Coroner Service
West Sussex, Brighton & Hove

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Sussex Partnership NHS Foundation Trust** **2 NHS Sussex**
1	**CORONER** I am Joanne ANDREWS, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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.
3	**INVESTIGATION and INQUEST** On 08 March 2023 I commenced an investigation into the death of Margaret Kagure Pauline REECE aged 39. The investigation concluded at the end of the inquest on 12 May 2025. The conclusion of the inquest was that: Margaret Kagure Pauline Reece died on 7 March 2023 at [redacted], Shoreham-by-Sea, West Sussex having been found hanging at her home address.
4	**CIRCUMSTANCES OF THE DEATH** Margaret Kagure Pauline Reece attended her GP on 13 February 2023 in a state of extreme distress reporting suicidal ideation without intent. Due to her distress her GP prescribed her 2mgs PRN Diazepam in the form of 12 tablets which would last her for 2 days at the maximum dosage. The GP also issued a deferred prescription for collection on 16 February of the same amount. Her GP at that time referred her for a mental health assessment by Sussex Partnership NHS Foundation Trust. The Court heard that it was the GP's intention that Mrs Reece would be seen by the Mental Health services prior to the end of the Diazepam prescription. On 17 February 2023 Mrs Reece was seen by the Mental Health Team who were concerned about her use of Diazepam due to its risk of dependency and as such decided that she should be weaned from Diazepam and started on an increasing dose of Quetiapine. A GP Medication Letter was handwritten by the Associate Specialist that and sent to the GP which detailed the actions which the Doctor had determined should be taken by the GP to achieve the titration of medication for Mrs Reece. This was not received by the GP surgery and no explanation can be provided as to why this was. This was the only document which detailed the role which the GP was being

	asked to perform in relation to the reduction of the Diazepam. A letter was also sent by Sussex Partnership NHS Foundation Trust on the same day to the GP with the outcome of the assessment of Mrs Reece which was received. This detailed that there was a plan for the reduction of Diazepam and introduction of Quetiapine but no information was given as to how this should be done or what was expected of the GP in that process. This letter was received by the GP on 18 February 2023. The GP in their evidence stated that they assumed that Mrs Reece had been given instructions as to how to reduce the Diazepam. Mrs Reece requested further Diazepam from the GP on 21 February. The GP was aware of the letter from Sussex Partnership NHS Foundation Trust and as such gave a limited prescription of 2mgs Diazepam which, if taken at maximum dose, amounted to a further 2 days. Mrs Reece was sent a text by the GP requesting that she make an appointment to check on her titration of Diazepam in 2 weeks' time. On 28 February 2023 Mrs Reece was seen by Sussex Partnership NHS Foundation Trust and found to be in withdrawal from Diazepam having last taken Diazepam on 24 February when she ran out. She had contacted 111 over that weekend to obtain a prescription but had been unable to do so. She was issued with a prescription for Diazepam by the Psychiatrist that day. This was a prescription for the doses which had been set in the GP Medication Letter of 17 February 2023 to titrate Mrs Reece's medications. In the course of the evidence, the Court heard that whilst Sussex Partnership NHS Foundation Trust have access to Plexus and thus a limited amount of information from the GP surgeries there is no reciprocal arrangement in place so as to enable GPs to understand the prescriptions which have been issued for their patients or to check that they have instructions on medications which they are or are not supervising for the Mental Health Services. The Court heard that the NHS England project for sharing of information was in progress but in the interim, and no date was given as to when this would be completed, the position remains as it was at the time that Mrs Reece died.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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 that in the absence of information being made available to the GP there is a risk that patients will not receive any medication or receive excessive amounts of medication due to the risk of duplicitous prescribing.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have 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 July 08, 2025. 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 **The family of Mrs Reece** **Northbourne Medical Centre** [redacted] 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 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 by the Chief Coroner.
9	Dated: 13/05/2025 J. Andrews Joanne ANDREWS Area Coroner for West Sussex, Brighton and Hove