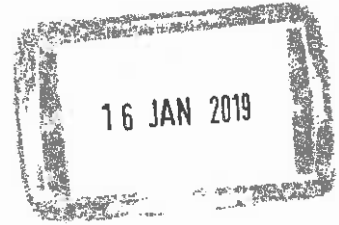


MF



M.D Fleming  
Senior Coroner  
City Courts  
The Tyrls  
Bradford  
BD1 1LA

Date: 15/1/2019

**IN CONFIDENCE**

Dear Mr Fleming,

**Re: Regulation Report on the Inquest Touching the Death of Ursula Niamh MacEochaigh Keogh – Action to Prevent Future Deaths**

Thank you for sending a copy of the above report, received on the 28<sup>th</sup> November 2018. We have carefully considered the three matters of concern raised with us and worked in partnership with Calderdale Council to agree a set of actions which we have attached as required.

Our response has been compiled in partnership with Calderdale Council's Children and Young People's senior managers and the CCG's clinical lead, [REDACTED] is also a GP member of our Governing Body.

A meeting was convened to produce the attached action plan which we trust will provide you with the necessary assurance that existing processes have been reviewed and revised with new actions identified to prevent future deaths occurring.

Provided below is a brief response to the three recommendations raised in your report. Please also see the attached action plan which sets out the existing and new actions identified.

1. **To review the current practice of referral by GP to the school for consideration as to the appropriateness of referral to CAMHS.**

The group reviewed the existing Child and Adolescent Mental Health Service (CAMHS) referral pathway for GPs and schools (copy enclosed). Following a comprehensive discussion, the group were satisfied with the accuracy of the process described. However, the review highlighted some gaps in respect of external training and education about the pathway which has resulted in the new actions set out in the attached.

2. **Consider improving communications between professionals, particularly health and education to eliminate contradictions offered in the advice.**



Chair | Dr Steven Cleasby  
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The group noted the widespread training and education programmes being delivered by services to key partners, parents and carers in Calderdale. However, it also recognised the importance of ongoing training, education and communication plans.

The multi-agency Open Mind Partnership (CAMHS) Steering Group will take ownership of the attached action plan. The Steering Group will monitor delivery against this plan at its monthly meeting, reporting into the CCG's Quality Committee.

**3. Consider the appropriateness of fast tracking the implementation of preventative measures currently under consideration at North Bridge Halifax**

A discussion has been held with Calderdale Council's Public Health Consultant (Lead for Mental Health) and a full response will be provided by Calderdale Council on this recommendation. Below is a summary of the response:

- A review was undertaken of North Bridge in January 2018 looking to prevent further suicides at this location.
- This outlined the need for installation of anti-climb mesh affixed to horizontal rails.
- A resolution was passed by the Council for an application for listed building consent and an application for planning permission is submitted to the Local Planning Authority.
- The listed building application has been approved and consent has now been granted with the works to be completed by the end of May 2019. The Council has also installed an additional CCTV camera to provide coverage of North Bridge.

We hope that the above, together with the enclosed action plan, demonstrates the seriousness with which we have viewed this case and ask that our sincere condolences be passed onto the family.

Yours sincerely,



Dr Matt Walsh  
Chief Officer  
Enc.

Chair | Dr Steven Cleasby  
Chief Officer | Dr Matt Walsh

