# Regulation 28: Prevention of Future Deaths report

## Helen COOGAN (died 18.10.22)

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| | **THIS REPORT IS BEING SENT TO:**<br><br>**1. [redacted]**<br>**Ritchie Street Group Practice**<br>**34 Ritchie Street**<br>**London N1 0DG** |
| 1 | **CORONER**<br><br>I am: Coroner ME Hassell<br>Senior Coroner<br>Inner North London<br>St Pancras Coroner's Court<br>Camley Street<br>London N1C 4PP |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and<br>The Coroners (Investigations) Regulations 2013, regulations 28 and 29. |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 27 October 2022, I commenced an investigation into the death of Helen Coogan aged 77 years. The investigation concluded at the end of the inquest earlier today. I made a determination at inquest as follows.<br><br>"Helen Coogan died in October 2022 from a natural cause, being cancer. She first sought advice from her general practitioner regarding related symptoms in July 2022, but there was no result from the qFIT (faecal immunochemical test) ordered." |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>The medical cause of death was:<br>1a sudden cardiac death<br>1b metastatic neuroendocrine carcinoma of the ileocaecal valve and coronary artery atheroma |

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| | 2 chronic obstructive pulmonary disease, hypertension and atrial fibrillation |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows.<br><br>You provided a statement regarding the care given to Ms Coogan by you and your colleagues at the Ritchie Street Group Practice. In it, you said that she reported to Dr [redacted] in July 2022 that she had had abdominal cramps present for months, with alternating loose stool and constipation. You said that a qFIT tool test for blood was requested but there was no subsequent result. You said the same about the qFIT requested on 13 September 2022.<br><br>It was not clear to me why there were no qFIT results but, given the cause of Ms Coogan's death, that seems to me to be a matter worthy of your investigation, particularly in case there is some system issue. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 July 2023. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the following.<br><br>• [redacted], children of Helen Coogan<br>• HHJ Thomas Teague QC, the Chief Coroner of England & Wales |

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| | 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.<br><br>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 | **DATE** **SIGNED BY SENIOR CORONER**<br><br>04.05.23 *ME Hassell* |