IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 004802

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Judge John Cain, State Coroner
Deceased:	Frank Kastelic
Date of birth:	2 October 1961
Date of death:	2 August 2023
Cause of death:	1(a) Epilepsy
Place of death:	Monash Medical Centre, 246 Clayton Rd, Clayton Victoria 3168
Keywords:	Specialist Disability Accommodation resident, supported independent living, disability support, reportable deaths, natural causes

INTRODUCTION

1. On 2 August 2023, Frank Kastelic (**Mr Kastelic**) was 61 years old when he died at Monash Medical Centre following a two-week hospital admission preceded by a significant seizure at home.

2. At the time of his death, Mr Kastelic was a National Disability Insurance Scheme (**NDIS**) participant. He received funding to reside in a Specialist Disability Accommodation (**SDA**) enrolled dwelling[1] provided by the then-Department of Health and Human Services. Mr Kastelic was receiving these supports due to epilepsy.

3. Mr Kastelic enjoyed a close relationship with his brother John and other members of his family including his nieces. He enjoyed a structured routine, socialising, and relaxing in the afternoon with a cuppa and a snack while watching television. Mr Kastelic is affectionately remembered by those around him as a friendly person who got along well with others.

4. Mr Kastelic had complex health needs as a result of epilepsy and recurrent stomach blockage issues. In the years leading up to his death he was regularly hospitalised to due suffering multiple seizures which resulted in increased care needs. At the time of his death, Mr Kastelic mobilised using a wheelchair, required assistance with personal care and medication needs, and was placed on a modified diet with thickened liquids to minimise his stomach blockage issues.

THE CORONIAL INVESTIGATION

5. Mr Kastelic's death fell within the definition of a reportable death in the *Coroners Act 2008* (**the Act**) as he was a 'person placed in custody or care' within the meaning of the Act, as a person receiving funding for Supported Independent Living (**SIL**) and residing in an SDA enrolled dwelling immediately prior to his death. This category of death is reportable to ensure independent scrutiny of the circumstances leading to death given the vulnerability of this cohort and the level of power and control exercised by those who care for them. The

[1] SDA enrolled dwelling is defined under the *Residential Tenancies Act 1997* (Vic). The definition, as applicable at the time of Mr Kastelic's death, is a permanent dwelling that provides long-term accommodation for one or more SDA residents, that is enrolled as an SDA dwelling under relevant NDIS (Specialist Disability Accommodation) Rules in force at the relevant time. An SDA resident means a person who is an NDIS participant funded to reside in an SDA enrolled dwelling, or who receives continuity of supports under the Commonwealth Continuity of Support Program in respect of specialist disability services for older people (from 1 July 2021, the Disability Support for Older Australians program). The definition of SDA resident was amended on 1 July 2024 pursuant to the *Disability and Social Services Regulation Amendment Act 2023* to extend to include persons who are residing, or propose to reside, in an SDA dwelling under an SDA residency agreement or residential rental agreement.

coroner is required to investigate the death, and publish their findings, even if the death has occurred as a result of natural causes.

6. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death, and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. This finding draws on the totality of the coronial investigation into the death of Frank Kastelic, including information from the National Disability Insurance Agency (**NDIA**) and the NDIS Quality and Safeguards Commission, as well as a Medical Certificate Cause of Death (**MCCD**) completed by a medical practitioner at Monash Medical Centre. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[2]

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

9. On 19 July 2023, Mr Kastelic suffered an absence seizure that lasted more than 15 minutes. His carers contacted emergency services and Mr Kastelic was conveyed via ambulance to the Monash Medical Centre where he was admitted. On admission, it was also discovered that Mr Kastelic was positive for COVID-19.

10. Mr Kastelic's condition continued to decline over the course of his admission. On 28 July 2023, discussions were held between Mr Kastelic's treating team, family, and carers at OC Connections about transferring Mr Kastelic to palliative care at the McCulloch House

[2] Subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

Supportive and Palliative Care Unit. He remained in hospital over the coming days until he peacefully passed away in his sleep on 2 August 2023.

Identity of the deceased

11. On 26 December 2022, Frank Kastelic, born 2 October 1961, was identified by Medical Practitioner Dr Benedict Low via review of medical records.

12. Identity is not in dispute and requires no further investigation.

Medical cause of death

13. On 2 August 2023, Medical Practitioner Dr Benedict Low reviewed Mr Kastelic's complete medical history and completed a MCCD. Dr Low provided an opinion that the medical cause of death was due to 1(a) epilepsy.

14. On 18 August 2024, a Medical Liaison Nurse (**MLN**) at the Victorian Institute of Forensic Medicine, reviewed the MCCD at my direction and confirmed that the cause of death was due to natural causes.

15. I accept Dr Low's opinion and am satisfied that the death was due to natural causes.

FINDINGS AND CONCLUSION

16. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Frank Kastelic, born 2 October 1961;

    b) the death occurred on 2 August 2023 at Monash Medical Centre, 246 Clayton Rd, Clayton Victoria 3168 from epilepsy; and

    c) the death occurred in the circumstances described above.

17. The available evidence does not support a finding that there was any want of clinical management or care on the part of the SIL provider, or clinical staff at Monash Medical Centre that caused or contributed to Mr Kastelic's death.

18. Having considered all the available evidence, I find that Mr Kastelic's death was from natural causes and that no further investigation is required. As such, I have exercised my discretion under section 52(3A) of the Act not to hold an inquest into his death and to finalise the investigation of Mr Kastelic's death in chambers.

I convey my sincere condolences to Mr Kastelic's family, friends and carers for their loss, and acknowledge the distress caused by the delay in the reporting and investigation of Mr Kastelic's death.

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:

J Kastelic, Senior Next of Kin

OC Connections

Monash Health

Signature:

Judge John Cain, State Coroner

Date : 08 January 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 investigation. 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.