REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex.
2.	**DATE OF REPORT** **17 JULY 2026**
3.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3.	**THIS REPORT IS BEING SENT TO** 1. Chief Executive Officer of Essex County Council 2. Chief Executive Officer of North-East London NHS Foundation Trust You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 September 2026. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**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.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 5 October 2023 an investigation was commenced into the death of Scotty HENNIKER, aged 14 years. The investigation concluded at the inquest on 4 March 2026. The conclusion of the inquest was Narrative: Scotty did not have the capacity to form an intent when he hanged himself on 24 September. Scotty's cognitive understanding was lower than his chronological age, and he did not understand the concept of death. Scotty was deemed high risk of harming himself in April 2023 and the specific risk factors and circumstances reported of Scotty's deteriorating mental health presentation were not fully shared by social care with mental health services. Scotty was not reviewed by a psychiatrist. Scotty was discharged by mental health services on 2 August 2023 with no treatment. A further family request for psychiatric assessment in August was not made to mental health services by social care and family were not informed they could self-refer. No professionals' meetings were arranged in the 12 months prior to Scotty's death and this contributed to Scotty's death.

	Medical cause of death of 1a Asphyxiation due to Hanging
8.	**CIRCUMSTANCES OF DEATH** Scotty Kenneth Henniker was found deceased hanged in his bedroom at home on 24 September 2023 and died of Asphyxiation due to Hanging. [redacted] in the early hours of 24 September and had been deceased for several hours prior to being found. Scotty was a child in need was under community social care. The conditions of a Supervision Order in the community were not being met in the months prior to Scotty's death. Scotty was not offered adapted cognitive behavioural therapy and was probably not taking his increased dose of ADHD medication for approximately 6 weeks prior to his death. Scotty was a complex child with a previous history of hanging himself and self-harm and he struggled with his mental health. Autism and ADHD made him impulsive and remained partially treated. Concerns were raised about a deterioration in Scotty's mood and a mental health referral for therapy and a psychiatric assessment was made at the end of April 2023 that was chased twice in May. Scotty had no further input from mental health services from 9 June and was discharged from children and adolescent mental health services on 2 August 2023. Information about Scotty hearing voices was not shared between the multiagency teams or explored in the nursing assessment on 9 June 2023. Scotty had agreed to see the psychiatrist, but no appointment was provided. Scotty had not been seen by any multi agency professional from 4 August, and no proper explanation was given about why his education provision transport was not being provided.
9.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (1) Scotty was a Looked After Child for a significant period of time 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. (2) The Educational Outreach Program who had provided specialised education support for Scotty in term time were not commissioned to provide support over the summer

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.

10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. Family (Parents of Scotty) 2. Care Quality Commission 3. REACH – Educational Outreach Program 4. East Suffolk & Norfolk NHS Foundation Trust I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
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