

# CORONERS COURT OF SOUTH AUSTRALIA

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## INQUEST INTO THE DEATH OF WAYNE LINCOLN FOWLES

[2025] SACC 1

**Inquest Findings of his Honour State Coroner Whittle**

**6 March 2025**

### CORONIAL INQUEST

Examination of the cause and circumstances of the death of Wayne Lincoln Fowles, a 59-year-old man subject to an inpatient treatment order who, without authority, left his open acute psychiatric treatment ward and was found two days later hanging in scrubland. The inquest examined the circumstances of Mr Fowles' detention under the inpatient treatment order, the appropriateness of his hospital care and the adequacy of the police search.

Held:

1. Wayne Lincoln Fowles, aged 59 years of Huntfield Heights, died at Huntfield Heights on 19 October 2021 as a result of hanging.
2. Circumstances of death as set out in these findings.

No recommendations made.

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**Counsel Assisting: MR M KIRBY**

**Hearing Date/s: 24/10/2024**

**Inquest No: 39/2024**

**File No/s: 2295/2021**

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**INQUEST INTO THE DEATH OF  
WAYNE LINCOLN FOWLES  
[2025] SACC 1**

**Introduction and cause of death**

- 1 Wayne Lincoln Fowles was born on 4 July 1962 and was 59 years of age at the time of his death.
- 2 Mr Fowles was an inpatient at the Morier Ward, Noarlunga Hospital, subject to a level 1 inpatient treatment order (ITO) issued under the Mental Health Act 2009. On 19 October 2021 he left the ward without authority and was reported as missing. After an extensive search he was found on 21 October 2021 in scrubland hanging from a tree by a length of wire.
- 3 Professor Roger Byard, a senior specialist forensic pathologist at Forensic Science SA, undertook a CT scan and external examination of Mr Fowles' body and expressed the cause of his death as 'hanging', which I find to have been the cause of death.

**Mandatory Inquest**

- 4 Due to Mr Fowles' detention under the inpatient treatment order, his death was a death in custody, as defined in the Coroners Act 2003, requiring a mandatory inquest, which proceeded by affidavit only.

**Background**

- 5 Mr Fowles came from an established Blewitt Springs family. His parents were Ron and Doris Fowles. His siblings are Desmond, Kenneth, Steven and Sue. Mr Fowles was warmly regarded amongst his siblings and extended family. He lived on a small acreage in a house next door to his parents' old house at Blewitt Springs.
- 6 A friend of Mr Fowles, Sheila Phopo, provided investigating police with some other background information. Ms Phopo did not provide an affidavit, but through information she provided to police,<sup>1</sup> and Mr Fowles provided later to hospital staff, I am aware that Mr Fowles had been doing casual gardening work, working two to three days a week, relying on word-of-mouth for jobs. He was a very private person but had a group of friends. He did not drink alcohol. He had never married and had no children. He was a keen cyclist and was physically fit. Ms Phopo suggested that Mr Fowles, at least towards the end of this life, was living a somewhat emotionally isolated life.

**Mental health decline**

- 7 On 10 October 2021 Ms Phopo attended Mr Fowles' home for a barbeque that he had organised the day before. Mr Fowles appeared unwell and seemed to have forgotten

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<sup>1</sup> See Exhibit C11

that he had organised the barbeque. Ms Phopo was concerned for Mr Fowles' mental health and convinced him to call Beyond Blue. She then heard him on the phone speaking of feeling depressed and not wanting to be in his house anymore.

- 8 The next day Ms Phopo returned to Mr Fowles' home, taking him dinner, which they ate together. Still concerned for his mental health she tried to convince him to see a doctor, but he refused. They spoke again the next day and Mr Fowles admitted that he was not doing well and said he might have to stop working. They arranged for Mr Fowles to drive to Ms Phopo's house the next day so that they would go together to the Flinders Medical Centre (FMC).

