REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, Walsall Healthcare NHS Trust** **2. Chief Executive, Walsall Local Authority** **3. NHS England (Reg 28 Reports) -email address** [redacted] **4. Practice Manager, Birchill's Health Centre**
1	**CORONER** I am Mr Zafar Siddique, Senior Coroner for the Black Country.
2	**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 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	**INVESTIGATION and INQUEST** On 12 July 2025, I commenced an investigation into the death of the child, Joshua Lee Allcock, born on the 7 March 2017, who died on the 3 January 2023. The investigation concluded at the end of the inquest on 5 December 2025. The inquest was heard before me and the conclusion at inquest was a narrative conclusion: The deceased died from severe dehydration due to limited fluid intake. This was exacerbated by his conditions of autism and Avoidant Restrictive food intake disorder (ARFID). The medical cause of Joshua's death was recorded as: 1a Cerebral Venous Infarction, Brain Swelling and Coning 1b Dural Sinovenous Thrombosis 1c Dehydration with Hypernatraemia
4	1. Joshua Lee Allcock was a 5-year-old boy with complex medical needs. He had suspected autism although this was never formally diagnosed. He would only drink milk and had a limited diet. As a consequence, he was diagnosed with anaemia. 2. After concerns were raised about his mother looking after Joshua, due to missed appointments with health professionals, attending school and her illicit drug use. Joshua was placed into the care of foster parents on the 21 December 2022 after a risk assessment by Walsall Local authority and care proceedings. 3. The foster parents were presented at the time with inadequate information about his dietary needs and were encouraged to try different foods and liquids including fruit juice as part of his diet.

	4. However, Joshua was reluctant to eat and drink these alternatives and continued to drink milk. Over the course of the week, he developed dehydration and was admitted to Walsall Manor Hospital on the 25 December 2022 but later discharged when he didn't at that time present with acute dehydration. 5. He was also seen by a GP on the 28 December 2022, but again his examination did not detect dehydration which was a potential missed opportunity for earlier intervention. 6. By the 29 December 2022 he was readmitted to Walsall Manor Hospital and was severely dehydrated. His condition declined rapidly, and he was transferred to Birmingham Children's Hospital. Despite intensive treatment he died on the 3 January 2023.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters 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. During the course of the inquest, I heard evidence from health professionals from the Hospital Trust, Local authority service providers and an expert, Paediatric Nephrologist. 2. My concern is that Joshua was never formally diagnosed with Autism and there appears to be nationally, a variation in practice before an assessment for autism can be made. Some areas specify 3 years of age or above but there is no clear national guidance. 3. Regrettably, without a formal diagnosis of autism being made, there was no onward referral to dieticians with experience of autism and therefore an understanding of the link between autism and Avoidant restrictive food intake disorder (ARFID). 4. In addition, I heard expert evidence that Joshua's death wasn't an isolated incident and another autistic child died in very similar circumstances by developing dehydration. 5. The expert evidence also indicated that the Capillary Refill Time (CRT) test used to assess dehydration by checking peripheral blood flow is a very insensitive test and can provide misleading reassurance. Therefore, my concern is that young children with similar circumstances to Joshua maybe at risk when assessing levels of dehydration. NHS England may wish to consider reviewing their guidance for health professionals. 6. In summary, all the agencies involved in Joshua's care, may wish to consider reviewing your guidance and approach for assessing children with complex medical needs of autism and ARFID.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE**

	You are under a duty to respond to this report within 56 days of the date of this report, namely by 6 March 2026. I, the coroner, may extend the period. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Family. I am also under a duty to send a copy of your response to the Chief Coroner, and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**Mr Zafar Siddique** **Senior Coroner** **Black Country Area** **7 January 2026**