

Birmingham, Black Country and Solihull Integrated Care Board  
Civic Centre  
St Peters Square  
Wolverhampton  
West Midlands  
WV1 1SH

[REDACTED]

9<sup>th</sup> March 2026

Mr Zafar Siddique  
Senior Coroner for the Black Country

Dear Mr Siddique,

**Consolidated Response to Regulation 28 Report - In the Matter of the Death of Joshua Lee Allcock**

Following the inquest into the death of Joshua Lee Allcock and the subsequent Regulation 28 Prevention of Future Deaths Report, this submission provides a coordinated summary of the actions taken and learning implemented by partner agencies across the Walsall system.

This response incorporates the attached detailed submissions from:

- Birchills Health Centre
- Walsall Healthcare NHS Trust
- Walsall Metropolitan Borough Council

These responses collectively outline the actions already taken and the further measures being implemented to strengthen safeguarding, clinical assessment, and multi-agency oversight for children with complex needs.

First and foremost, all organisations wish to reiterate their deepest condolences to Joshua's family and carers following this tragic loss.

**Key Areas of Learning Identified**

Across the inquest findings and subsequent reviews, several themes for improvement were identified:

1. Recognition and Assessment of Complex Neurodevelopmental Needs

The inquest highlighted the challenges that can arise when a child presents with developmental delay, possible autism, and complex dietary behaviours, particularly when a formal diagnosis has not yet been established.

Evidence heard during the inquest also raised awareness of Avoidant Restrictive Food Intake Disorder (ARFID) and the potential risks associated with restrictive diets and dehydration in children with neurodevelopmental conditions.



## 2. Multi-agency Understanding of Health and Developmental Needs

There was learning across the system regarding the need for stronger multi-disciplinary coordination, particularly where multiple services are involved in supporting a child.

## 3. Recognition and Escalation where Children with Complex Needs may be at Risk

Learning was identified in relation to professional escalation where concerns exist about a child's health, diet, or development, even when a clear medical diagnosis has not yet been confirmed.

## 4. Clinical Assessment and Documentation

The importance of clear documentation and structured clinical assessment, particularly in relation to hydration status and dietary intake in young children, was highlighted.

### **Actions Taken by Individual Organisations:**

#### 1. Birchills Health Centre

The Practice would have welcomed the opportunity to attend the Inquest to give them an insight into the case and wider learning. Following the PFD notice Birchills Health Centre has undertaken internal clinical review and learning following Joshua's death.

Key actions include:

- Review of the case within clinical governance meetings and safeguarding discussions.
- Reinforcement of enhanced documentation standards, particularly around hydration assessment and fluid intake recording.
- Education for clinicians regarding assessment of dehydration in children, including recognition of early signs and use of appropriate clinical indicators.
- Increased awareness of ARFID and its association with autism and other neurodevelopmental conditions, with emphasis on maintaining a lower threshold for escalation to secondary care where concerns arise.
- Review and improvement of paediatric assessment equipment, including the purchase of additional paediatric blood pressure cuffs and oxygen saturation probes.
- Reinforcement of processes for obtaining additional clinical information when children newly register with the practice and historical records are not yet available.

These measures aim to strengthen the early identification of clinical risk and improve documentation and decision-making in primary care settings.

#### 2. Walsall Healthcare NHS Trust

Walsall Healthcare NHS Trust outlined the existing pathways used to assess children with developmental and neurodevelopmental concerns.

Key points include:

- The Trust has long-standing Under-5 clinical pathways designed to guide the assessment of young children presenting with developmental or behavioural concerns.
- A specialised autism assessment pathway, in place since 2016 and updated in 2023 and 2025, supports multi-disciplinary assessment of children suspected of having autism.



- The Trust recognises the wider concern raised regarding national guidance about the age at which autism can be reliably diagnosed and continues to operate local clinical pathways alongside national standards.
- The Trust is working collaboratively with partners across the Black Country Integrated Care System to ensure that learning from this case informs system-wide improvements.

### 3. Walsall Metropolitan Borough Council

Walsall Council undertook a comprehensive review following the both the Child Safeguarding Practice Review and the inquest findings.

A number of system improvements have been implemented within Children's Services and as part of the Multiagency learning identified from the Child Safeguarding Practice review

Key actions include:

#### Multi-Disciplinary Team (MDT) model

A new process has been introduced whereby Multi-Disciplinary Team meetings are convened for children with complex needs. These meetings provide a forum for shared professional analysis of a child's developmental, health and care needs and ensure coordinated planning across agencies.

