CORONERS COURT OF SOUTH AUSTRALIA

INQUEST INTO THE DEATH OF ANNE CAROL ANDRYSIK

[2025] SACC 22

Inquest Findings of her Honour Deputy State Coroner Roper

28 August 2025

CORONIAL INQUEST

Examination of the cause and circumstances of the death of an 80-year-old woman who died following a fall while detained within the memory support unit of her residential aged care facility pursuant to section 32 of the *Guardianship and Administration Act 1993*.

Held:

1. Anne Carol Andrysik, aged 80 years of Woodcroft, died at Woodcroft on 5 October 2022 as a result of fractured left neck of femur on a background of rectal carcinoma and dementia.

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

No recommendations made.

Counsel Assisting: MR D EVANS
Hearing Date/s: 11/06/2025
Inquest No: 14/2025 **File No/s: 2472/2022**

INQUEST INTO THE DEATH OF ANNE CAROL ANDRYSIK [2025] SACC 22

Introduction and reason for inquest

1 Anne Carol Andrysik was 80 years of age when she died on 5 October 2022. She sustained a fall 11 days prior to her death, which resulted in a fractured left neck of femur.

2 Mrs Andrysik was diagnosed with dementia in early 2020. As a result, she developed a degree of confusion and engaged in behaviours that placed her safety in jeopardy, such as placing candles in the combustion fire and leaving the stove on after cooking. After careful consideration, a decision was made to transition Mrs Andrysik into a residential aged care facility.

3 Mrs Andrysik required accommodation within the memory support unit of the facility, which is a secure unit providing specialist care to persons living with dementia.[1] An application was made to the South Australian Civil and Administrative Tribunal (SACAT) for special powers to authorise her detention at her place of residence pursuant to section 32 of the Guardianship and Administration Act. This order was necessary to lawfully accommodate Mrs Andrysik within the memory support unit as this involved environmentally restraining her in a manner that prevented her free exit.[2]

4 On 14 December 2021, the special powers order was granted.[3] As required by section 57(1)(a) of the Guardianship and Administration Act, the special powers order was reviewed and extended on 25 August 2022 and was in place at the time of her death.[4] The next review of the order was scheduled for 24 August 2023.[5]

5 At the time of Mrs Andrysik's death she had been transferred out of the memory support unit into a quieter room within the facility, and was therefore not detained at the time of her death. However, death in custody is defined in section 3 of the *Coroners Act 2003* as follows:

> '***death in custody*** means the death of a person where there is reason to believe that the death occurred, or the cause of death, or a possible cause of death, arose, or may have arisen, while the person -
>
> (a) was being detained in any place within the State under any Act or law…'

6 Mrs Andrysik's death followed a fall in which she was believed to have fractured her left neck of femur, which was later confirmed radiologically. The fall occurred during her detention within the memory support unit.

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[1] Exhibit C4 at [7]
[2] *The Public Advocate v C, B* [2019] SASCFC 57
[3] Exhibit C4 at [7]; Exhibit C5, Annexure DA8
[4] Exhibit C5, Annexure DA10
[5] Exhibit C6, p9

7 As will be detailed later in these findings, I am satisfied that the cause of Mrs Andrysik's death was a fractured left neck of femur on a background of rectal carcinoma and dementia.

8 Accordingly, I find that Mrs Andrysik's cause of death arose while she was detained pursuant to section 32 of the Guardianship and Administration Act and that her death constitutes a death in custody pursuant to section 3 of the Coroners Act 2003. An inquest into the cause and circumstances of her death is therefore mandatory.[6] These are the findings of that Inquest.

Background

9 Mrs Andrysik was born in Hastings, England on 23 December 1941.[7] When she was about 14 years old she migrated to Australia with her parents and five siblings. She left high school to commence work as a telephonist at the telephone exchange.

10 Mrs Andrysik married in April 1963 and had three daughters with her first husband. She was employed as a receptionist at a medical practice and as a duty officer at Minda Incorporated.

11 She enjoyed gardening, geology, music, reading and travel. She was a member of her local tennis club and enjoyed dancing. While travelling in Egypt, she met the man who would later become her second husband, Paul Andrysik. Following their marriage in 1988, the couple lived in Melbourne where they worked together in the bakery Mr Andrysik owned. They returned to Adelaide in 2010.

12 In May 2018, Paul Andrysik passed away following a diagnosis of pancreatic cancer. Mrs Andrysik was deeply affected by his death and experienced significant grief.

13 In early 2020, Mrs Andrysik underwent a brain scan which demonstrated changes consistent with mixed dementia, predominantly Alzheimer's.[8] Her physical and cognitive health declined in the latter half of that year, and in August 2020 a rectal examination led to a likely cancer diagnosis.[9] She conveyed to her family that she was grateful for the cancer, viewing it as a means to be with her late husband.[10]

14 Mrs Andrysik declined further investigation or treatment and accordingly the mass was not definitely diagnosed as carcinoma.

15 Mrs Andrysik received strong support from her daughters who provided care to her within the home until it was no longer feasible to do so and Mrs Andrysik was placed into high level residential care in Myrtle Bank. However, she was removed from this facility by her family as she did not appear to cope well with the environment. An assessment conducted by the Southern Adelaide Aged Care Assessment Team on 24 August 2020

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[6] Coroners Act 2003, section 21(1)(a)
[7] Exhibit C2 at [2]
[8] Exhibit C3 at [3]
[9] Exhibit C2 at [6]; Exhibit C3 at [3]
[10] Exhibit C2 at [6]

noted that her daughters were committed to providing their mother with home-based care and were strong advocates for her, despite their work and family commitments.[11]

16 On 1 February 2021, Mrs Andrysik moved into Cottage Grove, a residential aged care facility managed by Eldercare in Woodcroft, South Australia. She later transitioned into the secure memory support unit due to concerns that she may fall and/or leave the facility unaided.