### **Flinders Medical Centre**

- 9 On 13 October 2021 Mr Fowles went with Ms Phopo to the FMC and waited several hours before being seen. Mr Fowles attempted to leave several times but Ms Phopo convinced him to stay.
- 10 Case notes from the FMC<sup>2</sup> record that Mr Fowles was admitted to the Emergency Department (ED) at 3:44pm.
- 11 He was admitted as a voluntary patient at the mental health short stay unit at 9pm and at 9:31pm a registered nurse conducted an assessment which included a mental state examination. It was noted he had presented with malaise, poor concentration, poor sleep and loneliness, and generally feeling depressed. Collateral history was obtained from Ms Phopo, who was concerned that he lived alone and had minimal supports. He denied suicidal ideation, although he had earlier expressed passive thoughts to an ED doctor. He was noted as having difficulty engaging in the assessment and appearing guarded. He said he had been slowly going downhill over the last month or so. It is noted that some negotiation was required for Mr Fowles to agree to stay in the unit, but after a few minutes of reassurance he agreed to stay. He was subject to 15-minute observations for two hours and then an hourly visual check. He was given lorazepam and olanzapine.
- 12 Ms Phopo left at about 11pm, from which time Mr Fowles was observed to be asleep.
- 13 The next day Mr Fowles was reviewed by a doctor who prepared a plan, with Mr Fowles' agreement, for a four-day voluntary admission. During that time, if he wished to self-discharge, nursing staff were to organise a medical review to assess his mental state and risks and discuss with the on-call consultant. Medications were prescribed, a referral to the Community Mental Health Team was to occur, hospital staff were to continue to liaise with Ms Phopo, and Mr Fowles was encouraged to engage with a general practitioner.
- 14 Concerns about Mr Fowles' deteriorating mental state arose when, with the agreement of clinicians, Ms Phopo accompanied Mr Fowles home to collect some belongings and she reported back about what happened while they were out. Mr Fowles exhibited a

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<sup>2</sup> Exhibit C19

high level of agitation, drove erratically, could not organise himself to gather up some clothes and accused Ms Phopo of stealing from him. She reported that he really did not want to stay in hospital and did not believe he needed to be there. The extent of his anger and unsafe driving led Ms Phopo to express the fear that he would harm himself in the community.

- 15 Resident Medical Officer Dr Bishop discussed Mr Fowles with consultant psychiatrist Associate Professor Dhillon, who suggested an inpatient treatment order in a closed ward. Dr Bishop recorded a diagnostic impression of major depression with psychotic features (paranoia, irritability, disorganisation). Mr Fowles was assessed as a very high absconding risk. Dr Bishop assessed upon examination that Mr Fowles met the criteria for the issue of a level 1 ITO pursuant to section 21(1) of the Mental Health Act 2009, namely that he had a mental illness; that because of the mental illness he required treatment for his own protection from mental or physical harm (including harm involved in the continuation or deterioration of his condition) or for the protection of others from harm; that he had impaired decision-making capacity relating to the treatment of his mental illness; and there was no less restrictive means than an ITO of ensuring appropriate treatment of his illness.
- 16 The ITO was made at 1:30pm on 14 October 2021 and was to expire at 2pm on a business day not later than seven days after the order was made, unless varied or revoked. As required, Dr Bishop arranged for Mr Fowles to be examined by a psychiatrist or authorised practitioner within 24 hours, or as soon as practicable thereafter.
- 17 I find that the level 1 inpatient treatment order was lawfully and properly imposed.

