IN THE CORONERS COURT **COR 2022 001018**

OF VICTORIA

AT MELBOURNE

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

*Section 67 of the **Coroners Act 2008***

Inquest into the Death of Maria Grazia Nardiello

Delivered On:	14 March 2025
Delivered At:	Melbourne
Hearing Dates:	13 March 2025
Findings of:	Coroner Simon McGregor
Police Coronial Support Unit	Leading Senior Constable Clinton Smith
Keywords	Aged care resident, dementia, resident aggression, fractured neck of femur

I, Coroner Simon McGregor, having investigated the death of Maria Grazia Nardiello, and having held an inquest in relation to this death on 13 March 2025 in the Coroner's Court of Victoria at Melbourne, find that the identity of the deceased was Maria Grazia Nardiello, born on 21 March 1931, and the death occurred on 23 February 2022, at The Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052, from:

1a: Surgical repair of fractured neck of femur sustained in a fall complicated by COVID-19 infection

I find, under section 67(1)(c) of the *Coroners Act 2008* (**the Act**) that the death occurred in the following circumstances.

INTRODUCTION

1. Maria Grazia Nardiello was 90 years old when she died at the Royal Melbourne Hospital on 23 February 2022. At the time of her death, she was resident of the Hope Aged Care Facility in Brunswick.

2. Maria resided in Unit 122 of the Memory Support Unit in the aged care facility, which is a secure ward housing residents who suffer from varying stages of dementia/Alzheimer's Disease.

3. Maria suffered from a number of pre-existing medical conditions, including Alzheimer's Disease, vascular dementia, osteoarthritis and a previous stroke. She had been diagnosed with dementia in 2018. Despite having dementia, Maria was very mobile and walked around by her own free will.[1]

4. Another resident of the Memory Support Unit, in Unit 109, was Mr Leslie Pearcy. Mr Pearcy was 70 years old at the time and had health conditions that required assisted care, including dementia with aggressive behaviour and an intellectual disability.[2] Mr Pearcy had been recorded by Hope Age Care facility as being involved in several

[1] Statement of Rosetta FABRIS, paragraphs 3-4, page 18
[2] Statement of Dr Ala ALETHAN and medical documentation starting page 49

incidents involving Maria and other residents leading up to the incident with Maria on 12 February 2022.

5. On 2 December 2021 at 7:10 am, Maria walked into Mr Pearcy's unit, which triggered Mr Pearcy. Mr Pearcy approached Maria and slapped her to the face while they were inside Mr Pearcy's unit. Staff were alerted to the incident when they heard a scream and attended Mr Pearcy's unit. Staff separated Mr Pearcy and Maria by taking Maria out of Mr Pearcy's room. Staff observed Maria to have slight redness to her right cheek as a result of the slap. The incident was recorded on the incident registry.[3]

6. On 2 December 2021 at 3:40 pm, Maria walked into Mr Pearcy's unit. Staff were alerted to the incident when they heard yelling coming from the vicinity of Unit 109. Upon turning the corner, staff observed Maria falling backwards onto the floor and Mr Pearcy yelling at her. Staff observed Mr Pearcy attempt to kick Maria, however stopped when instructed to do so. Mr Pearcy returned to his unit and locked the door.[4]

7. On 22 January 2022 at 1:25 pm, Mr Pearcy was involved in a verbal dispute with another resident which occurred outside his unit. Staff were alerted to the incident when they heard Mr Pearcy and the other resident arguing and separated both parties. The incident was not directly witnessed by staff and was recorded on a 'Serious Incident Response Scheme' register.[5]

8. On 30 January 2022 at 9:30 am, Mr Pearcy was inside Unit 109. Maria entered Mr Pearcy's unit and Mr Pearcy pushed her out, resulting in her falling to the ground. This incident was not witnessed by staff, however, staff cleared Maria of any injuries and listed the incident on the incident register.[6]

9. On 1 February 2022 at 9:30 am, Mr Pearcy was observed by staff to be walking around the corridor before attempting to hit a co-resident. Staff attempted to intervene, but Mr Pearcy was aggressive towards to staff members. Staff contacted 000 and requested an ambulance

[3] Serious Incident Response Record 1274434 page 82
[4] Serious Incident Response Report 1275247, page 80
[5] Serious Incident Response Record 1373368 page 79
[6] Serious Incident Response Record 1344098 page 63

to take Mr Pearcy to hospital for a behavioural plan review. The incident was recorded on the register.[7]

Incident

10. On Saturday 12 February 2022 at approximately 9:30 am, Mr Pearcy was in his unit. Maria was using her walking frame and had walked into Mr Pearcy's unit, which is located off the communal corridor of the Memory Support Unit.

