

## Walsall MBC - PFD (JA) response to Coroner

1. Walsall Metropolitan Borough Council (the local authority) acknowledges the concerns identified by the coroner and the Regulation 28 Report of the coroner following the inquest for Joshua Allcock.
2. These concerns relate specifically to a lack of formal diagnosis of autism for Joshua, and that this meant there was a subsequent lack of specialist understanding of his needs, and the likelihood that he experienced a condition known as Avoidant Restrictive Food Intake Disorder (ARFID). The coroner invites all agencies to review guidance and approaches to assessing the needs of children with complex medical needs.
3. The local authority accepts these points and consistently strives to develop learning and practices.
4. An Action Plan was provided to the inquest setting out the learning and actions from the local authority undertaken following the Child Safeguarding Practice Review for Joshua (WS15 Children's Services Action Plan). This document is provided alongside this response to offer a detailed overview of learning and changes made (Appendix A).
5. With regards to the diagnosis of autism, Joshua had been assessed by the Walsall Child Development Centre when he was 3 years old. That assessment concluded that Joshua had Global Developmental Delay, and showed traits of autism, but a diagnosis was not given at this time.
6. Joshua's needs and dietary intake required specialist assessment and oversight. Joshua was not diagnosed nor understood to have the condition ARFID. This understanding was provided by medical experts after his death.
7. It is recognised that all professionals should have had a greater focus on understanding Joshua's complex health and dietary needs. There should have been an escalation of professional oversight where it was considered there were gaps in understanding a child's needs, and/or providing appropriate support to them.
8. A new process of Multi-Disciplinary Team (MDT) meetings has been put in place for children with complex needs. These meetings should be held to identify a shared professional analysis of children's needs, and progress actions required for assessment and support. MDTs occur in addition to multi-agency monthly Child in Need and Child Protection meetings. They are focused on understanding health and developmental needs, especially when there are specific complexities and/or challenges. An MDT policy and toolkit has been developed and launched with partners, with refresher training provided to local authority practitioners last year. All Team Managers and more experienced social workers who would work with a child with Joshua's needs have undertaken this training. MDTs should be held as frequently as required, but with clear outcomes and expectations on professional networks of actions to assess children's needs and enhance support as required.
9. MDTs for Joshua would have enabled a specific focus on his health and development, and on what the developmental delay he experienced meant for him in respect of his everyday care, assessments and specific interventions or actions required. This would include multi-agency consideration of any advice or support that

had been provided. This serves as a more focused consideration of developmental needs and delay, and strategies to support a child and their family, which sits alongside a more holistic consideration of a Child in Need Meeting or Child Protection Core Group. An MDT would have helped to highlight the need for a diagnosis of autism given this was the condition his family and professionals felt he had, given his presentation and the actions required to achieve this.

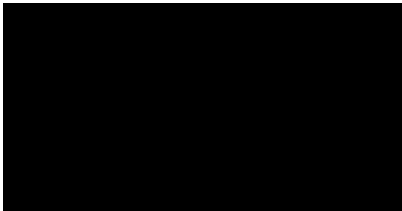
10. It is now standard practice that an MDT should be convened by the local authority prior to a child entering care. This is significant for Home Finding Referrals to find the right home for a child when they enter care, and the Placement Planning process, where a meeting held to make sure carers have the right information to care for a child. The use of MDTs was identified as part of the WS15 Children's Social Care Action Plan, and this is now in place and consistently used.
11. Quality assurance activity is undertaken to understand and improve practice, and to monitor the use and impact of policy and practice changes. The support for children with complex needs has been subject to multi-agency auditing through the Walsall Safeguarding Children's Partnership, and internal local authority practice learning. This has shown that MDTs are now consistently used.
12. Children's services have reinforced expectations that placement planning for children with known or suspected complex health or dietary needs must include clear, written information for carers with explicit guidance on escalation should concerns arise. This oversight is applied to all children who enter care from senior managers through the local authority Legal Gateway Panel where these decisions are made, and locality area managers then oversee the implementation of these recommendations.
13. A key challenge for Joshua was that he often was not brought to health appointments. This was a part of the pattern of neglectful care he experienced, and the significant harm that resulted from this. This impacted on understanding and assessing his health and development needs. The local authority has shared information across the workforce about existing Was Not Brought health policies. A Multi Agency task and finish group was stood up following the recommendations of the Safeguarding Practice Review in order to develop a Was Not Bought Policy a draft has been developed.
14. The neglectful care that Joshua experienced was subject to oversight and review, and this continues to be an area of focus. Neglect is one for the key priorities for the Walsall Safeguarding Children's Partnership. The WS15 Children's Social Care Action Plan sets out key areas for training and development to continue to enhance social care practice where children experience neglect.
15. Walsall Council has been a Pathfinder for national Children's Social Care reform in the Families First for Children programme. There is an emphasis in these reforms on multi-agency working and identifying and meeting children's needs at the earliest opportunity. New processes and ways of working have been introduced and are subject to ongoing evaluation. This has demonstrated a positive impact to date, including external oversight from industry regulator Ofsted. This work includes children with the most complex of needs and their families. There has been strong partnership involvement in this reform programme at a strategic and operational level.

