IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

**COR 2019 006767**

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

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

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| Findings of: | Coroner Paresa Antoniadis Spanos |
| Deceased: | Emma Gertrude Weidemann |
| Date of birth: | 5 June 1943 |
| Date of death: | 11 December 2019 |
| Cause of death: | 1(a) Effects of fire in a woman with head and neck injuries |
| Place of death: | 29 Templeton Street, Wantirna, Victoria, 3152 |
| Keywords: | Family violence, homicide, fire related death, mental health |

## INTRODUCTION

1. On 11 December 2019, Emma Gertrude Weidemann was 76 years old when she was found deceased following a fire at her residence on Templeton Street, Wantirna, Victoria. At the time of her death, Mrs Weidemann lived with her husband, Mr Rudolf Weidemann.

2. Mr and Mrs Weidemann were both born in Austria and migrated to Australia as adolescents. Mrs Weidemann met and married Mr Weidemann after arriving in Australia in the early 1960s. The couple have four adult children and lived at the Templeton Street address since 1980.

3. Mrs Weidemann worked as a commercial cleaner at a nursing home and school. Mr Weidemann worked as a moulder with metal castings. Both Mr and Mrs Weidemann were retired for twenty years prior to the fatal incident.

4. 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 the fatal incident. 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 up until the fatal incident.

5. On 29 November 2019, Mr Weidemann was involved in a police siege at his residence due to threats that he made in front of family members to take his own life while wielding a knife. The incident was resolved by attending police members and Mr Weidemann was admitted to Box Hill Hospital and assessed for mental health treatment. Mr Weidemann was discharged on 3 December 2019.

## THE CORONIAL INVESTIGATION

6. Mrs Weidemann'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. It is self-evident that Mrs Weisemann's death falls within this definition.
7. Moreover, as Mrs Weidemann's death was a suspected homicide, section 52(2)(b) of the Act mandates that, subject to stipulated exceptions, an inquest should be held. One of those exceptions is in section 52(3)(b) which provides that an inquest need not be held if a person has been charged with an indicatable offence in respect of the death under investigation, as indeed Mr Weidemann was in this case.

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mrs 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.

11. This finding draws on the totality of the coronial investigation into the death of Ms Weidemann Gertrude 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

### Circumstances in which the death occurred

12. Following Mr Weidemann's discharge from Box Hill Hospital on 3 December 2019, he was reported by family members to be erratic and paranoid in his behaviour. Mr Weidemann's youngest son, David, reported him to be anxious and pessimistic two days prior to the fatal incident and making comments like, "*this is my last day*".[2]

[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.

[2] Coronial brief, Statement of David John Weidemann dated 11 December 2019, 76

13. On 10 December 2019, the day prior to the fatal incident, David reportedly checked in on his parents to ensure that they had taken their medications and left the premises around 3.00pm that afternoon.

14. On 11 December 2019, at approximately 7.48am, David received a phone call from Mr Weidemann during which he claimed "*your mother's gone*" and "*we were arguing last night, she's dead. Come over now because I'm going to kill myself*."[3]

15. At approximately 7.56am, several witnesses nearby the 29 Templeton Road address called emergency services reporting a fire at the address. Witnesses at the scene further reported that they observed Mr Weidemann on the roof of the garage and yelling out that his wife was deceased.[4]

16. Fire services arrived first at the scene at approximately 8.04am followed by Ambulance Victoria paramedics and Victoria Police members. Attending fire fighters found Mrs Weidemann's body with extensive burns outside the front door of the house and she was confirmed deceased.[5]

17. Mr Weidemann was arrested by attending police members and conveyed by ambulance to Maroondah Hospital where he was treated for minor smoke inflation, lacerations to his neck and mental health concerns. He was later transferred to the Alfred Hospital where he was treated for psychotic depression and paranoia.

