INQUEST OF ERIKA FRANCIS

REGULATION 28 REPORT .

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Devon Partnership NHS Trust**
1	**CORONER** I am Deborah Archer , Area Coroner, for the coroner area of The County of Devon , Plymouth and Torbay .
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 26th March 2021 I commenced an investigation into the death of 36 year old Erika Francis. The investigation concluded at the end of the inquest on 5th August 2023 . In Box 3 , the circumstances of the death were recorded as follows : **The deceased, who was experiencing a deterioration in her mental health and was involved in a domestically abusive relationship, died as a result of an overdose of amisulpride. The overdose was taken shortly before she contacted the police by way of a non-emergency email. The deceased was not discovered until approximately 30 hours later and was pronounced dead on 20 March 2021**. The Conclusion of the inquest was a Narrative one : **The deceased died as a result of an overdose of amisulpride tablets. It has not been possible to determine her intention or state of mind at the time the tablets were taken.**
4	**CIRCUMSTANCES OF THE DEATH** Erika Francis died on 20 March 2021. She suffered from fibromyalgia, which meant that she was often in physical pain. She also suffered from depression and

	anxiety and had diagnoses of Emotionally Unstable Personality Disorder and psychosis. At the time of her death, she was prescribed medication, including the antipsychotic amisulpride. Erika had previously been discharged from the Community Mental Health Team. However, from around December 2020 until the date of her death, she experienced a deterioration in her mental health. During this period, she contacted the police on 7 January, 22 February, 10 March and 19 March 2021. Tragically, on the final occasion, namely 19 March 2021, she sent an email to the police in which she stated that she had taken an overdose of [redacted] amisulpride tablets. As this was sent to a non-emergency email address, it was not read by police staff until approximately 30 hours later, by which time Erika had sadly been found deceased. Erika had been in a domestically abusive relationship. Evidence of this included a Domestic Violence Protection Order made in June 2020 and a subsequent breach of that order in July 2020. Although there was no evidence of a coercive and controlling relationship between the couple, nor any evidence that the perpetrator was at the property or had contacted Erika after he had been required by police to leave her address on 15 March 2021, the inquest found that the abusive relationship contributed to Erika's state of mind at the time of her death. Although the inquest did not find that the actions or omissions of any single agency caused or contributed to Erika's death, it did consider issues relating to training within the police, the GP surgery and Devon Partnership NHS Trust. In particular, consideration was given to the need for bespoke training regarding the link between domestic abuse and suicide, as explained in evidence to the court by [redacted]
5	**<u>CORONER'S CONCERNS</u>** 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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) Devon Partnership NHS Trust staff had not received detailed training on domestic abuse and its significance for patients and service users experiencing domestic abuse. (2) Although there appeared to be evidence that training in relation to domestic abuse was being developed or planned, it did not appear to be sufficiently comprehensive, readily accessible to all staff, or focused on the particular challenges of identifying domestic abuse in patients with mental ill health. Nor did it adequately address the established links between domestic abuse, homicide and suicide. (3) Recent Domestic Homicide Reviews undertaken in Devon had identified shortcomings in professionals' understanding and recognition of domestic abuse, and had highlighted the importance of improved training and awareness across agencies.

	(4) There remains a need for training to assist professionals in identifying the effects that domestic abuse may have on patients and service users with mental health conditions, including how domestic abuse may present, the barriers to disclosure, and the increased risks of self-harm and suicide associated with such experiences .
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 8th October 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 [redacted] Pembroke Medical Group , Devon and Cornwall Constabulary. I have also sent it to [NAMED PERSON] who may find it useful or of interest. 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	**12TH AUGUST 2026** **DEBORAH ARCHER**