



Regulation 28: Prevention of Future Deaths report

Derrick Frederick Tully (died 20 March 2024)

	<p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. Islington Council2. Daryel Care3. Integrated Community Aging Team, Whittington Health
1	<p>CORONER</p> <p>I am: Melanie Sarah Lee Assistant Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 3 April 2024 an investigation was commenced into the death of Derrick Frederick Tully, age 61 years. The investigation concluded at the end of the inquest on 19 March 2025. Derrick's cause of death was 1a. acute traumatic right-sided subdural haemorrhage, 2. anticoagulant therapy, ischaemic coronary heart disease, hypertensive heart disease, status post aortic aneurysm repair (2008; 2021). I made a determination at inquest of accident.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Derrick Frederick Tully was found deceased at his home address on the evening of 20 March 2024. He had suffered a massive traumatic subdural haemorrhage. He'd been suffering from falls in the months leading up to his death following a decline in his health and diagnosis of vascular dementia in October 2023. He had background history that included strokes in 2016 and 2021 which left him with weakness and dysphasia. He also had hypertension, chronic kidney disease, repaired aortic aneurysms, and paranoid disorder.</p>

	<p>From February 2023 Derrick had been living in temporary accommodation following a homeless application. After a mental health crisis in-patient admission in May 2023, he declined rapidly.</p> <p>From at least January 2024, Derrick began suffering multiple falls and was getting muddled with his medication. In February 2024 the rapid response team raised concerns about him with his GP and suggested that he required supported housing. His case was discussed at integrated network MDT meetings.</p> <p>Derrick had a very supportive family but they were also providing care to their terminally ill mother. On the day that Derrick was found deceased, carers had been unable to contact him in the morning or the evening. They had no way of accessing his accommodation if he didn't answer.</p>
5	<p>CORONER'S CONCERNS</p> <p>During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur unless action is taken. In the circumstances, it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows.</p> <p>Islington Housing Options</p> <p>Derrick was provided with a wheeled walker to reduce the risk of falls. Although's Derrick's temporary accommodation was ground floor, there were steps down from the building to street level and he was thus unable to manoeuvre the walker out of the property. Despite a social care letter of support, outlining concerns that his current accommodation was unsuitable and detailing Derrick's health problems, the housing options team did not award him any medical points.</p> <p>Derrick required carers twice a day. He was also given a pendant alarm for emergencies. However, no key safe was installed meaning that even in an emergency, neither carers nor emergency services could gain entry to his flat. This was raised repeatedly by his family, carers and other professionals.</p> <p>Islington Adult Social Services</p> <p>On discharge from hospital on 3 February 2024 following a fall, Derrick was provided with a good package of care. On 23 February this changed to a reablement package. Derrick was not suitable for reablement because of his declining cognition and progressive dementia. The occupational therapist raised concerns that he was not suitable for reablement for these reasons and because there were no rehabilitation goals. There was an over-reliance on Derrick's self-reporting which was inaccurate given his memory problems, and a</p>

	<p>focus on him doing more for himself. He began losing weight because he was not eating, and he was not able to cope with self-care.</p> <p>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 carers 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.</p> <p>Integrated Community Aging Team, Whittington Health Following MDT meetings due to concerns over Derrick’s increasing deterioration and ability to cope with his own care needs, the Integrated Community Aging Team reviewed him on 6 March. They discharged him from the service on 12 March because he did not want to engage with their home assessment of him. Derrick was suffering from cognitive impairment as a result of previous strokes and newly diagnosed dementia. He also had a mental health history and was paranoid. This was compounded by problems he’d experienced with neighbours and cuckooing concerns meaning that at times, he didn’t feel safe at home. It does not appear that these were factored into his inability to engage with the team.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion, action should be taken to prevent future deaths and I believe that you and your organisation have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 23 May 2025. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the following.</p> <ul style="list-style-type: none"> • Family of Derrick Frederick Tully • CCH Group • HHJ Alexia Durran, the Chief Coroner of England & Wales

	<p>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.</p> <p>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.</p>		
9	<table border="0"><tr><td data-bbox="304 633 766 824">DATE 28 March 2025</td><td data-bbox="766 633 1350 824">SIGNED BY ASSISTANT CORONER </td></tr></table>	DATE 28 March 2025	SIGNED BY ASSISTANT CORONER 
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