11. Mr Pearcy became aware of Maria's presence and was upset that Maria had not knocked prior to entering his unit. He began pushing Maria out of his unit. While Mr Pearcy was pushing Maria, she lost her balance and fell backwards out of the doorway of Unit 109, landing on the ground in the corridor. At the time of the fall, Maria was wearing a hip protector.[8]

12. Nurse Nandasiri Gamaralalarge and Personal Care Assistants Aakriti Thapa and Rebecca Gurung heard a scream come from the direction of Unit 109, which was out of view of the Communal Common Area.

13. Ms Thapa and Ms Gurung immediately attended Unit 109, where they observed Maria on the ground and Mr Pearcy standing in the doorway. Nurse Gamaralalarge was called down by Ms Thapa and Ms Gurung. First Aid was immediately provided to Maria by staff. While Maria was receiving First Aid, Nurse Gamaralalarge enquired with Mr Pearcy about what had occurred. Mr Pearcy advised him that Maria had attempted to enter his unit, also stating that he believed that it was illegal for Maria to enter his unit.[9]

14. Nurse Gamaralalarge conducted an assessment of Maria while she was lying on the ground to assist in determining if she had suffered a fracture as a result of the fall. Maria did not complain of or show any signs of discomfort. When Maria was assisted by staff to her feet it became evident that she was experiencing considerable pain. Maria was seated in a wheelchair to transport her to her bed in Unit 122, so as to keep her comfortable while an

[7] Serious Incident Response Record 1347024 page 85
[8] Serious Incident Report Record 1359942, page 61
[9] Statement of Nandasiri GAMARALALAGE, page 24

Ambulance was called. She remained under observation by staff until an ambulance arrived.[10]

15. While Maria was receiving treatment in her unit, Mr Pearcy remained inside his unit. The push that resulted in Maria falling to the ground was not witnessed by any staff or residents of the care facility.

16. Maria was transported to the Royal Melbourne Hospital, where it was discovered that she had suffered a fracture to the right neck of her femur, and she would require surgery. Maria also tested positive to COVID-19.

17. On Monday 14 February 2022, Maria underwent surgery, where a femoral nail was inserted for the neck of the femur without complications. While Maria was recovering from surgery, she began to experience a reduced state of consciousness with symptoms of hypoxia and tachypnoea as a result of the COVID-19 infection.

18. Maria was transferred to the Palliative Care Unit, where she subsequently passed away on Wednesday 23 February 2022.

19. Mr Pearcy was subsequently transported to The Royal Melbourne Hospital North-Western Mental Health Psychiatric team for the purpose of a psychiatric assessment. Dr Liam Nalder assessed Mr Pearcy as having a longstanding, undiagnosed neurodevelopmental disorder, similar to autism spectrum disorder, as well as signs of frontotemporal dementia.[11]

INVESTIGATIONS

20. Conversations between then Detective Senior Constable Alex Nucci and Maria's daughter, Rosetta Fabris, indicated she was not seeking for Mr Pearcy to be charged nor held responsible for her mother's death.[12]

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[10] Statement of Nandasiri GAMARALALAGE, page 24
[11] Assessment of Leslie Pearcy by Dr Liam Nalder, Consultant Psychiatrist of Ageing, Aged Persons Mental Health Program, North Western Mental Health, The Royal Melbourne Hospital, page 151
[12] Statement of D/Acting Sergeant Alex NUCCI

21. Attempts to have a Forensic Medical Officer assess Mr Pearcy's fitness for interview were refused by his family, after they sought legal advice, due to the impact it would have on his mental state.[13]

22. Reports obtained from Mr Pearcy's treating physicians detailed a diagnosis of intellectual disability with behavioural and psychological symptoms of dementia, underlying delusional disorder/schizophrenia and underlying bipolar disorder.[14]

23. Mr Pearcy was not interviewed or charged in relation to the incident at the Hope Aged Care facility, but was subsequently moved to Corpus Christi Aged Care Facility, where he received more specialised care.

24. Maria's death was also reported to the coroner, as it falls within the definition of a reportable death under the Act. Reportable deaths include deaths that are unexpected, unnatural, violent or result from accident or injury.[15] The death of a person as a result of an uncharged homicide attracts a mandatory inquest.[16]

25. The role of the coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. The purpose of a coronial investigation is to establish the facts, not to determine criminal or civil liability.

26. Victoria Police assigned Acting Sergeant Alex Nucci to be the Coronial Investigator for this matter. Acting Sergeant Nucci conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence on 4 March 2024.

27. This finding draws on the totality of the coronial investigation into the death of Maria Grazia Nardiello including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or

[13] Statement of Detective Acting Sergeant Alex NUCCI
[14] Statement of Dr Ala ALETHAN and medical documentation starting page 49
[15] Coroners Act 2008, Section 4 (1)
[16] Coroners Act 2008, Section 52(2)(a); Section 52 (3)(b)

necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.

