S and Estates teams with a senior clinician. To review findings from the last inspection, undertake a review of a sample of rooms to consider ligature risks. To discuss management of clinical risk re ligature.	Ward
Ligature inspection summary (1 page summaries) **[AS02-35: Ligature Inspection Summary]**	Summary of ligature annual inspections including key areas for action. This is shared with the Ligature Risk Reduction Group to consider any new risks and share learning across the Trust	Delivery and Shared Learning
H&S Report to Ligature Risk Reduction Group Provided monthly to LRRG	Reports highlighting: • Good practice found at inspections • Learning opportunities found at inspections • Summary of ligature inspections undertaken and forward plan • Actions identified at ligature inspections monitoring for completion • Fixed point ligature incidents • Safety alerts regarding ligature	Delivery and Shared Learning
Secured and Unsecured Ligature Incident Report Presented to LRRG	Reports providing incident data and analysis looking at both secured ligature incidents and unsecured ligature incidents	Delivery and Shared Learning

Ligature Risk Review Group assurance report to Health Safety and Security Committee	Assurance reports providing details of the last meeting and escalations	Delivery and Shared Learning
Annual and Quarterly Ligature Reports Presented to Ligature Risk Reduction Group, health safety and security committee, Safety of Care Group and Quality Committee (standing committee of TB)	Reports providing information about ligature activating including learning, incident analysis, inspection programme and environmental changes	Strategic Assurance
Trust Risk Registers **[AS02-36: CRR81 Ligature Risk Report]**	One ligature risk has been identified and escalated to the Corporate Risk Register (CRR81). This risk was overseen by the Ligature Risk Reduction Group and has reduced over time following action taken	Delivery and Risk escalation
Risk Stratification Document	Document developed by the Trust estates team against the Trust Environmental Standards to prioritise environmental improvements.	Delivery
Capital Planning Group	A group responsible for allocating available capital to and overseeing improvement works across the trust, including projects that would reduce ligature risk	Delivery
Capital Plan	The plan setting out the agreed capital project works for the current financial year	Delivery

Ligature Governance Structure **[AS02-37: Ligature Governance Structure - 2024]**	Sets out the committee structure for flow of ligature information from ward to board	Ward to Board
Suicide Prevention Groups	There is a Trust suicide prevention group that meets monthly, this then meets bi-monthly with the local system and quarterly with the wider system. The focus of these groups is suicide prevention, primarily in the community but also on inpatient wards.	Shared Learning

Statement of Truth

The content of this statement is true to the best of my knowledge and belief.

Signed: [I/S]

Dated 25 March 2025