RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS
REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

THIS RESPONSE IS BEING SENT TO:

Sonia Hayes, Area Coroner, for the coroner area of Essex in response to a 'REPORT TO PREVENT FUTURE DEATH REGULATION 28' following an inquest into the death of Scotty Henniker.

1.	**RESPONDENT** In line with our duty under Regulation 29 of the coroners (Investigations) Regulations 2013, [redacted], Chief Executive Nurse and Executive Lead for Patient Safety at North East London NHS Foundation Trust, provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths.
2.	**DATE OF RESPONSE** 10th September 2026
3.	**CONFIRMATION OF CORONER'S MATTERS OF CONCERN** The **MATTERS OF CONCERN** were identified in the report are as follows: *(1) Scotty was a Looked After Child for a significant period and his needs were complex such that it was not possible to find a placement in the community. Later Scotty returned home subject to conditions of an Interim Order made by the Court on 26 August 2022, and Scotty became a Child in Need. A final child arrangements order was made on 18 November 2022 with a 12-month Supervision Order. The conditions of a Supervision Order were then not being met:* *a. no joint care plan was made, as required, between social care and mental health services* *b. Scotty was not seen by any professional from 4 August 2023* *c. the family were reaching out for assistance and support and records incorrectly reflected that there was a lack of engagement and did not consider the omissions in care and treatment being complained of* *c. social care stated:* *i. they could not compel compliance with the Supervision Order, and* *ii. it was not appropriate to escalate this as the Order, was due to expire in the* *middle of November.*

The Educational Outreach Program who had provided specialised education support for Scotty in term time were not commissioned to provide support over the summer

(2) *holidays once Scotty transitioned from a Looked After Child to a Child in Need. There was no clear understanding of this transition issue by any organisation involved in the care of Scotty, until the Inquest hearing. This was never properly understood or explained to his Family and led to a significant breakdown in communication as this was interpreted as failure to provide care and there was no application for funding to provide this for Scotty thereafter. It was not escalated as a safeguarding concern when Family was raising concerns that they could not care for Scotty 24 hours a day without any respite. The Social Care response was to offer a carer in the family home, and this was not what was required. Scotty was entitled to educational provision.*

(3) *Scotty's Family raised concerns about struggling to care for Scotty and this was compounded by Scotty not having educational outreach over the summer holidays and then transport to attend during term time. The bulk of the responsibility for Scotty's complex needs was falling one parent alone when it was known and understood that no single person could meet these needs.*

(4) *Social Care escalated concerns to mental health that Scotty was at significant risk of a repeat of previous behaviour when he hanged himself in December 2021 but:*
   a. *did not share all of the details that had been received from educational outreach staff who knew Scotty well.*
   b. *escalated the lack of an urgent appointment to a named mental health nurse who provided advice on this case despite him:*
      i. *not having seen Scotty for 18 months*
      ii. *not having up-to-date case information, and*
      iii. *who had been previously removed from Scotty's case.*

   On 10 May 2023, this mental health nurse advised that the urgent referral was not required. There was no escalation to a senior manager.

(5) *No further information was provided or sought from Educational Outreach who were closely involved with Scotty and:*
   a. *with whom he and the family had a trusting relationship and*
   b. *who had been consistently involved in Scotty's care for several years.*

Evidence was heard that Scotty was one of the most complex children that organisation had dealt with. Educational Outreach were never invited to a mental health appointment or to a Professionals Meeting for Scotty to assist in communication.

(6) No Professionals Meetings were held to seek further information on concerns for Scotty's health, to undertake a risk assessment or make a plan for Scotty.

a. On 5 May 2023 Educational Outreach raised concerns with social care that:

i. Scotty's mood had dramatically changed
ii. he was sad in his appearance and was saying that he was depressed
iii. that his behaviour had deteriorated and he had become dysregulated at REACH
iv. that Scotty had hurt animals and was saying that he thought a family member did not love him
v. further that Scotty may do something extreme to win back his family member's affection and gain the attention of others as he had done in the past when he hanged himself
vi. Scotty had regressed further in his thinking and did not understand the concept of death

This referral to mental health services was chased by social care on 30 May 2023 as Scotty had done a drawing of "a stick man hanging" and left this drawing by his father's bed.

b. On 7 June2023, Educational Outreach again raised concerns that Scotty was hurting animals and that. Whilst Educational Outreach are not trained mental health nurses, they have significant experience of working with the most challenging and complex children and within their experience that Scotty was the most complex child they had under their care.

(7) On 14 June 2023 the request for psychiatry review was declined and that Scotty showed no symptoms of depression. Mental health services were reassured that as Scotty was going out that he was not depressed. There was no consideration that children with ADHD may not exhibit classic symptoms of depression and Scotty did not have a psychiatric review.

	(8) Scotty's Family continued to raise concerns that Scotty was not being seen by the correct professionals and wanted him to have a review and medication. This did not happen, and the Family were not provided with information that they could self-refer to mental health services despite several requests for Scotty to be provided with a medical review and medication as he was deteriorating. *(9) Scotty was never offered any adapted therapy as a child with Autism and ADHD where his cognitive understanding was lower than his chronological age.* *(10) It was incorrectly recorded that Scotty and his Family had refused to engage with services:* *a. Family had taken Scotty to all his appointments* *b. Engaged in Child in Need meetings* *c. Reported concerns about Scotty and deterioration in his mental health* *d. Requested appointments for a psychiatric review that were declined* *e. Explained barriers to engagement, that social care could not attend the family home from August 2023 until the educational provision problem had been resolved.*
4.	**DETAILS OF ACTIONS TAKEN and TO BE TAKEN** NELFT recognises the importance of the learning identified through this case and the concerns raised by the Coroner. Whilst several areas of concern expressed by HM Coroner fall outside the statutory and operational remit of SET CAMHS and rests with Social Care, Education or commissioning bodies, the Trust has reviewed HM Coroner's concerns from the perspective of its own services and has implemented, or is in the process of implementing, the following actions to strengthen multi-agency working, clinical decision-making, risk assessment, care planning and documentation. **Action 1: Implementation of Essex Multi-Agency Shared Care Plan** **Action Taken:** The Essex Multi-Agency Shared Care Plan has been introduced across services supporting children and young people with complex needs. The care plan requires all relevant agencies to contribute to and agree a shared formulation, identified risks, agreed actions and professional responsibilities.