Mrs Andrysik's placement at Cottage Grove

17 Mrs Andrysik was observed to be very happy at Cottage Grove. One of her three daughters provided an affidavit[12] in which she stated that for the majority of the time she was happy with the care provided to her mother, and described some of the carers as 'absolutely fabulous'. She did, however, raise concerns with the facility regarding their staffing levels. She also described occasions when she needed to advocate for her mother to receive appropriate pain relief.[13]

18 The concerns regarding pain management were conveyed to Dr Brooke-Davey, Mrs Andrysik's general practitioner. Dr Brooke-Davey stated that she took immediate action in response and increased the dose of Mrs Andrysik's Norspan patch.[14]

19 Mrs Andrysik's health continued to decline in a manner consistent with her diagnoses, and she experienced several occasions of tachycardia. Her tumour grew to the point that it was externally visible and fungating.[15]

20 Mrs Andrysik had executed an Advanced Care Directive on 27 July 2018 in which she made the following entry under the heading 'binding refusals of heath care':

> 'I do not consent to the use of life sustaining measures (within the meaning of s4 of the *Consent to Medical Treatment and Palliative Care Act 1995*) or other life sustaining medical or surgical intervention when the expected outcome of such measures or such intervention is poor.' [16]

21 Mrs Andrysik's family ensured that their mother's express wishes were complied with and did not authorise investigation or active treatment for the presumed cancer.[17] Mrs Andrysik was instead managed conservatively, with medication being administered for anaemia, and to manage her pain and agitation.[18]

22 During her stay at Cottage Grove Mrs Andrysik sustained three falls.[19] She was not transferred to hospital for investigation after these falls. This was in accordance with the instructions of her daughter who had been appointed as the substitute decision maker in Mrs Andrysik's Advanced Care Directive. Mrs Andrysik's family expressed hesitancy to have their mother transferred to hospital due to a prior negative experience during

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[11] Exhibit C2 at [7]
[12] Exhibit C2
[13] Exhibit C2 at [10]
[14] Exhibit C3 at [10]
[15] Exhibit C3 at [4]
[16] Exhibit C5, Annexure DA3
[17] Exhibit C2 at [9]; Exhibit C3 at [4]
[18] Exhibit C3 at [5]; [10]
[19] Exhibit C2 at [11]

which she waited for hours in the back of an ambulance and then waited for a further two hours in the Emergency Department.

23 The first of the three falls occurred on 30 August 2022 and was unwitnessed. This fall resulted in no apparent injury. A falls plan was put in place on 2 September 2022 after an occupational therapy review on 31 August 2022. The plan had the following strategies:

- Uncluttered environment
- Sensor beam at night
- Discrete supervision for transfers and mobility
- Appropriate footwear
- Bed at correct height [20]

24 The second fall occurred on 20 September 2022 and resulted in a graze to the temple.[21] The falls plan was reviewed the following night, and it was recorded that 'current strategies remain appropriate'.[22]

25 The third fall occurred on 24 September 2022, with staff being alerted to the fall by the activation of the sensor mat.[23] Mrs Andrysik was found on the floor complaining of pain in her left hip.

26 In consultation with family, a decision was made not to transfer Mrs Andrysik to hospital for an x-ray to confirm the suspected hip fracture. Mrs Andrysik's daughter refused surgical intervention in line with her mother's wishes, and as such, Mrs Andrysik remained at Cottage Grove.[24] She was moved to a quieter room when it became apparent that she was nearing the end of her life.[25] Mrs Andrysik began refusing meals and was administered morphine subcutaneously to manage her pain.[26]

27 Mrs Andrysik died on 5 October 2022 at 6:50am.[27]

Cause of death

28 A post-mortem examination was conducted by forensic pathologist Dr Stephen Wills comprising an external examination and CT scan.[28] The imaging confirmed the clinically suspected left neck of femur fracture. It did not identify a scalp haematoma, skull fracture or intracranial haemorrhage. Cerebral atrophy was observed, consistent with her diagnosis of dementia. No pathologically significant acute injuries were observed during the external examination, other than the injury to the hip. Changes to the lungs were observed but considered to represent a degree of terminal pneumonia.

29 Rectal thickening with indurated perianal mass was observed. Dr Wills opined that this was 'almost certainly a carcinoma'. Accordingly, Dr Wills concluded that Mrs Andrysik

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[20] Exhibit C7, Transfer form dated 2 September 2022
[21] Exhibit C4 at [10]
[22] Exhibit C7 at page 14 of 98
[23] Exhibit C7, page 13
[24] Exhibit C3 at [8]
[25] Exhibit C2 at [13]; Exhibit C4 at [12]
[26] Exhibit C7, page 10
[27] Exhibit C4 at [13]
[28] Exhibit C1a

died as a result of a fractured neck of femur which has occurred on a background of rectal carcinoma and dementia.

Conclusions

30 The investigation did not establish any shortcomings in the care provided to Mrs Andrysik that contributed to her death. I am satisfied that the falls management plan appropriately balanced risk reduction with respect for her personal autonomy.

31 I find that Mrs Andrysik was lawfully and appropriately detained on 24 September 2022 when she fell, fracturing her left neck of femur.

32 I further find that Mrs Andrysik's death was caused by a fractured left neck of femur on a background of rectal carcinoma and dementia.

33 I have no recommendations to make.

34 I express my sincere condolences to the family of Mrs Andrysik and acknowledge the dedicated care and support they provided to her.

Keywords: *Death in Custody; Section 32 Powers*