	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Deputy Chief Constable [redacted], Durham Constabulary** **2. Chief Executive Officer of the College of Policing, [redacted]**
1	**CORONER** I am Rebecca Sutton, assistant coroner, for the coroner area of County Durham and Darlington.
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 7 January 2025 an investigation into the death of Sophie Ann Louise Cotton, 24 was commenced. The investigation concluded at the end of the inquest on 23 May 2025. The conclusion of the inquest was suicide, the medical cause of death being pressure on the neck due to hanging.
4	CIRCUMSTANCES OF THE DEATH The Deceased had a long history of mental health problems. These came to the fore in late 2024. The Deceased was under the care of mental health services both in the community and, for a short period of time, as a voluntary in-patient on a psychiatric ward. On 6 January 2025 the Deceased was due to attend an important meeting and when she did not turn up for that meeting there was serious concern for her welfare. Four calls were made to the police that day to request that they attend the Deceased's home address to check on her welfare. However, due to the "Right Care, Right Person" assessment, the police refused to attend. The first call was made by a social worker at 15:46, expressing concerns that: 1. The Deceased had not attended family contact with her children, which was very out of the ordinary. 2. There was no reply at the Deceased's home address, but the Deceased's dog was present inside. 3. The Deceased's phone was switched off. 4. None of the Deceased's family had a key to the property. 5. The Deceased had a history of mental health problems and had attempted suicide on numerous occasions. The "Right Care Right Person" decision was no. The social worker was advised by the call handler to ring the ambulance service. The call handler also said that they would speak to their supervisor for the decision to be reviewed. The second call was made by the Deceased's mother at 16:38. The call was made on the 999 number. The call handler asked the Deceased's mother if the Deceased had made a threat of suicide today and when the Deceased's mother said that she hadn't, the call handler advised the Deceased's mother to call back on 101. It was acknowledged at the inquest that it was not best practice to have asked the caller to call back on 101. The third call was made by the Deceased's mother (on the 101 number) at 16:44, expressing concerns that: 1. The Deceased had a history of mental ill-health and suicide attempts.

	2. The Deceased was mean to attend family contact time that day and hadn't. The Deceased never missed family contact time. 3. No one had spoken to the Deceased since Saturday (4 January 2025). 4. Family had attended the house and the Deceased was not answering the door, but the dog was inside and the Deceased would not usually leave the dog alone for that long. 5. The same lights had been on in the property since Saturday (4 January 2025) and the deceased did not usually leave the lights on., 6. A chewed up teddy bear could be seen on the living room floor and the Deceased would not normally leave a chewed up teddy bear on the floor for fear that it would choke the dog. 7. The Deceased's phone was going straight to voicemail. 8. To the direct question of was there a real an immediate risk to the Deceased's life the Deceased's mother said yes, because the police have had to cut the deceased down before from previous suicide attempts. 9. The Deceased's mother informed the call handler of the police also attending suicide attempts at the train lines. 10. The Deceased had recently been reading court papers, which can cause her to spiral downwards. 11. The Deceased had previously attempted suicide with no warning The "Right Care Right Person" decision was no. The Deceased's mother was advised to call the Mental health Crisis team or NHS 111. The Deceased's mother said that the social worker had already contacted mental health services and that the social worker had advised the Deceased's mother to call the police to see if they could do a welfare check. The call handler said that the "Right Care, Right Person" decision was still no, but the decision would be reviewed by supervision. The fourth call was made by a social worker at 16:57, expressing concerns that: 1. The Deceased was vulnerable and over the past six months had attempted to end her life many times. 2. The Deceased was due to attend family contact time and had not turned up and she would never miss family contact time and this was really concerning. 3. The family had attended the Deceased's address and the dog was barking inside, but there was no sign of the Deceased. 4. The lack of contact was unusual, as often the Deceased would cry out for help and contact the Crisis team. 5. The police had had to break the door down previously to get in to cut the deceased down. The call handler said that she could not confirm if a welfare check would be done. Very shortly after this the Deceased's family forced entry into the Deceased's home address, and found the Deceased hanging by a ligature [redacted].
5	**CORONER'S CONCERNS** 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. – (1) During the 16:44 call, by following the "Right Care, Right Person" procedure there was a refusal to the request that the police attend, even when a family member was expressing the view that there was a real and immediate risk to life. (2) During the 16:44 call the "Right Care, Right Person" advice to contact mental health services appears to have disregarded the fact that the mental health crisis team do not have the power to enter locked premises and so would require police attendance to facilitate entry to the premises. (3) During the 16:57 call there was no decision for police to attend, even though this was the third caller (and second professional caller) that had expressed serious concerns

	about the Deceased. (4) Although there is a procedure in place to have a negative “Right Care, Right Person” decision reviewed by a supervisor, this causes additional delay in circumstances when attendance could be extremely time-sensitive.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or your organisations 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 23 July 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: [redacted] (Mother of the Deceased) [redacted] (Legal representative of Durham Constabulary) I am also under a duty to send the Chief Coroner a copy of your response. 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	**DATE: 27.05.25**  **Rebecca Sutton, Assistant Coroner for County Durham and Darlington**