CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF COLLEEN MARGARET FOWLE

[2026] SACC 16

Inquest Findings of her Honour Deputy State Coroner Roper

19 June 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a woman who died following a fall while detained within the memory support unit of a residential aged care facility pursuant to section 32 of the *Guardianship and Administration Act 1993*.

Held:

1. Colleen Margaret Fowle, aged 78 years of Largs North, died at Largs North on 18 April 2023 as a result of urinary tract infection and pneumonia on a background of facial fractures and dementia.

2. Circumstances of death as set out in these findings.

No recommendations made.

Counsel Assisting: MS R SCHELL
Hearing Date/s: 26/02/2026
Inquest No: 05/2026 **File No/s: 0981/2023**

INQUEST INTO THE DEATH OF COLLEEN MARGARET FOWLE [2026] SACC 16

1 Colleen Margaret Fowle was 78 years old when she died on 18 April 2023. She had been a resident of the Marten Residential Care Centre (Marten) since October 2019, and at the time of her death, was accommodated in the memory support unit.

2 On 22 March 2023 Mrs Fowle suffered an unwitnessed fall, striking her head and lacerating the corner of her left eye. She was taken to The Queen Elizabeth Hospital for treatment then discharged back to Marten for ongoing care. She gradually deteriorated, resulting in a review by a general practitioner on 31 March 2023. Her medication regime was adjusted, but her condition continued to decline. She became increasingly drowsy, and her oral intake decreased.

3 On 15 April 2023 Mrs Fowle was returned to the Queen Elizabeth Hospital. She was diagnosed with a urinary tract infection, hyperosmolality and hypernatraemia. A CT scan of her brain also demonstrated facial fractures, consistent with the fall sustained on 22 March 2023. These fractures had not been identified during the March admission as radiological imaging of her head had not been considered necessary.

4 Despite treatment, Mrs Fowle showed little improvement. A decision was made to return her to Marten for palliative care, and she passed away peacefully on 18 April 2023.

Cause of death and reason for inquest

5 Dr Erin O'Connor, a medical practitioner experienced in providing opinions as to cause of death, conducted an examination of Mrs Fowle's longitudinal medical history. In consultation with senior specialist forensic pathologist Dr Stephen Wills, she formed the view that the cause of Mrs Fowle's death was urinary tract infection and pneumonia on a background of facial fractures and dementia, and I so find.

6 The contribution of facial fractures to the death of Mrs Fowle was clarified by Dr Wills. He explained that the fractures likely contributed to the development of urinary and respiratory infections by reducing Mrs Fowle's oral intake and mobility in the context of underlying dementia. He opined that the failure to identify the facial fractures in March 2023 did not contribute to the death, as these fractures would have been managed conservatively in any event. I accept the opinion of Dr Wills and find that the failure to identify the facial fractures in March 2023 did not contribute to the death of Mrs Fowle.

7 At the time of her death, Mrs Fowle was a protected person under a guardianship order made pursuant to s 32(1)(b) of the *Guardianship and Administration Act 1993*. Accordingly, her death is a death in custody, and a mandatory inquest is required, unless the death is certified to be from natural causes. The contribution of the fall causing the facial fractures precluded such a certification.

8 As there was no factual ambiguity in the evidence that required clarification by oral evidence, the Court determined to conduct the inquest on the papers.

Who was Mrs Fowle?

9 Mrs Fowle was born on 3 August 1944 in Adelaide. She married in 1978 and had three children. In her early working life, Mrs Fowle was employed as a stewardess on freight and cargo ships. She was then employed as a pharmacy assistant, a position she held for most of her working life until her retirement in approximately 2002.

10 Mrs Fowle lived independently at home until her cognition began to decline, leading to a diagnosis of mixed Alzheimer's and vascular dementia with BPSD.[1]

11 Mrs Fowle moved into Marten on 2 October 2019. Initially she resided in a semi-independent section of the facility. However, as her dementia worsened, it became necessary to transfer her to the memory support unit.

12 Mrs Fowle suffered her first fall at Marten on 13 July 2021. Mrs Fowle's care plan was regularly adjusted to ensure that it aligned with her physical and cognitive capacity. Measures were taken to reduce her risk of falls, including lowering the height of her bed, placing sensor mats around her bed, conducting regular visual checks and ensuring that she was wearing appropriate footwear. However, Mrs Fowle's refusal to use a four-wheeled walker, as recommended by her occupational therapist, reduced the effectiveness of these strategies and she suffered a further 17 falls. Fortunately, only two of these falls resulted in injuries requiring medical attention.

13 Mrs Fowle also experienced frequent urinary tract infections, which were difficult to manage as her cognitive capacity often led to her refusing care. These infections were usually identified by staff who observed changes in her behaviour.

14 Mrs Fowle's other known medical conditions included diabetes mellitus, high cholesterol, ischaemic heart disease, hypertension, hyperlipidaemia, obstructive sleep apnoea and depression. She was under the care of a geriatrician, who reviewed her management plan and provided care staff with advice regarding how to best manage her dementia, depression, and falls risk.