Timescale: Initially piloted then implemented from 5 August 2024 and now embedded within practice.

Action 2: Strengthened Multi-Agency Risk Formulation and Professional Meetings

Action Taken:

SET CAMHS has adopted a structured risk formulation framework to support a shared understanding of risk across agencies. Guidance has been introduced requiring consideration of multi-agency professional meetings where significant concerns are raised by multiple agencies, where information differs between agencies, or where there is evidence of escalating risk.

Timescale: Guidance implemented in September 2025.

Action 3: Inclusion of Partner Agencies in Care Planning

Action Taken:

Clinical teams have embedded consideration of multi- agency professionals into assessments, reviews and planning processes. This has improved the incorporation of relevant information from those who know the young person well, supporting more comprehensive assessments, better-informed risk formulation and more coordinated multi-agency planning.

Timescale: Implemented within the practice since 5 August 2024.

Action 4: Improved Documentation of Clinical Reasoning and Decision-Making

Action Taken:

Enhanced documentation templates have been implemented to improve recording of:

- clinical formulation;
- consideration of risk;
- consultation and MDT discussions including requests for escalations and exploration of barriers to engagement;
- decisions regarding psychiatric review;

	Timescale: Implemented early 2025. **Action 5: Neurodiversity-Informed Mental Health Assessment** **Action Taken:** SET CAMHS has strengthened workforce development relating to Autism, ADHD, emotional regulation, masking and atypical presentations of mental health difficulties in neurodivergent children and young people, by way of tailored training programmes. This training has been added to the essential-to-role training matrix for SET CAMHS. **Timescale:** Training programme commenced in September 2025 and continues as essential-to-role training. **Action 6: Strengthening Consideration of Psychiatric and Prescribing Decisions** **Action Taken:** Prescribing and medication review pathways have been updated to provide greater clarity regarding psychiatrist involvement where psychotropic medication is being considered. MDT documentation now requires clear recording of psychiatric involvement. **Timescale:** Implemented mid-2025. **Action 7: Quality Assurance of Discharge Communication and Ongoing Support Arrangements** **Action Taken:** To provide assurance regarding the quality and consistency of discharge communications, a snapshot audit of a sample of closed cases from Risk Support and Getting More Help caseloads will be undertaken. The audit will review the quality of discharge letters, including the clarity of ongoing support arrangements, communication of risk-related information and evidence of multi-agency planning. Learning from the audit will be shared across the service to improve the quality of discharge letters.

	Timescale: The audit will be completed by January 2027 **Action 8: Interagency Communication to Inform Clinical Decision-Making** **Action Taken:** Clinical teams are now required to ensure that they incorporate information from relevant partner agencies when undertaking assessments and risk formulation for young people who are part of a wider multi-agency network. This ensures that decisions are informed by the most complete and current understanding of the young person's presentation, needs, risks and support arrangements. **Timescale:** In line with Actions 1 & 2, the practice was updated in August 2024 and September 2025 respectively **Action 9: Managing Complex Family Dynamics in Care Planning** **Action Taken:** A learning event for clinical and operational staff is planned for November 2026 to strengthen practice where relationships between professionals and families become strained or break down. Drawing on learning from this case, the event will include a focus on information gathering, documentation, professional curiosity and multi-agency decision-making in complex circumstances, ensuring that differing perspectives are considered appropriately and that staff are supported through the process. **Timescale:** Learning event to be completed by November 2026. **Action 10: Enhancement of Assessment and Formulation Training** **Action Taken:** In-house clinical training programmes have been revised to strengthen consideration of neurodivergent presentations within assessment, formulation, risk assessment and care planning. This learning has already been embedded within key training programmes, including Emotion Regulation and DBT-Informed Skills training from May 2025.

	In addition, the Initial Assessment and Formulation training programme has been updated to incorporate learning from this case, with a specific focus on recognising and responding to the impact of neurodevelopmental needs on presentation, engagement, formulation and intervention planning. Roll-out of the revised programme is scheduled for completion by January 2027. **Timescale:** Full implementation by January 2027. **Action 11: Strengthening the Management and Documentation of Complex Professional, Family and Engagement Dynamics** **Action Taken:** A service-wide learning event will be held in November 2026 to strengthen the management and documentation of fractured relationships between services, young people, families and professionals that may impact assessment, engagement, decision-making and care-planning. **Timescale:** To be implemented by the end of November 2026 **Action 12: Governance Oversight** **Action Taken:** The Trust's Patient Safety and Quality Governance structures will continue to oversee learning from this case. The Trust will review the effectiveness of the actions identified in this response. **Timescale:** Review to be completed by June 2027. **Conclusion** NELFT extends its sincere condolences to Scotty Henniker's family. The Trust has carefully considered the Coroner's concerns and is committed to ongoing learning and improvement. We believe the actions outlined above will strengthen multi-agency working, improve the sharing of information, enhance neurodiversity-informed assessment and risk formulation, and support more transparent and robust clinical decision-making for children and young people with complex needs.

6.	**SIGNATURE** 