IN THE WEST YORKSHIRE WESTERN CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Ursula Niamh MacEochaigh Keogh
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: **Minister for Department Health** **NHS Calderdale Clinical Commissioning Group** **Chief Executive Calderdale Council**
1	**CORONER** Martin Fleming HM Senior Coroner for West Yorkshire Western
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 30/1/18 I opened an inquest into the death of **Ursula Niamh MacEochaigh Keogh** who, at the date of her death was aged 11 years old. The inquest was resumed and concluded on 15/11/18 I found that the cause of death to be: - 1a. Head injury 1b Fall from a height I arrived at a narrative conclusion as follows: On 22/1/18 Ursula Niamh MacEochaigh Keogh intended to take her own life.
4	**CIRCUMSTANCES OF THE DEATH** On 22/1/18 Ursula left her school at Lightcliffe Academy and boarded the school bus in company with her friend. At approximately 3.30pm Ursula got off a stop earlier than usual and made her way to the North Bridge in Halifax from which she jumped. She was subsequently located at 6.20am in the river approximately 100 yards away from the Shears Inn Public House, 2km downstream from the North Bridge. When Ursula was retrieved from the waters paramedics found that she had very sadly

	passed away and this was confirmed at the hospital.
5	**CORONER'S CONCERNS** During the inquest I heard that Ursula's mother contacted Ursula's GP at spring Hall Medical Centre by telephone on 13/11/17 in order to discuss her concerns about Ursula's history of self-harm and that this resulted in her mother being advised by a GP to get Ursula's school involved. Although the school subsequently advised Ursula's mother to contact her GP, during the telephone conversation of 14/12/17 to further discuss Ursula's self-harming, the GP advised her mother to contact the Psychology Team attached to the school, so that Ursula could be assessed for referral to Child & Adolescent Mental Health Team if necessary, in accord with the protocol previously issued by Calderdale CAMHS referral pathway, notwithstanding that at this time the school did not have the services of a Psychology team to make the referral. I further heard helpful evidence from [redacted] Highway Asset Manager, Calderdale Council), who told me about the current plans for preventative measures at North Bridge, Halifax in order to deter further like tragedies. The **MATTER OF CONCERN** is as follows: - • To review the current practice of referral by GP to the school for consideration as to the appropriateness of referral to CAHMS • Consider improving communications between professionals, particularly health and education to eliminate contradictions offered in the advice. • Consider the appropriateness of fast tracking the implementation of preventative measures currently under consideration at North Bridge Halifax
6.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Minister for Department of Health, NHS Calderdale Clinical Commission Group and Chief Executive for Calderdale Council have the power to take such action specific to them. In the circumstances it is my statutory duty to report to you.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to: • [redacted] - Mother • [redacted] - Father • [redacted] – Head of Behaviour, Attendance and Safeguarding Abbey Multi Academy Trust • [redacted] - GP • [redacted] – Principal of Lightcliffe Academy • [redacted] – Chair of CSCB • [redacted] – Chair of Serious Case Review and Learning Lesson review panels – Calderdale Clinical Commissioning Group • [redacted] – Public Health Consultant and Chair of child Death Overview Panel • [redacted] – Interim Business Manager of CSBC • Chief Coroner
9	**DATED this 21/11/18** **Senior Coroner – West Yorkshire - Western Division** MD Fleet