### **Noarlunga Hospital, Morier Ward HDU**

- 18 In accordance with his treatment plan, Mr Fowles was transferred from the FMC mental health short stay unit to the High Dependency Unit (HDU) of the Morier Ward at the Noarlunga Hospital. The HDU is a closed ward comprising four beds of the Morier 20-bed adult acute inpatient psychiatric ward, with two patients per nurse. Patients in the HDU have access to an internal courtyard but are not permitted to smoke. Leave from the hospital is generally not permitted from the HDU, which is designed as a low stimulus environment. The open ward, comprising 16 beds, has a nursing ratio of four patients per nurse. Patients have access to the external garden and an area for smoking cigarettes. Leave from the open ward is negotiated on an individual basis, depending on clinical need.<sup>3</sup>
- 19 On 15 October 2021 at 12:55pm Mr Fowles was reviewed by the Morier treating team, including psychiatry registrar Dr Woo and consultant psychiatrist Dr Budd, who confirmed the level 1 ITO, which was to expire on 21 October. At the time of this assessment Mr Fowles accepted he was not 100% well and had had suicidal thoughts, which he said was something new for him. He denied any active intent or plans to act

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<sup>3</sup> Exhibit C7 - Statement of Head of Unit Dr Heidi Newton

on these thoughts, citing the potential impact this would have on his friends as a reason he would not do so. He also said he appreciated the beauty of the world.

20 Dr Budd's diagnostic impression was of a major depressive disorder in a single older male, exacerbated by social isolation and possible schizoid personality traits, which tend to be isolative and avoidant of social contact by temperament. A differential diagnosis was recorded of early dementia.

21 I find that the confirmation of the level 1 ITO was lawful and appropriate.

22 Mr Fowles' treatment plan included:

- containment in HDU with a plan for a supported transition to the open ward;
- stabilisation of diet;
- observation on the ward;
- provision of prescribed medication;
- referral to psychology;
- provision with printed information and encouragement regarding taking the antidepressant mirtazapine, to commence the following week if indicated;
- occupational therapy assessment when required;
- complete organic screen including CT head scan, and cognitive screening tests;
- liaise with designated friends.

23 Mr Fowles was prescribed lorazepam and olanzapine for agitation, paracetamol for pain and lorazepam injections for severe agitation.

24 Blood tests were undertaken and disclosed no significant abnormalities. A CT brain scan showed no intracranial pathology and an MRI brain scan was requested, but did not occur before Mr Fowles absconded from the hospital.

25 On 16 October 2021 Mr Fowles was reviewed by Dr Jonathon Brailey<sup>4</sup> who was then a psychiatric registrar and is now a psychiatry consultant. The purpose of the review was to follow-up on the documented plan from the previous day in order to determine whether it was clinically appropriate for Mr Fowles to transfer from the HDU to the open ward.

26 Before attending Mr Fowles, Dr Brailey reviewed Dr Budd's assessment from the previous day and noted that he had spent some time in the open ward on a trial basis. Nursing staff told Dr Brailey that there had been no significant management problems with Mr Fowles overnight and that he had been cooperative.

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<sup>4</sup> Exhibit C6

- 27 Upon review, Dr Brailey found Mr Fowles to be calm and polite. His speech was soft and hesitant, and he was generally vague in his responses. Dr Brailey observed no clear psychotic symptoms. Mr Fowles admitted to having experienced suicidal ideation but not in the past 24 hours. Dr Brailey was not certain of the diagnosis, but suspected Mr Fowles was suffering from major depression. Dr Brailey states that Mr Fowles was agreeable to remain an inpatient in the hospital, understood the limitations imposed upon by him by the ITO and agreed to remain on the ward if he was transitioned to the open ward. He agreed to talk to the nurses if he found himself thinking about suicide and agreed to continue with treatment.
- 28 Dr Brailey concluded that the least restrictive way to reasonably manage Mr Fowles at that time was on the open ward, under the continuing ITO, with no leave from the ward permitted, and no changes to his medication. As a result, Mr Fowles was transferred to the open ward at 12:15pm on 16 October 2021. Dr Brailey had nothing further to do with Mr Fowles' admission.
- 29 Dr Heidi Newton,<sup>5</sup> the Head of Unit at Morier Ward, explained in her affidavit that patients commonly commence their hospital treatment in the HDU because this allows closer observation and is a safer, more controlled space. Most often they spend just a few days in this area and then moved to the open ward if their behaviour is settled or does not require high levels of nursing care. Most patients spend most or all of their hospital admission on open wards even when they are quite significantly unwell.
- 30 I find that the decision to transition Mr Fowles to the open ward was appropriate.

