REGULATION 29 RESPONSE TO A REPORT ON ACTION TO PREVENT FUTURE DEATHS

Please do not include any living person names in this document, in accordance with the Chief Coroner's publication policy PDF.

THIS RESPONSE IS BEING SENT TO:

The Senior Coroner, Sonia Hayes for the Coroner Area Essex in response to a '**REPORT TO PREVENT FUTURE DEATH REGULATION 28**' following an investigation into the death of **Scotty Kenneth HENNIKER**, and an inquest that concluded on **04 March 2026**.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013,Essex County Council provides this response within 56 days of the date of the Report to Prevent Future Deaths or any extension granted.
2.	**DATE OF RESPONSE**
3.	**SUMMARY OF CORONER'S CONCERN** 1. Accurate of appropriate recording of information in social care records and in Child in Need Meeting Minutes 2. Accurate of appropriate recording of information in child mental health records and in formulation of risk assessments and care plans with up-to-date information 3. Accurate reporting and recording of concerns with appropriate communication of sharing of risk information between professionals in social care and mental health. 4. The Family and also Educational Outreach were raising concerns that Scotty's mental state and behaviour were deteriorating and that he posed a risk to himself such that this mirrored a previous episode where Scotty had attempted to take his life by hanging and was fortunate to survive.. These concerns were not appropriately recorded in the records and not shared between professionals. 5. Scotty was a child who had a significant history of trauma and had very complex needs. Educational Outreach had been one of the few constant features in Scotty's life and a place where as a child with Autism, he felt safe. There was a failure by social care to understand why there was no educational support over the summer holidays that had previously been provided for Scotty. The support was available, but there was no application then made for funding.

	6. In the final months of Scotty's life there was no transport to take Scotty to his educational support in term time that had previously been provided. This caused Scotty great distress and removed a significant support network for Scotty and a place that he felt safe. This compounded communication difficulties between the family and agencies required to support Scotty and shifted the focus away from him. 7. On 9 June 2023 at a mental health assessment with mental health nursing, Scotty had agreed to see a psychiatrist, and this was supported by his family. However, no appointment was provided. Instead, it was recorded that Scotty was not engaging. 8. Scotty had a previous history of suicide attempts and was closed to child mental health services on 2 August 2023 when there were still outstanding concerns about Scotty's risk to himself from April, May and June and then ongoing in August and September 2023. 9. The Family continued to raise concerns about Scotty's deterioration and were asking for a medical review and a change in his medication. The family were not informed that they could self-refer and were relying on social care to make the referral.
4.	**DETAILS OF ACTION TAKEN** Essex County Councils (ECC) involvement and statutory oversight were maintained throughout Scotty's involvement with Children's Services and practice reflected the procedures in place at the time. Oversight was not reduced when Scotty moved from being a Looked After Child to a Child in Need under a Supervision Order. The case transferred from the Children in Care Team to Family Support and Protection in March 2023, with regular social work visits, Child in Need reviews and independent reviewing officer involvement continuing throughout the period. ECC accepts that opportunities were missed when the family disengaged. From September 2023 Mr Henniker declined visits and engagement with Children's Services. While consultations and management oversight occurred, ECC acknowledges that, with hindsight, there should have been a more assertive safeguarding response, including an unannounced visit and stronger efforts to address the issues causing family stress, particularly education, transport, benefits and health concern. ECC acknowledges that there were systemic challenges in providing a coordinated therapeutic response to Scotty. Services for Scotty, who suffered with multiple interacting needs, were fragmented and not always sufficiently responsive. Multi-agency support was in place, including involvement from CAMHS, REACH, education and health professionals. Concerns about Scotty's emotional wellbeing were identified and referrals

	were made, including a request for consideration of a psychiatric assessment, although this was not subsequently offered by CAMHS. Essex County Council has reviewed the Coroner's concerns and has implemented a number of improvements to strengthen safeguarding practice. • **Information sharing and recording:** Guidance is being developed to improve recording of significant information, including partner agency communications and email correspondence. Service Managers now oversee evidence and disclosure requirements for inquests and legal proceedings. • **Mental health risk assessment:** A new mental health risk assessment framework and practice guidance are being developed, supported by a two-day training programme for practitioners. • **Transition and Supervision Order oversight:** A multi-agency Case Management Discussion (CMD) will be introduced which takes place within 4 weeks of a Supervision Order being granted and cases transfer between teams, ensuring court findings, risks and support needs are fully understood and reflected in plans. • **Support for neurodivergent children:** The Dynamic Support Register (DSR) launched in December 2023 provides multi-agency oversight and specialist support for autistic children and young people. Additional training in autism, neurodiversity and mental health has been rolled out across Children's Services. • **Non-engagement and missed appointments:** Practice has been strengthened so that reduced engagement is treated as a potential indicator of increased risk. Greater management oversight and, where appropriate, unannounced visits will be considered when concerns remain. • **Multi-agency learning:** Learning from the inquest has informed wider safeguarding developments, including improved escalation processes, continued use of "Of Concern" meetings, strengthened reflective supervision and enhanced multi-agency working for children with complex needs.
5.	**DETAILS OF FURTHER ACTION PROPOSED.** Essex County Council will continue to work with the Essex Safeguarding Children Board, Integrated Care Board, CAMHS and partner agencies to strengthen services for children with complex needs to implement the recommendations of the Child Safeguarding Practice Review. The following further actions are being taken: Improving escalation where risks increase: Clearer escalation routes will be implemented where concerns regarding education, transport, service access or disengagement may increase risk to a child. Workforce development: Ongoing training in mental health, neurodiversity, autism, communication and risk assessment will continue alongside strengthened reflective supervision arrangements for practitioners working with vulnerable children. In April 2026 the learning was presented to the Child Safeguarding Practice Working Group.

	These actions will continue to be overseen through Children's Services governance arrangements, the Mental Health Workstream and the Child Safeguarding Practice Review Working Group to ensure practice and learning is embedded and sustained.
6.	**SIGNATURE** 