15 As Mrs Fowle was living with severe dementia and was subject to a guardianship order authorising her detention, her vulnerability necessitates careful scrutiny of the care provided to her, both at Marten and at The Queen Elizabeth Hospital.

Circumstances leading to Mrs Fowle's death

16 On 22 March 2023, Mrs Fowle was admitted to The Queen Elizabeth Hospital following an unwitnessed fall in which she struck her head. She had been found on the floor by care staff, having been observed a short time earlier walking with another resident. Mrs Fowle could not describe how the fall occurred. It was noted that there were no environmental hazards in the area where she was located, and no other residents in the vicinity.

17 Mrs Fowle sustained a 2.5 cm laceration to the outer aspect of her left eye and a bruise to her left upper shoulder as a result of the fall. The laceration was sutured. As there was no evidence of a basal skull fracture, she was discharged back to Marten, without any radiological imaging deemed necessary.

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[1] Behavioural and Psychological Symptoms of Dementia

18 Mrs Fowle's general practitioner arranged for x-rays to determine whether the fall had caused any fractures to her hip or shoulder. The x-rays showed no evidence of fracture.

19 Following a physiotherapy assessment on 28 March 2023, it was noted that Mrs Fowle's mobility had declined since the fall.

20 Mrs Fowle was reviewed again by her general practitioner on 31 March 2023 due to her ongoing clinical decline. Although adjustments were made to her medication regimen, her condition continued to decline, including a decrease in her oral intake.

21 On 15 April 2023, she was taken to The Queen Elizabeth Hospital Emergency Department with a Glascow Coma Scale reading of 8, indicating a severely impaired conscious state. Investigations revealed a high concentration of sodium in the blood and high blood sugar. A urine dipstick was positive for leukocytes, and a culture subsequently grew a bacterial infection. A chest x-ray also showed patchy consolidation in the right lung.

22 A CT scan was performed of Mrs Fowle's brain. This showed significant brain volume loss, consistent with a neurodegenerative process. There were also acute fractures to the left side of Mrs Fowle's face, including her cheekbone, orbit and maxillary sinus. There was no acute intracranial bleed. These facial fractures were considered to be caused by the fall in March 2023.

23 Despite treatment with intravenous antibiotics, intravenous fluids and insulin, there was little improvement in her condition. Mrs Fowle was discharged from The Queen Elizabeth Hospital on 16 April 2023 back to Marten for end-of-life care. She passed away on 18 April 2023.

Was Mrs Fowle provided with an appropriate standard of care by The Queen Elizabeth Hospital?

24 The only shortcoming identified in the care provided to Mrs Fowle by The Queen Elizabeth Hospital was the failure to identify facial fractures following her fall in March 2023. Considering her presentation, it is unclear why radiological imaging was not deemed necessary to rule out a significant head or facial injury. However, as set out earlier in these findings, I am satisfied that the failure to identify these facial fractures did not contribute to the death of Mrs Fowle.

25 I find that the standard of care provided to Mrs Fowle by The Queen Elizabeth Hospital in March and April 2023 was of an appropriate standard.

Was Mrs Fowle provided with an appropriate standard of care by Marten Aged Care?

26 From the time of her admission to Marten, Mrs Fowle's medical care was provided by a general practitioner and a geriatrician.

27 Mrs Fowle suffered many falls during her time at Marten. These were mechanical falls, including simple trips. The Charter of Aged Care Rights operative at the relevant time recognised Mrs Fowle's right to move freely around the secure area of the facility. I am satisfied that Marten appropriately balanced the need to minimise Mrs Fowle's risk of injury with the obligation to respect her freedom of movement and quality of life.

Was Mrs Fowle lawfully detained?

28 On 23 August 2019 the South Australian Civil and Administrative Tribunal received an application for appointment of a financial administrator due to concerns for Mrs Fowle's ability to protect her assets considering her mixed vascular dementia. A second application was lodged on 28 August 2019 for appointment of a guardian with powers of detention. Both applications were lodged by representatives from the Hampstead Rehabilitation Centre, where she resided at that time, and were considered simultaneously.

29 The Tribunal was satisfied that there were proper grounds for appointing the Public Trustee as Administrator, and the Public Advocate as full Guardian. Special Powers were also granted pursuant to s 32 of the *Guardianship & Administration Act 1993* which authorised the detention of Mrs Fowle at her place of residence. These orders were reviewed by the Tribunal at regular intervals throughout 2019 to 2022 and remained in place at the time of Mrs Fowle's death.

30 I find that Mrs Fowle was lawfully detained at the time of her death.

Conclusions

31 I am satisfied that the care provided to Mrs Fowle was appropriate in the circumstances and that her death represented the natural consequence of her underlying illness.

32 I make no recommendations.

Keywords: *Death in Custody; Section 32 Powers; Fall*