### **Morier open ward**

- 31 On 17 October 2021 Mr Fowles was seen to be pacing the corridors and at times to be perplexed and vague in behaviour. He would pack and unpack his bag, once carrying it in the common area, but complying without complaint with a request to return it to his room. He said he did not want to be there and felt locked up. He was noted by the nightshift nurse to be lying on his bed clothed and later standing in the toilet in the dark. He accepted 5mg of olanzapine at 2am and settled to sleep.
- 32 Due to his night-time behaviour, nursing staff initiated 30-minute visual observations (increased from the routine of 60-minute) to more closely monitor Mr Fowles' mental state. A medical review was also requested and undertaken by Dr Woo. During the day he was appearing perplexed and disorganised, packing and repacking his belongings and expressing anxiety about his admission. Lorazepam and olanzapine were noted to have good effect as he became calmer and less distressed.
- 33 On 18 October 2021, Mr Fowles was reviewed by Dr Budd who considered his symptoms to be consistent with depression so he was commenced on mirtazapine at night, which generally takes two to four weeks to have a significant effect on a person's mood. He expressed no active suicidal ideation, intent or plan.

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<sup>5</sup> Exhibit C7

- 34 Cognitive screening suggested mild cognitive impairment with deficit in short-term memory, executive function and inhibitory control, but in the light of Mr Fowles' reluctance to have an MRI of his brain, it was agreed to wait until his response to the new antidepressant could be assessed.
- 35 On 19 October 2021 he had an inpatient psychology review with psychologist Mr Loset, who agreed to stop the session when Mr Fowles quickly became confused.
- 36 During the day Mr Fowles was compliant with all nursing interventions, observations were within normal limits and no new issues were reported. Drs Newton, Budd and Woo discussed his progress that day and it was decided to cease olanzapine in case it was contributing to confusion. Visual observations were returned to 60-minutes, the standard frequency.

### **Mr Fowles absconds from Morier Ward**

- 37 At 6:25pm nursing staff conducting a routine check of the ward noted Mr Fowles was in the toilet in his room, in the dark, but when asked he replied he was okay.
- 38 When staff looked for him at 6:30pm to tell him he had a phone call, he was not to be found. Other patients in the smoking area said they had seen him leaving in the direction of the Colonnades Shopping Centre. Mr Fowles had taken his backpack and phone but had left behind his wallet and his cash. Upon discovering that he had left, mental health nurse Kerry Maley<sup>6</sup> called South Australia Police (SAPOL) and at 6:44pm reported Mr Fowles as missing.
- 39 Susan McLean,<sup>7</sup> Nursing Director, Acute Services in the Division of Mental Health for the Southern Adelaide Local Health Network, provided the Court with the following documented procedures:
- Approval of Inpatient Leave - Mental Health Procedure CC1.1667 V2.1 (August 2021);
  - Recognising and Responding to Missing Patients Procedure CC1.2469 V1.0 (November 2019); and
  - Visual Observation of Consumers Procedure CC1.1808 V2.0 (September 2019).
- 40 Ms McLean also provided the following internal documents:
- Medical Orientation Folder, Morier Ward, Registrars RMO's Interns and Medical Students (2020); and
  - Nursing Orientation Booklet, Morier Ward (2017).
- 41 There is no evidence of any breaches of any of these policies or procedures and I make no criticism of the content of any of them.