28. In considering the issues associated with this finding, I have been mindful of Maria's human rights to dignity and wellbeing, as espoused in the *Charter of Human Rights and* Responsibilities *Act 2006*, in particular sections 8, 9 and 10.

Medical cause of death

29. On 25 February 2022, Forensic Pathologist Doctor Yeliena Baber of the Victorian Institute of Forensic Medicine conducted a postmortem external examination of Maria.

30. On the basis of the external examination and a post-mortem CT scan, Dr Baber provided an opinion that the medical cause of death was *surgical repair of fractured neck of femur sustained in a fall complicated by Covid-19 infection*.[17]

31. I accept Dr Baber's opinion.

Concerns of care

32. In communications with the Court,[18] Maria's family expressed understandable concerns about whether there were adequate safety measures in place in the Specialist Dementia Unit at Hope Aged Care.

33. I directed that further information be obtained from Hope Aged Care, and a comprehensive and considered statement was subsequently provided by Cath McDonald, Service Manager Hope Aged Care, dated 23 July 2024.

34. I also directed the independent practitioners in the Health and Medical Investigation Team of the Coroners Prevention Unit (**CPU**)[19] to review Maria's case, including the available evidence, the family's concerns and the response provided by Hope Aged Care.

[17] Medical Inspection Report of Forensic Pathologist Yeliena BABER
[18] Telephone conversations with CAE on 22 and 23 February 2022.
[19] The CPU is a team made up of health professionals and personnel with experience in a range of areas including medicine, nursing, mental health, public health, family violence and other generalist non-clinical matters. The unit may review the medical care and treatment in cases referred by the coroner, as well as assist with research related to public health and safety.

35. In summary, the CPU concluded that:

    a. Hope Aged Care's memory support unit aligned with standard practice required to provide appropriate care for persons with dementia and Behaviours and Psychological Symptoms of Dementia (**BPSD**);

    b. The facility staffing levels aligned with industry standards; and

    c. Hope Aged Care staff recognized that Mr Pearcy's behaviour had escalated and was causing risks to staff and residents, and particularly to Mrs Nardiello whose wandering behaviour continued despite a geriatrician assessment.

36. The CPU observed that many residents with BPSD are successfully managed in residential care with good behaviour management strategies, individualised care plans, environment modification[20] and staff training. There care is often strengthened by support teams of general practitioners, residential in-reach[21], geriatricians, Dementia Support Australia advice line and Aged Psychiatry services.

37. The CPU also identified that there appears to be a gap in escalation pathways to support residential aged care homes when resident behaviours become acutely unmanageable, as none of the currently available services appear to be able to provide a timely and intensive response.

Improvements since Maria's passing

38. Finally, the Court is aware that improvements have been implemented by Hope Aged Care since Maria's death, including more rigorous pre-admission screening and assessment, earlier referral to Dementia Support Australia, more regular and detailed case conferencing

[20] Considering the physical layout of the unit and choosing room location to optimize specific needs within the cohort of other residents with needs

[21] An acute hospital service to aged care facilities to divert residents from the Emergency Department whilst providing medical treatment in the facility

regarding difficult issues, an occupational violence working party, installation of CCTV and staff training.[22]

Other Aged Care Facility resident aggression matters

39. I am aware, there are currently a number of other cases before this Court that engage issues similar to those in Maria's case. For instance, Deputy State Coroner Spanos has scheduled a cluster inquest into aged care resident aggression to commence in May 2025 – clustering nine cases from 2021 where aged care facility resident aggression has led to deaths of a fellow resident. During that investigation, Deputy State Coroner Spanos has conducted a broad consultation to explore the systems that support residential aged care homes to manage escalating behaviour in residents with BPSD.

CONCLUSION

40. Having considered all the evidence, I am satisfied that Maria's death was not intended by anyone involved.

41. I commend the aged care facility for nonetheless taking this sad opportunity to reflect on these events and implement improvements in their own practises that they have identified during that process.

I convey my sincere condolences to Maria's family for their loss.

Pursuant to section 73(1B) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

I direct that a copy of this finding be provided to the following:

Rosetta Fabris, Senior Next of Kin

Sergeant Alexander Nucci, Coronial Investigator

[22] Statement of Cath McDonald dated 21 June 2024, provided in coronial investigation into the death of George Yacoub (COR 2023 002089).

Andrew Mariadason, Royal Melbourne Hospital

Cath McDonald, Hope Aged Care Brunswick

Signature:

Coroner Simon McGregor

Date: 14 March 2025

NOTE: Under section 83 of the *Coroners Act 2008* (**the Act**), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.