MDTs are now standard practice and are particularly required:

- When children have complex health or developmental needs
- When there is uncertainty about diagnosis or support requirements
- Prior to children entering care to ensure carers receive appropriate information.

#### Strengthening safeguarding oversight

Due to Walsall being a Families First for Children Pathfinder pilot site, a Multi-Agency Child Protection Team has been established.

The scope and focus of these teams are to improve child protection practice, with a focus on:

- Developing a consistent network of professionals leading child protection practice, and knowledge of how to access advice and guidance
- Improved information-sharing and communication between agencies
- Shared reflective and analytical thinking
- Multi-agency decision-making throughout child protection processes
- Increasing expertise where this is needed

#### Improved information sharing

New protocols have been introduced to strengthen coordination between health services and social care where multiple professionals are involved with a child.

#### "Was Not Brought" safeguarding policy

A multi-agency policy is being developed to provide clear expectations and escalation pathways when children are not brought to health appointments which will align with local Safeguarding threshold documents.



## Training and workforce development

Training programmes for foster carers and social workers are being updated in 2026 to include:

- Understanding of ARFID
- Supporting children with autism and complex needs
- Enhanced safeguarding and neglect recognition.

## Safeguarding partnership response

In addition to the learning identified as part of the Coroner's Inquest it is also significant to note that a Child Safeguarding Practice Review was undertaken. The review is now published and identified learning for a number of agencies. Governance arrangements through the Walsall Safeguarding Children Partnership provide ongoing oversight of both the Multiagency Child Safeguarding Review action plan and individual agency action plans through performance monitoring and auditing.

These measures are intended to ensure that children with complex needs are safeguarded and receive coordinated and responsive support across agencies.

## **System-Wide Learning**

Across all organisations, the following key areas of learning have been recognised:

- Greater awareness of ARFID and restrictive eating behaviours
- The case has highlighted the importance of recognising restrictive eating behaviours associated with neurodevelopmental conditions and the associated risk of dehydration and malnutrition.
- Importance of multi-agency collaboration
- All agencies recognise that complex cases require earlier and stronger multi-disciplinary coordination, particularly where diagnosis remains uncertain.
- Strengthening escalation processes
- There is now greater emphasis on ensuring professionals escalate concerns where a child's presentation or needs are not fully understood.
- Improved communication between health and safeguarding partners
- New protocols and MDT processes aim to ensure that all professionals involved with a child share information effectively and develop a common understanding of risks.

## **Assurance Regarding Prevention of Future Deaths**

Partner organisations across the Walsall system are committed to learning from Joshua's death and ensuring that the changes described above reduce the risk of similar events occurring in the future.

Collectively, the actions undertaken provide assurance that:

- Clinicians are better supported to assess dehydration and complex feeding issues in children
- Professionals have improved understanding of ARFID and neurodevelopmental conditions
- Multi-agency decision-making structures are now strengthened
- Safeguarding systems provide stronger oversight of children with complex needs
- Training and policy improvements are being implemented across the workforce.



These changes are subject to ongoing governance, quality assurance, and audit through the Safeguarding Partnership and organisational governance structures to ensure sustained improvement.

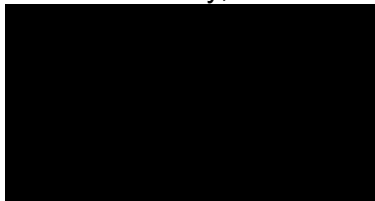
### **Conclusion**

Joshua's death was a deeply tragic event. All agencies involved remain committed to learning from this case and to strengthening partnership working so that children with complex needs are recognised earlier, supported appropriately, and protected from harm.

We trust that this consolidated response provides assurance regarding the actions taken and the system-wide learning that has occurred following the inquest.

Should the Court require any further information or clarification, we would be pleased to provide it.

Yours sincerely,



Chief Nurse/Clinical & Quality Officer  
Birmingham, Black Country and Solihull (Cluster) Integrated Care Board  
SRO for Black Country Local Maternity and Neonatal System

On behalf of the Walsall Safeguarding Partnership Organisations

### Attachments

- Birchills Health Centre – Regulation 28 Response (5 March 2026)
- Walsall Healthcare NHS Trust – Regulation 28 Response (23 February 2026) – includes Under 5's multiagency ASD assessment process and Walsall Child Development service autism diagnostic pathway.
- Walsall Metropolitan Borough Council – Regulation 28 Response (3 March 2026)

CC:  Chief Nursing Officer, Walsall Healthcare NHS Trust  
 Director of Children's Services, Walsall Metropolitan Borough Council