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<sup>6</sup> Exhibit C5

<sup>7</sup> Exhibit C8

## The search

- 42 It quickly became apparent that Mr Fowles was not returning and was not to be found at nearby public locations, including the Colonnades Shopping Centre. A triangulation on his phone was authorised at 8:28pm and identified the phone as being in an area south from a tower located on the eastern side of the Southern Expressway near the termination of Barcelona Road and the commencement of Corrimal Avenue, Noarlunga Downs.
- 43 An image of the triangulation zone contained in the affidavit of BD,<sup>8</sup> a qualified Field Search Controller in the SAPOL Special Tasks and Rescue (STAR) Group shows it is a semicircular strip about 300 metres wide and approximately 1½ kilometres from the northernmost point to the southernmost point just north of Pigott range Road at Old Noarlunga. It includes areas to the east, to the west and to the south of the intersection of the Southern Expressway and Main South Road. The topography of the triangulation area was complex, containing suburban streets and housing, parks, scrubland, major roads, a major intersection, minor roads and open paddock. Further triangulations during the next two days showed that Mr Fowles' phone did not move within that time.
- 44 Local police initially concentrated their search efforts in and around the triangulation area, also contacting Ms Phopo and other family members and people identified as possible contacts, seeking information about where Mr Fowles might be or may have gone.
- 45 The police search was quickly expanded and involved vehicles including a trail bike, foot patrols, mounted units and a police helicopter with specialised search capability. Police Water Operations members searched the Onkaparinga River and banks from Old Noarlunga to Port Noarlunga. SES volunteers were also involved. The police regularly called Mr Fowles' mobile phone, hoping he would either answer or that they would hear it ring or see it light up. As a result of information that Mr Fowles was very fond of and familiar with the Onkaparinga Gorge, the PolAir flight search area was extended very substantially along the Onkaparinga Gorge. During the search there were 18 different search areas established and searched.
- 46 The search continued through day and night until 3:11pm on 21 October 2021, when SES officer Sharon Kemp observed Mr Fowles' body in an area of dense scrubland near the junction of the Southern Expressway and Main South Road, Huntfield Heights.
- 47 SAPOL crime scene investigator officer Lyndon Lawson<sup>9</sup> attended and took photos of the scene. Mr Fowles' body was hanging from a length of old fencing wire attached to a tree and was very well camouflaged by bush, and difficult to see. Chief Inspector McDaid,<sup>10</sup> who was involved in the coordination of the search, attended the location and commented in his affidavit, having regard to the location and the thick scrub involved,

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<sup>8</sup> Exhibit C14

<sup>9</sup> Exhibit C16a

<sup>10</sup> Exhibit C12

that it was a credit to the searchers that Mr Fowles' body was found. Mr Fowles' phone was with his body, which was some 100 metres outside of the triangulation zone.

### **Conclusion**

- 48 As occurs in every case of suicide, an investigation was undertaken by a SAPOL detective on behalf of the State Coroner. This investigation was undertaken by Detective Brevet Sergeant Scott DeBruyn<sup>11</sup> and I agree with the conclusions he reached and expressed in his report.
- 49 I repeat my earlier conclusions that Mr Fowles was appropriately and lawfully detained under the ITO as initially imposed, and then confirmed.
- 50 I conclude that Mr Fowles was properly managed and cared for in the Flinders Medical Centre and in the Morier Ward. Visual checks on Mr Fowles were made in accordance with the Visual Observation of Consumers Procedure. There was nothing Mr Fowles had said or done to indicate, or which ought to have indicated, to staff any intention to abscond or to take his own life.
- 51 The SAPOL search was competent and thorough, and it cannot be suggested that Mr Fowles' body ought to have been located earlier. I observe that it is not uncommon for thorough searches to be unsuccessful due to difficult terrain and dense vegetation.
- 52 I find Mr Fowles' suicide was not one which ought to have been predicted and was not preventable.
- 53 Having regard to the fact that Mr Fowles' phone was found with his body and is known not to have moved since the first triangulation on 19 October 2021, I find that Mr Fowles died on 19 October 2021.

### **Recommendations**

- 54 Having regard to my findings, I make no recommendations.

*Keywords: Death in Custody; Inpatient Treatment Order; Missing Person; Suicide*

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<sup>11</sup> Exhibit C7