18. On 23 December 2019, Mr Weidemann was formally charged with the indictable offence of arson causing death and remanded in custody. Mr Weidemann died from natural causes on 17 February 2020 while still in custody.[6]

**Identity of the deceased**

19. On 13 December 2019, Emma Gertrude Weidemann, born 5 June 1943, was identified via dental record comparison.

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

[3] Ibid, 78; Exhibit 1 – Telephone call data
[4] Coronial brief, Exhibits 2-37 – 000 audio calls and transcripts
[5] Coronial brief, Statement of CFA fire fighter 1 dated 6 February 2019, 177; Statement of CFA fire fighter 2 dated 9 January 2020, 187
[6] Related coronial investigation with case number COR 2020 0889

**Medical cause of death**

21. Forensic Pathologist Dr Melanie Archer, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 11 December 2019 and provided a written report of her findings dated 4 August 2020.

22. The post-mortem examination revealed:

    a) Extensive burns which were distributed mainly over the anterior (front) surface of the body.

    b) There was no evidence of significant smoke inhalation.

    c) There were a number of injuries identified including one incised injury to the left ear, blunt force trauma in the form of bruising over the scalp, the left jaw, the inside of the lower lip, the arms and right-side strap muscles of the neck.

    d) No evidence of defensive injuries.

23. Whilst some family members held a belief that Mrs Weidemann suffered from dementia, she was never formally diagnosed with or treated for dementia. Rather, Mrs Weidemann was diagnosed with and treated for depression from by her general practitioner since June 2017. A neuropathological report dated 24 August 2021 was prepared by Dr Linda Iles at the VIFM which concluded that there was no evidence of clinical dementia.

24. Toxicological analysis of post-mortem samples identified the presence of the antidepressant venlafaxine in keeping with therapeutic use.

25. Dr Archer provided an opinion that the medical cause of death was 1 (a) Effects of fire in a woman with head and neck injuries.

26. I accept Dr Archer's opinion.

**FAMILY CONCERNS**

27. Mr Weidemann's son, David Weidemann, held a number of concerns with regards to the care and services provided to both his parents in the lead up to the fatal incident and directly after. The concerns can be summarised as follows:

a) That the treating General Practitioner (GP) was out of his depth when treating Mr and Mrs Weidemann;

b) The release of Mr Weidemann from compulsory admission to Box Hill hospital in November 2019 was pre-mature and there was a lack of consideration provided to the family to support Mr Weidemann after discharge; and

c) Mr Weidemann's mental health treatment whilst in custody.

28. I have carefully considered the concerns raised and a thorough review was conducted by the Coroners Prevention Unit of the mental health services provided by Eastern Health and the General Practitioner (**GP**) who treated both Mr and Mrs Weidemann.

29. The role of the coroner is limited. Concerns that are not sufficiently proximate to, or directly causative to, or contributory to, the cause of death fall outside the coroner's remit and are not investigated by a coroner.

30. The available evidence does not support any link between alleged deficiencies in care provided by Eastern Health or the treating GP and the cause of Mrs Weidemann's death.

## FURTHER INVESTIGATIONS AND CORONER'S PREVENTION UNIT REVIEW

*Family violence investigation*

31. The unexpected, unnatural and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given that everyone has a right to safety, respect and trust in their most intimate relationships.

32. For the purposes of the Family Violence Protection Act 2008, the relationship between Mr and Mrs Weidemann was one that fell within the definition of '*spouse'*[7] under that Act. Moreover, the fatal attack on Mrs Weidemann and consequent deliberately set fire constitutes '*family violence'*.[8]

33. In light of Mrs Weidemann's death occurring under circumstances of family violence, I requested that the Coroners' Prevention Unit (**CPU**)[9] examine the circumstances of her death

[7] Family Violence Protection Act 2008, section 8(1)(a)
[8] Family Violence Protection Act 2008, section 5
[9] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety

as part of the Victorian Systemic Review of Family Violence Deaths (**VSRFVD**).[10] I also requested the CPU Mental Health team review records for the mental health treatment provided to Mr Weidemann.