16. A key strand of these reforms has been the establishment of a Multi-Agency Child Protection Team. This is to further enhance practice where there are child protection concerns for a child. The Multi-Agency Child Protection Team includes additional oversight of experienced professionals, mechanisms for improved information-sharing and professional collaboration, and a process to provide swift escalation and multi-agency oversight for decision-making.
17. The local authority supports early diagnosis of autism where this is appropriate and is committed to multi-agency working to identify and assess health needs early for children, especially those with complex needs. An understanding of Joshua's autism and the likelihood that he experienced ARFID, would have brought to the fore a different understanding of how to support his dietary needs. In particular, this would have meant understanding his highly restrictive diet and working with this condition, and professionals would have been attentive to the importance of consistency when he came into care at a point when everything in his life changed. The local authority will continue to work with safeguarding partners to ensure that learning regarding autism, ARFID and the risk of dehydration is shared across agencies.
18. The Safeguarding Partnership hosted a reflective discussion with strategic safeguarding leaders to consider the learning from the Safeguarding Practice Review alongside the findings from the Inquest. This was to consider how to further incorporate learning in the Safeguarding Practice learning review following what was further understood from the Inquest.
19. The significance of ARFID was brought out in the inquest for Joshua, this condition and its impact is being incorporated into mandatory training for social workers and foster carers on working with disabled children and those with complex needs. Mandatory service workshops will also be used to share learning about ARFID and autism, so all social workers and carers understand this condition. These workshops will cover all practitioners working in Children's Social Care and will be completed by May 2026.
20. The training provided to foster carers has also been reviewed, with a specific focus on supporting children with autism and special educational needs. This training is being updated to include ARFID and will be rolled out as a part of the mandatory training for all foster carers, to cover all local authority carers across 2026.
21. Joshua's death was a tragedy of the greatest magnitude. Walsall Council is committed to working with our partners to learn and continue to improve our practice and responses to children with complex needs and their families. Further work is being undertaken specifically focused on developing multi-agency practice and specialist knowledge for these children. Joshua's needs were complex and unique, however it is the responsibility of professional systems to work together to assess, meet children's needs as early as possible, and to navigate challenging circumstances such as in child protection contexts.
22. The local authority is committed to learning from this tragic death and to working collaboratively with partner agencies to reduce the risks of similar death in the future. The Walsall Safeguarding Children's Partnership has robust governance arrangements in place in respect of all Action Plans, incorporating the WS15 Child Safeguarding Practice Review Action Plan. This includes reporting to the

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Performance and Quality Assurance Group who audit and sample work with children and families, and actions to improve practice and systems. This work is then subsequently overseen by the Safeguarding Partnership Leadership Group, and any issues are reported to the Safeguarding Partnership Executive Leadership Team.

23. We trust that this response addresses the matters raised within the Regulation 28 report and remain open to providing any further clarification the coroner may require.



**Date: 03/03/2026**

**Director Children's Social Care  
Walsall Council**

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	Identified Learning	Action	Responsible Lead	Completion Date	Progress/update
1.	The partnership should seek assurance that the GCP2 tool is understood and used by professionals where neglect is considered to be a feature	Neglect is one of 4 Safeguarding Partnership priorities and Neglect Steering Group to provide oversight of use of NSPCC GCP2 tool across the Safeguarding Partnership	Director for Partnerships – Neglect Steering Group	April 2024	Neglect Steering Group established, meets monthly, and oversees uptake GCP2 training
		Neglect Lead role established to drive GCP2 training and neglect practice improvement and training	Director for Partnerships	April 2024	Neglect Lead post established and recruited to – LC
		GCP2 training delivered across Children’s Social Care managers and practitioners	LC and Principal SW	April 2025	114 staff trained in GCP2  Continued rollout of training – all staff to be trained by end of March 2026
		Multi-Agency Child Protection Team and Lead Child Protection Practitioners to oversee practice working with families where neglect occurs (inc. all CP enquiries and Plans)	Group Manager for MACPT	January 2025	MACPT pilot operational. Lead Child Protection Practitioner role established and now used 3 of 4 localities  Full rollout due by April 2026

