PROVIDER RESPONSE TO REPORT MADE UNDER PARAGRAPH 7, SCHEDULE 5 OF THE CORONERS AND JUSTICE ACT 2009

IN THE MATTER OF AN INVESTIGATION INTO THE DEATH OF DERRICK FREDERICK TULLY (DECEASED)

29 April 2025

SERVICE USER: Derrick Frederick Tully (Deceased)
NHS Number: [redacted]
Date service Ended: 22 February 2024

1. Overview

This report constitutes the formal response of Daryel Care pursuant to its duty under Paragraph 7(1) of Schedule 5 to the Coroners and Justice Act 2009 and Regulation 28 of the coroners (Investigations) Regulations 2013. It addresses the matters of concern raised in the Prevention of Future Deaths (PFD) report issued by HM Assistant Coroner Melanie Sarah Lee dated 28 March 2025, following the conclusion of the inquest into the death of Mr Derrick Frederick Tully.

Daryel Care provided time-limited home support to Mr Tully from 2 February 2024 to 22 February 2024 under the framework of the Islington Local Authority's 'Take Home and Settle' (THS) pilot project. This project aimed to facilitate timely hospital discharge through short-term, flexible care packages delivered by community providers, operating within a multi-agency framework involving Islington Council, Whittington Health NHS Trust (including Rapid Response and Reablement services), and the Integrated Discharge Service. Decision-making regarding care pathways and clinical oversight involved multiple stakeholders, as fundamental in the pilot's design.

Daryel care approaches its duty to respond with the utmost seriousness and is committed to learning, transparency, and the continuous improvement of its services to ensure the safety and well-being of all service users.

2. Coroner's Concern

Daryel Care & Islington Adult Social Services: On 20 February Derrick suffered a fall. Severe bruising and swelling developed on his face over the following days but this was not recorded in his care notes by his care workers and not escalated until his daughter raised concerns on 24 February. "No Concerns" was written in Derrick's care record and no consideration given to whether he needed to be reviewed by a doctor.

Daryel Care has undertaken a thorough internal review, examining all contemporary electronic care records (held on the CM2000 system), communication logs, incident reports, and relevant email correspondence pertaining to Mr Tully's care during the period 2 February 2024 to 22 February 2024. Our response addresses each element of the concern based on this evidence.

3. Response to Specific Elements of the Concern

a. Recording of the Fall Incident (20 February 2024)

The assertion that the fall incident was "not recorded" is factually incorrect based on Daryel Care's existing records. The electronic care note entry for the visit commencing at 19:00 hrs on 20 February 2024, logged at 19:04 hours, explicitly documents the following: "The carer observed Mr Tully upon arrival with a fresh plaster wrap and wound dressing on his scalp. Mr Tully informed the carer he had sustained an injury from a fall. The carer

immediately contacted Mr Tully's daughter via telephone for clarification. The daughter confirmed Mr Tully had fallen near a local shop, had been transported to hospital via ambulance, received treatment for his wound, and had subsequently been discharged home shortly before the carer's visit." This record confirms the incident was documented promptly by the attending care worker and the office team.

b. Escalation of the Fall Incident (20 February 2024)

The assertion that the incident was "not escalated until his daughter raised concerns on 24 February" is factually incorrect. At 22:33 hrs on 20 February 2024, approximately three hours after the incident was recorded by the carer, a Daryel Care Care-coordinator sent an escalation email detailing the head injury incident. This email was addressed to key professionals within the multi-disciplinary team (MDT), including the Specialist Domiciliary Pharmacy Technician (Islington Reablement Service, Whittington Health/Islington Council), the Single Point of Access (SPOA), and the Rapid Response team contact. This documented email demonstrates timely and appropriate escalation to the relevant health and social care professionals responsible for Mr Tully's wider care coordination and clinical oversight, in line with multi-agency working practices of the THS pilot.

c. Recording of Developing Injury Presentation (21 – 22 February 2024)

The PFD report states that "Severe bruising and swelling developed on his face over the following days but this was not recorded". On 21 February 2024 (11:18 hrs), the care worker noted Mr Tully was "having some pains due to the injury on his head." On 22 February 2024 (11:16 hrs), the care worker observed and recorded that the "injury on the head has made his eye to be swollen." These entries demonstrate that Daryel Care staff did continue to observe and document the presentation of the injury, including pain and the subsequent development of facial swelling, during their visits on the days following the initial incident. Daryel Care acknowledges the importance of detailed descriptions of injury progression, particularly evolving bruising and swelling. While observations were recorded, we recognise that greater specificity regarding the extent and nature of the swelling could have enhanced the record. This is addressed further under Section 5 (Actions Taken).

d. Reference to "No Concerns" Entry

The PFD report states, ""'No concerns" was written in Derrick's care record". Daryel Care utilises the CM2000 electronic care monitoring and recording system for all care worker visit notes. A review of all CM2000 electronic care notes logged by Daryel Care staff for Mr Tully between 20 February 2024 and the final visit on 22 February 2024 has been conducted. This comprehensive review has not located any entry made by a Daryel Care staff member within the CM2000 system during this period that contains the phrase "No concerns" or substantively similar wording used in an inappropriate context (i.e., as an overall assessment negating the known head injury). All located notes contain specific details pertinent to the care provided and observations made, including the entries regarding the head injury referenced above. Daryel Care acknowledges the information presented by HM Assistant Coroner regarding this entry. However, as we can find no record of such an entry within our official electronic care recording system attributable to our staff during the relevant timeframe, we are unable to comment definitively on its origin or intended context. It is possible the reference pertains to records held in a different recording format outside of Daryel Care's CM2000 system.