*Mental health services provided to Mr Weidemann proximate to the fatal incident*

34. Mr Weidemann was diagnosed and treated for depression in June 2017. He reported significant improvement following initial treatment with an antidepressant but was involved as a driver in a car versus bicycle accident in September 2017. Mr Weideman presented at that time with anxiety and depression, and was noted to have developed delusions, which proximate to his death and following a psychiatric assessment by Box Hill Hospital clinicians, were attributed to cognitive impairment.

35. Mr Weidemann's treating General Practitioner (**GP**), Dr Butrev, prescribed the antipsychotic quetiapine and by January 2018, Mr Weidemann presented as improved without delusions and requested his antidepressant be reduced, however the delusions re-emerged shortly afterwards. Dr Butrev believed Mr Weidemann had ceased the quetiapine and recommended recommencement which controlled the delusions. Mr Weidemann attended the GP clinic regularly and his mental state was stable until his cancer diagnosis in 2019. [11]

36. On 7-11 November 2019, Mr Weidemann was admitted to the oncology ward at Box Hill Hospital. Mr Weidemann was treated with a likely diagnosis of cancer. Mr Weidemann's condition improved, and he was discharged home with an outpatient appointment for 19 November 2019. [12]

37. On 14-20 November 2019, Mr Weidemann was admitted to the Oncology ward at Eastern Health after presenting to the emergency department with similar symptoms to his 7-11 November admission and he was diagnosed with adenocarcinoma. He was teary and worried about his future; stated his family was moving into his home to look after him and his wife; that he only had weeks to live (which was disputed by staff); that he did not want any further treatments; and wanted to go home with his son's support. Mr Weidemann was assessed as

[10] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focused recommendations aimed at reducing the incidence of family violence in the Victorian Community

[11] Statement of Dr Audrey Butrev re Ruldoph Wediemann dated 29 December 2020.

[12] Statement of Dr Margaret Lee dated 6 May 2021.

having capacity and was allowed to discharge himself against medical advice on 20 November 2019 with scheduled outpatient follow-up appointments.

38. On 25 November 2019, Mr Weidemann with his wife Ms Weidemann and son David consulted with Dr Butrev who was made aware Mr Weidemann had discharged himself against medical advice and had refused treatments. Mr Weidemann stated he would suicide if the pain was too bad, but was not suicidal at the time, and refused a referral to psychiatric services. The family was noted to have agreed with the treatment offered and the plan for a review in two weeks. Crisis contact information was provided by Dr Butrev.

39. On 29 November 2019, Mr Weidemann was taken to Eastern Health after he had been the focus of a five-hour siege, was tasered and transferred by police under Section 351 of the *Mental Health Act 2014* (Vic) to the emergency department at Box Hill Hospital. Dr Liu removed the taser spikes and physically cleared Mr Weidemann. Dr Liu assessed him as competent, orientated, logical, coherent and upset over the incident, but did not believe he was suicidal. [13] Dr Liu assessed his presentation as unchanged since his discharge on 20 November 2019 and he was admitted to the Direct Assessment Short Stay Unit (**DAS**) and assessed by the DAS intern the Psychiatric Triage Service (**PTS**) who documented the paranoid beliefs associated with the accident two years earlier and spoke with Mr Weidemann's sons, David and Robert.

