IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2020 000889

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paresa Antoniadis Spanos
Deceased:	Rudolf Weidemann
Date of birth:	15 November 1938
Date of death:	17 February 2020
Cause of death:	1(a) Complications of metastatic gastric neuroendocrine carcinoma
Place of death:	St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065

INTRODUCTION

1. On 17 February 2020, Rudolf Weidemann was 81 years old when he passed away at St Vincent's Hospital. At the time, Mr Weidemann was remanded in custody, having been charged with arson causing death and intentionally damaging property.

2. Mr Weidemann was diagnosed with metastatic gastric neuroendocrine carcinoma in early November 2019. He had experienced paranoia, delusions and a psychological decline over the two years prior to his death. Mr Weidemann refused treatment for his cancer and discharged himself from Box Hill Hospital against medical advice on 20 November 2019. He continued to attend outpatient follow-up appointments. At this time, Mr Weidemann was assessed to have decision-making capacity.

3. On 11 December 2019 there was an incident at Mr Weidemann's home which resulted in a house fire and the death of his wife, Emma Weidemann. In the aftermath, Mr Weidemann was arrested by police after attempting to take his own life and charged with arson causing death and intentionally damaging property.

THE CORONIAL INVESTIGATION

4. Rudolf's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

5. Mr Weidemann was a person in custody immediately prior to his death. Section 52 of the *Coroners Act 2008* recognises the vulnerability of people who are in custody by requiring that their deaths are reported to the coroner, irrespective of the cause of death. A further safeguard is the mandatory requirement for an inquest as part of the coronial investigation. However, as per section 52 (3A), if the investigating Coroner is satisfied that the death is due to natural causes, they may choose to finalise the investigation without an inquest. In such a case, the coroner must publish their finding.

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. Victoria Police assigned Detective Senior Constable Holly Ticehurst to be the Coroner's Investigator for the investigation of Mr Weidemann's death. The Coroner's Investigator 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.

9. This finding draws on the totality of the coronial investigation into the death Mr Weidemann 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 necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

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

Identity of the deceased

10. On 5 March 2020, Coroner Darren Bracken made a formal determination identifying Rudolf Weidemann, born on 15 November 1938, on the basis of circumstantial evidence and a comparison of medical records.

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

Medical cause of death

12. Senior Forensic Pathologist Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an external examination of Mr Weidemann's body in the mortuary on 18 February 2020. Dr Lynch further considered the Police Form 83, Mr Weidemann's medical records and the post-mortem computerised tomography (**CT**) scan and provided a report of his findings dated 19 February 2020.

[1] 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.

13. Dr Lynch noted that Mr Weidemann was an 81-year-old man who was a prisoner at Ravenhall Correctional Centre with a known history of metastatic gastric neuroendocrine carcinoma. He was admitted to hospital in January 2020 with nausea, vomiting, and loss of appetite and was managed palliatively. His original diagnosis was based on a gastric biopsy in November 2019, and he had refused any further treatment or investigations. Dr Lynch advised that his findings on examination, including gross ballotable ascites, were consistent with Mr Weidemann's known medical history.

14. A review of the post-mortem CT scan revealed marked ascites and bilateral pulmonary consolidation.

15. Routine full toxicological analysis of post-mortem samples detected a number of drugs consistent with therapeutic use in a palliative setting.

16. Dr Lynch concluded by advising that Mr Weidemann's death was Death due to natural causes, namely *1 (a) complications of metastatic gastric neuroendocrine carcinoma.*

17. I accept Dr Lynch's opinion.

Circumstances in which the death occurred

18. Mr Weidemann was admitted to the Alfred Hospital shortly after his arrest on 11 December 2019. He was reviewed by the oncology unit, referred for palliative care services, and confirmed that he would not receive any active cancer treatment. The discharge summary from the Alfred Hospital noted he had a prognosis of 3-6 months to live.

19. On 24 January 2020, Mr Weidemann was experiencing significant pain and he was taken to St Vincent's Hospital by ambulance. His prognosis was poor, and he was provided end of life care by the palliative care team at St Vincent's Hospital. A not for resuscitation order was in place.

20. Mr Weidemann's condition continued to deteriorate, and he was provided comfort care and pain relief. Mr Weidemann was kept comfortable until passed away at approximately 3:30am on 17 February 2020.

FAMILY CONCERNS

21. Mr Weidemann's son, David Weidemann, held a number of concerns with regards to the care provided to his father. As the majority of those concerns relate to the psychiatric and

psychological care provided to Mr Weidemann and whether the fire and Emma Weidemann's death may have been prevented, they will be addressed in the investigation into Emma Weidemann's death, which is ongoing.

22. In this finding I have focused on the care provided to Mr Weidemann for his cancer, and the effect that his psychiatric condition may have had on his decision-making capacity.

REVIEW OF CARE

23. Following Mr Weidemann's diagnosis of cancer, he advised his treating team that he did not want any further tests or investigations, and rather would prefer to go home and spend time with his family. The oncology registrar recommended he remain in hospital and undergo a colonoscopy. However, as he was considered competent to make decisions about his own medical treatment, this was ultimately his choice. Mr Weidemann was discharged against medical device but continued to attend hospital for drainage of built-up fluid until his arrest on 11 December 2019.

24. On 24 December 2019, a neuropsychology assessment was conducted by Eastern Health which found significant impairments in Mr Weidemann's executive function, complex attention, processing speed and secondary compromised learning and memory. Mr Weidemann was displaying impaired capacity and was diagnosed with major neurocognitive disorder of a fronto-temporal variance with associated secondary psychotic disorder. He was considered to be displaying the behavioural and psychological symptoms of dementia.

25. Mr Weidemann was prescribed the antipsychotic risperidone and the antidepressant venlafaxine, and on 31 December 2019 was assessed as having adequate insight and being competent to decide his not-for-resuscitation status.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Rudolf Weidemann, born 15 November 1938;

    b) the death occurred on 17 February 2020 at St Vincent's Hospital, 41 Victoria Parade, Fitzroy, Victoria, 3065;

    c) Mr Weidemann died from natural causes, namely the complications of metastatic gastric neuroendocrine carcinoma; and

d) the death occurred in the circumstances described above.

27. The weight of available evidence supports a finding that Mr Weidemann had capacity to refuse treatment for his cancer; the end of life and comfort care he was provided while on remand in custody was reasonable and appropriate; and there do not appear to have been any opportunities to have prevented Mr Weidemann'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:

David Weidemann, Senior Next of Kin

Allison Will, Justice Assurance and Review Office

Scott Swanwick, Justice Health

Dr Yvette Kozielski, Eastern Health

Dr Paul Katz, Eastern Health

Detective Senior Constable, Holly Ticehurst, Coroner's Investigator

Signature:

Coroner Paresa Antoniadis Spanos

Date: 11 April 2022

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.