e. Consideration of Medical Review

The PFD report raises concern that "no consideration given to whether he needed to be reviewed by a doctor." Daryel Care staff were operating within a complex multi-agency framework where clinical oversight, particularly post-discharge and concerning medication, was understood to be led by the Whittington Health Rapid Response team. The decision-making process regarding further medical review by Daryel Care staff considered the following factors: Firstly, Mr Tully had been assessed and treated at the hospital A&E department immediately following his fall on 20 February and was discharged home. Additionally, Daryel Care had formally escalated the head injury to the MDT (including Rapid Response) on the evening of 20 February. Observations during visits on 21 and 22 February recorded pain (on the 21st) and a swollen eye (on the 22nd). The existing records do not note the presence of additional 'red flag' indicators that would typically trigger an immediate, separate medical re-escalation, such as reported loss of consciousness, significant confusion beyond baseline, vomiting, seizure activity, or sudden deterioration in mobility or responsiveness. Furthermore, on 22 February, Mr Tully was

recorded as being alert and engaging with his daughter. It is also worth noting that on 21 February, following an MDT discussion during which Mr Tully's case was presented, confirmation was received that the Daryel Care THS package would end after the evening visit on 22 February, with care transferring to the Reablement service. Staff were aware that the handover was imminent. Therefore, based on these factors, the prior A&E review, existing escalation to MDT, absence of acute red flags during Daryel Care visits, and the imminent planned handover of care, Daryel Care staff continued observational monitoring as documented, anticipating review by the ongoing clinical teams. Daryel Care acknowledges that the basis for not seeking a further, immediate medical review beyond the initial escalation could have been more explicitly documented within the care notes. This aspect of reflective practice and documentation is addressed under Section 5 (Actions Taken).

4. Summary of Findings (Daryel Care Perspective)

- The fall incident and head injury on 20 February was promptly recorded in the electronic care notes and escalated appropriately via email to the multi-agency team within approximately three hours.
- Subsequent care notes demonstrate ongoing observation and recording of the injury's presentation, including pain and developing facial swelling, during visits on 21 and 22 February.
- A review of Daryel Care's electronic records (CM2000) did not locate the "No concerns" entry referenced by the coroner as having been made by Daryel Care staff during the relevant period.
- Consideration regarding further medical review was informed by Mr Tully's recent A&E assessment, the existing escalation to the MDT (Rapid Response), the absence of acute red flags during Daryel Care visits, and the imminent planned cessation of the Daryel Care package.
- Daryel Care's involvement ceased as planned on the evening of 22 February 2024, following the commissioner-led decision communicated on 21 February 2024.

5. Actions Taken and Proposed Further Action

Daryel Care is committed to learning from this incident and has taken and proposes the following actions to mitigate the risk of future similar occurrences:

Action	Responsibility	Target Date	Status
Mandatory refresher training delivered to all care staff on Falls, Head Injury Recognition, Recording, and Escalation Protocols.	Training Coordinator, Registered Manager	March 2024	Completed
Enhance digital photographic injury upload capability (with explicit client consent obtained according to policy) to supplement written descriptions in care notes.	Registered Manager, Deputy Care Manager, Care Coordinator, Field Care Supervisors, All Care Workers	30 June 2025	Scheduled
Update care documentation guidelines and training to include structured prompts reinforcing the need for detailed descriptions of injury evolution (e.g., bruising, swelling extent/colour) across visits, and explicit recording of the rationale when a decision is made not to escalate further after initial reporting.	Registered Manager, Training Coordinator	31 May 2025	Scheduled
Reinforce understanding of roles, responsibilities, and escalation pathways within multi-agency frameworks like THS during staff supervisions, staff and stakeholder meetings.	Registered Manager, Deputy Care Manager, Care Coordinators, Field Care Supervisors	Ongoing	Ongoing

6. Lessons Learned

- The importance of detailed, objective descriptions of injury development (particularly bruising/swelling) over subsequent visits, beyond initial recording, is vital. Training and documentation prompts must reinforce this.
- Care staff must be supported and trained to clearly document not only their observations but also the rationale behind their decisions regarding escalation or non-escalation, particularly following an initial incident report.
- While inherent in pilot schemes, this case underscores the critical need for absolute clarity regarding the designated clinical lead and specific communication procedures for ongoing condition monitoring versus acute escalation, especially during short-term transitional care packages. This must be clearly understood by all providers, service users, and families from the outset.

7. Conclusion

Daryel Care extends its sincere condolences to the family of Mr Tully. We acknowledge the concerns raised by HM Assistant Coroner Lee and have sought to address them fully and transparently based on the evidence available within our records. We submit that the evidence demonstrates Daryel Care staff acted promptly to record and escalate the initial incident on 20 February 2024 and continued to monitor Mr Tully's condition during the subsequent two days of the short-term package. We have addressed the specific points regarding record-keeping and the "No Concerns" entry based on the documented evidence. Daryel Care is committed to robust safeguarding practices and continuous improvement. We believe the actions already taken, along with those proposed as a result of lessons learned from this case, will strengthen our service delivery and documentation practices, thereby mitigating the risks identified within our sphere of operation. Daryel Care remains committed to working collaboratively with Islington Council, Healthcare providers, and other partners to ensure the safe and effective delivery of care. We are available to provide any further information required.

[redacted]
Safeguarding Officer, acting for Daryel Care