40. Mr Weidemann stated he had been searching for his will as he had recently written a new one because the old will did not include his wife.[14] This coincides with Ms Weidemann attending her GP because she wanted to make a will. While searching, he found a letter from a lawyer absolving him of any fault in the 2017 bicycle accident, then misplaced the letter, became frustrated with his son, could not be calmed and the police were called. On this occasion, he stated he was frightened, grabbed a knife and threatened suicide. Mr Weidemann was assessed as low risk of harm to self and others and was noted to be functionally coping however David believed his father had depression to which carer burden contributed. David reported he and his brother Robert had recently been assisting with household chores and caring for Mrs Weidemann. He was concerned their father would not allow them to continue to help because of their role in the pre-admission incident, including calling police.[15]

41. On 29 November 2019, a Box Hill Hospital social worker documented a discussion with Mr Weidemann about how he will care for himself as he deteriorates, and he stated David would

[13] Statement of Dr Anita Liu dated 7 May 2021.
[14] Eastern Health medical records RR prdd1-21550489, page117.
[15] Statement of Dr Anita Liu dated 7 May 2021.

do what was needed. David discussed with the social worker the help required including house cleaning, the laundry associated with his mother's incontinence and making sure his mother ate her food.[16] Mrs Weidemann was noted to have dementia, that David thought her safe in the home alone if her sons visited and stayed long periods during the day, and she was safe alone overnight with an early morning visit. [17] David described his father as irrational, paranoid, worried and stated that he was frightened of his father.[18] He advised that Mr Weidemann had been threatening suicide for some years, that carer burden played a part and that he was depressed even before the accident. [19]

42. The Palliative Care Team assessed Mr Weidemann and in addition to his cancer diagnosis and treatment, identified pain, delusions and discharge planning needs.[20] Mr Weidemann had been prescribed a buprenorphine[21] patch by his GP and denied any current pain. The delusions and paranoia were noted to have been related to the accident, that Mr Weidemann had constructed a wall unit to hide related documents and that his misplacement of a document led to the incident with police. He was disinhibited, labile and tangential, paranoid and obsessed with the document. He was orientated to time and place but was assessed as having impaired insight into his cancer diagnosis and ability to care for his wife. He said he would accept palliative care services. He denied suicidal thinking but stated he was prepared for the police to shoot him. It was noted that because of the circumstances preceding Mr Weidemann's admission, he would require a psychiatry assessment and possibly a neuropsychology assessment[22].

43. The Palliative Care Team noted David's assessment that his father genuinely wanted to die that day, that he was angry it was unsuccessful and noted from the social worker's assessment David's concerns regarding threats of suicide for the last few years and belief his father has depressive illness, that his mental state had deteriorated, and suicidal risk increased as he became more ill: [23]

*Despite repeated questions is unable to display insight into fact has incurable cancer and how he will be able to manage care for his wife with dementia and for his own*

16 Eastern Health medical records RR prdd1-21550489, page 72.

17 Eastern Health medical records RR prdd1-21550489, page 76.

18 Eastern Health medical records RR prdd1-21550489, page 76.

19 Eastern Health medical records RR prdd1-21550489, page 75.

20 Eastern Health medical records RR prdd1-21550489, page 124.

21 Statement of Dr Anita Liu dated 7 May 2021.

22 Statement of Dr Eswaran Waran Palliative Medicine Specialist dated 7 May 2021 & Statement of Dr Alan Starke dated 6 May 2021.

23 Eastern Health medical records RR prdd1-21550489, page 125.

*declining health. Advises would "have palliative care" but does not understand what this entails, nor once discussed how this would help his care and ability to manage at home.*

*Does not appreciate risk to self in that situation or how he and wife will manage their care, unclear that judgement is intact.*

*Needs Psychiatric and Neuro-Psychology assessment. Is likely to be high risk for self discharge home with no community supports with family that has grave fears for his safety.* [24]

44. The Palliative Care Team referred Mr Weidemann to the Consultation Liaison Psychiatry service (**CL**), the clinical inpatient referral-based service that does not manage patients directly but provides psychiatric support to the primary team who is responsible for the clinical care of the patient. CL psychiatric registrars assessed Mr Weidemann, noted his medical and recent psychosocial history including that he had been tasered; brought in by police on 29 November 2019; had a history of depression in the context of being harassed following his involvement in the accident in 2017; believed he had been chased by cameras and harassed; believed that people had broken into his home, and displayed some grandiosity[25]:

