

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. The Chief Constable Devon & Cornwall Police
1	CORONER I am Mrs Joanne Lees Area Coroner for the coroner area of The Black Country.
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. https://www.legislation.gov.uk/ukpga/2009/25/schedule/5 https://www.legislation.gov.uk/uksi/2013/1629/part/7
3	INVESTIGATION and INQUEST On 27/5/25 I commenced an investigation into the death of STUART MARTIN FOWKES aged 35 years who died on 26/05/2025. The investigation concluded at the end of the inquest on 30/9/2025. The conclusion of the inquest was SUICIDE .
4	CIRCUMSTANCES OF THE DEATH STUART MARTIN FOWKES resided in the Black Country at 195 Foxdale Drive Brierley Hill. On the late evening of 25/5/25 he travelled to his Mothers address in Cornwall after an incident involving his ex-partner. Whilst at his Mothers address, he reported to her that he [REDACTED] was suicidal. He was also likely under the influence of alcohol. After approximately 2 hours, he left the address and travelled out of Devon & Cornwall Police Area and travelled back to the West Midlands and was picked up on ANPR cameras heading towards Birmingham at 08:09 on 26/5/25. He was placed as wanted on PNC at 08:25. He was later confirmed as being in Birmingham by his Mother at approximately 13:00 pm. WMP attended Mr Fowke's home address later that evening in response to a concern for safety reported by Mr Fowkes's ex-partner. Mr Fowkes vehicle was parked outside of the address. Police Officers have knocked the door, enquiries have been made at local hospitals, police custody in addition to neighbours spoken to, multiple calls and messages sent. A decision was been made to force entry to the address, Mr Fowkes was located [REDACTED] [REDACTED] with a ligature [REDACTED]. DCP had a recorded log entry ref [REDACTED] of a domestic and suicidal report made to DCP by Mr Fowkes's Mother on 26/5/25 timed at 00:52.
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. – (1) DCP had a recorded log entry ref [REDACTED] of a domestic and suicidal report made to DCP by Mr Fowkes's Mother on 26/5/25 timed at 00:52. Coronial enquiries elicited a response from a PC [REDACTED] who confirmed the details of that report being from [REDACTED] (Mother of the deceased) who lives in Devon and Cornwall area. She reported her adult son Stuart Fowkes, born 17/6/89 had left her property in a vehicle whilst in drink and suicidal. Prior to leaving, Fowkes had been shouting and swearing at his mum [REDACTED] and whilst close to her, threatened to put his fist in her face. She said she couldn't stop him leaving as she thought he was going to hurt her. He had told her that if he hadn't come down to see her tonight, he would have gone to B and Q and [REDACTED] harm himself. (2) DCP recorded a second reference to Mr Fowkes being suicidal under the same reference [REDACTED] at 00:56 and 01:17 including further information that Mr Fowkes is suicidal and that his father committed suicide 8 years ago in Birmingham. (3) DCP had recorded a known risk to Mr Fowke's life. (4) DCP appear to have been aware of Mr Fowke's risk of suicide in the early hours of 26 May 2025. (5) WMP conducted an internal investigation which revealed that no risk to Mr Fowke's life was shared with West Midlands Police by Devon and Cornwall Police. WMP reported that based on information from DCP, Mr Fowkes was wanted for drink driving and domestic abuse offences. By the time Mr Fowke's ex-partner raised a concern for his safety and made reference to suicide it is likely Mr Fowkes was already deceased.
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 19/12/25. 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] 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	20/10/25 