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2.	The partnership should consider the development of a multi-agency “Was Not Brought” policy which makes clear the roles and responsibilities of all professionals in the safeguarding system when a child is not brought to a medical appointment and includes consideration of how this corresponds to the thresholds for social care intervention	Contribute to development of “Was Not Brought” policy, and ensure this is shared to all managers and practitioners in CSC	Head of Safeguarding Partnership Business Unit	In progress	Policy in development developed by Safeguarding Partnership, including representatives from Children’s Social Care
3.	The partnership should facilitate a discussion between children’s services and health leads to identify the most appropriate way to coordinate the sharing of information across the health system and into a child’s plan. This is particularly important when multiple health professionals are involved in supporting a child with complex needs	Multi-disciplinary Team Meetings to be held in addition to Core Group Meetings where there are identified specific health and developmental needs.	Head of Service Family Safeguarding	April 2023	Multi-agency protocol in place. This is now standard practice, it is reviewed through monthly audits and now subject to the enhanced oversight of the Multi-Agency Child Protection Team
4.	The partnership should seek assurance from children’s social care that there are	Additional training provided to Team Managers and Child Protection Conference Chairs on	Principal SW	September 2025	Programme of management training delivered through the Practice Leadership Programme

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	appropriate mechanisms in place to scrutinise the length of time a child is subject to a child protection plan to avoid delays in taking prompt action to address the concerns	Supervision and oversight of CP Plans			and during Service Development Days. Programme of training completed in September 2025
		Midway Review process reviewed and development work with CP Chairs	Group Manager for Safeguarding and Review	September 2025	Process reviewed and updated, shared to all CP Chairs
		Safeguarding Partnership FAST Escalation process reviewed and shared across to all managers and practitioners in CSC	Principal SW	February 2024	Process reviewed and updated, shared across communication channels by February 2024
		Multi-Agency Child Protection Team pilot established to enhance information-sharing and escalation where there are gaps in information	Group Manager for MACPT	January 2025	MACPT pilot operational  Full rollout due by April 2026
		Multi-Agency Child Protection Team and Lead Child Protection Practitioners to oversee CP Plans, with multi-agency review after 12 months of a CP Plan. The Neglect Lead joins all reviews where neglect is a feature	Group Manager for MACPT	January 2025	MACPT pilot operational  Full rollout due by April 2026

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		Strats – LCPPs to oversee and stay involved			
5.	Multi-agency chronologies should be used where children experience neglect to develop a holistic analysis of their needs and any gaps in accessing support and services	Chronologies training delivered across CSC	Principal SW	March 2025	Chronology training delivered to all practitioners in the Family Safeguarding Service
		Multi-agency chronologies to be used for all children where there are CP enquiries	Head of Service Family Safeguarding	March 2025	This is now a practice standard, it is reviewed through monthly audits and the oversight of the Multi-Agency Child Protection Team
6.	Enhance direct work skills to capture the voice of disabled children and children with developmental delay	The Disabled Children and Young Person’s Team will co-work with the Family Safeguarding Team where a child has significant developmental delay	Head of Service Family Safeguarding	April 2023	This is now a practice standard, it is reviewed through monthly audits and now subject to the enhanced oversight of the Multi-Agency Child Protection Team
		Consultant Social Worker role established – 1 per locality – to provide guidance and guidance to practitioners including direct work skills	Principal SW	January 2024	Role established and all CSW post recruited to
		Direct work training is delivered to all practitioners in Children’s Social Care, including training on	Principal SW	September 2023	Ongoing rolling programme for all practitioners, and this is

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		communicating with disabled children and children experiencing developmental delay			mandatory requirement for all practitioners
7.	Ensure that all health professionals are invited to Child Protection Core Groups	Communication to all managers and practitioners, reinforced in service and team meetings	Head of Service Family Safeguarding	April 2023	Briefings held and information shared through all communication channels
		New protocol implemented with 0-19 Health Service to provide overview of children's health needs	Head of Service Family Safeguarding	April 2025, reviewed August 2025	Protocol in place. This has been reviewed to enhance coordination and streamline process  Further review due January 2026
8.	When placing children in foster care with developmental delay needs, there should be additional support provided to understand and meet needs	Multi-disciplinary Team Meetings to be held where a child is experiencing developmental delay. If there is not sufficient clarity on a child's needs the escalation processes outlined elsewhere here	Head of Service Family Safeguarding	April 2023	Multi-agency protocol in place. This is now standard practice, it is reviewed through monthly audits and now subject to the enhanced oversight of the Multi-Agency Child Protection Team
		The Disabled Children and Young Person's Team will co-work with the Family Safeguarding Team where a child has significant developmental delay	Head of Service Family Safeguarding	April 2023	This is now standard practice, it is reviewed through monthly audits and now subject to the enhanced oversight of the Multi-Agency Child Protection Team

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9.	Make sure that parent's voices are heard and respected	A new Parental Advocacy Service has been established, with parents to be offered support from a representative from a local community organisation	Head of Service Family Safeguarding	September 2025	Offer established and available to all families – to be considered prior to all CP Conferences
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