*Mr Weidemann reported the circumstances surrounding police involvement as a "conspiracy". He advised he had hidden an important letter behind a wardrobe which his son was helping him locate. He found the letter and then it had disappeared and he became upset and ultimately the police were called. He was noted to minimise his standoff with police and advised that he was fearful for his safety but denied any suicidal intent or threats of self-harm at the time of the standoff and during the assessment on 2 December 2019.* [26]

45. Mr Weidemann was noted to minimise any distress about his cancer diagnosis but understood and was able to explain his reasons for not wanting any further treatment and he did not want mental health treatment. CL contacted Robert and David who were with Mrs Weidemann at her home. Robert wanted his father to remain in hospital for treatment of his delusional thoughts. The limitations of the *Mental Health Act 2014* (Vic) were explained and that their father did not meet the criteria for compulsory treatment. A mental state examination and Clinical Risk Assessment and Management tool (CRAM) assessed him as medium risk of self-harm and

24 Eastern Health medical records RR prdd1-21550489, page 125.

25 Eastern Health medical records RR prdd1-21550489, page 116.

26 Statement of Dr Jonathon Starke dated 6 May 2021.

suicide, low risk of harm to others and medium risk of cognitive impairment with a Montreal Cognitive Assessment score of 14/30[27]. CL noted he had decision-making capacity in the absence of depressive symptoms regarding his refusal for cancer treatment however the paranoid ideation was likely secondary to cognitive impairment and may result in impulsivity.

46. The plan was for a referral to Aged Psychiatry Assessment and Treatment Team (APATT) closer to discharge, advocacy for Eastern Palliative Care (**EPC**) to be involved and in home supports to assist Mr Weidemann to care for his wife and reduce the carer burden on the family[28]. CL contacted GP Dr Butrev and discussed that CL wanted to prescribe quetiapine and an antidepressant however Mr Weidemann had refused, and CL had assumed Dr Butrev had more rapport with Mr Weidemann, and he was asked to prescribe the medicines, which he agreed to try and arrange. [29]

47. Consultant medical oncologist Dr Anis Azhar Hamid assessed Mr Weidemann and noted he did not have any worsened symptoms associated with the cancer and that the focus of the admission was to organise multidisciplinary assessment. Mr Weidemann looked well, did not have pain, wanted to go home with his wife and following the earlier assessments by CL and the Palliative Team the plan was for discharge home and follow-up by EPC with an outpatient appointment for two weeks. Dr Hamid referenced the CL and social work notes that Mr Weidemann had looked after his wife well historically and was a low risk to others. Dr Hamid referred to the social worker reports that Mr Weidemann was able to care for his wife, including prompting her to shower and managing her hygiene and at times incontinence. When asked about how he would cope as he became more unwell, he stated his son David would provide practical assistance. [30]

48. A social worker from Box Hill Hospital spoke with David who described his father's relationship with his other siblings as estranged leaving only him and Robert with regular

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27 The Montreal Cognitive Assessment is used to detect mild cognitive impairment. It was developed to distinguish clients with mild cognitive impairment from normal elderly clients. It is intended for clients with memory problems who score within the normal range on the Standardised Mini Mental State Examination. The total possible score is 30 points, a score of 26 or above is considered normal. In the initial study data establishing the MoCA, normal controls had an average score of 27.4, compared with 22.1 in people with mild cognitive impairment (MCI) and 16.2 in people with Alzheimer's disease. The following ranges may be used to grade severity: 18-25 = mild cognitive impairment, 10-17= moderate cognitive impairment and less than 10= severe cognitive impairment. However, research for these severity ranges has not been established yet. https://www.mocatest.org/faq/

Eastern Health medical records RR prdd1-21550489, pages 89, 249.

28 Eastern Health medical records RR prdd1-21550489, page 115.

29 Eastern Health medical records RR prdd1-21550489, page 115.

30 Statement of Dr Anis Azhar Hamid dated 7 May 2021.

contact. David's concerns regarded his father's mental state, the previous level of care the brothers provided including to their mother, and Robert's fear of his father and wish not to be involved. David was going to limit any conflict with his father because his father wanted peace.

49. The social worker reported to David his parents could not have any in-home supports because of the siege and told David that, *given nil services available, responsibility sits with David to monitor + manage risk to Ruldolf + wife Ms Weidemann at home – David understanding of same and accepting risk*.[31] It is unclear why this decision was made by the social worker which resulted in referrals not being made to other in-home support services[32] who could reach their own assessment as was the case with referrals to APATT and EPC.

50. The social worker encouraged David to apply for a My Aged Care Aged Care Assessment Service (ACAS) urgent assessment for his mother, however David reported his efforts to do so caused conflict with his father and the family did not believe an assessment for his mother could be arranged "until dad is not on the scene" and *Further discussion re monitoring wife's safety + welfare at home, David agreeable to manage this on Rudolf's discharge and states he will continue to visit daily*[33].

51. The social worker highlighted the potential problems of securing home supports and that David understood, would visit daily and provide the necessary supports. David told the social worker that his enquires about ACAS had caused conflict between he and Mr Weidemann and David was encouraged to complete the My Aged Care application but felt this was not manageable at that time. Dr Hamid noted Mr Weidemann was able to continue to complete his usual activities.[34]

52. On 3 December 2019, Mr Weidemann was reviewed by the Oncology Team CNC who noted he was calm and wanted to go home. The nurse made a referral to EPC which included the CL and the Palliative Care Team notes, and the social work assessment made during the last admission. Mr Weidemann was discharged home and the discharge summary noted principal diagnosis as acute behavioural disturbance.

*Mr Weidemann's post discharge service contact*

31 Eastern Health medical records RR prdd1-21550489, page 71-72.

32 Such as home-help; personal care for Emma based on the belief she required care by Mr Weidemann.

33 Eastern Health medical records RR prdd1-21550489, page 72.

34 Statement of Dr Anis Azhar Hamid dated 7 May 2021.

53. On 4 December 2019, Mr Weidemann's referral was allocated to an APATT psychologist. Consultant Psychiatrist Dr Antonia Planinic noted the purpose of the referral was to provide support to EPC as there were concerns about worker safety and Dr Planinic requested further information about the scope of the referral. The APATT psychologist noted Mr Weidemann had refused cancer treatment and wanted to be at home with his wife who had dementia, that he had paranoia because of cognitive decline and a Montreal Cognitive Assessment[35] score of 15/30, that his sons were overwhelmed but supportive and palliative care were involved[36].

54. On 5 December 2019, EPC staff visited Mr Weidemann at his home and noted that he showed poor insight into how the course of the illness may look, and as carer for his wife who has Alzheimer's disease[37], that *Rudy is emotionally labile and requires an approach to his care which allows him to feel in control and that rapport building and client trust were necessary for ongoing support to Ms Weidemann and Mr Weidemann,*[38] and *At such times his conversation can become inconsistent, sometimes with a tendency towards volatility*[39]. It was agreed that EPC would provide services including CNC Mackinnon and Family Support Worker (FSW) Annabel[40].

55. On the same day, an APATT clinician spoke with Mr Weidemann who reported he had been visited by a palliative care nurse at home and had an analgesia patch which made him feel better. He did not believe APATT was needed as it doubled up with the other nurses and he said the events preadmission had been a mistake and he did not want to hurt himself or his family, that he had repaired his relationship with his son after 20 years (unclear which son or when) and was concentrating on being with his family. APATT explored Mr Weidemann's attitude to his family who said he felt disrespected by his son but would forgive him and agreed for APATT to speak with David. Unsuccessful attempts to speak with David via phone and SMS were made and the plan was for discussion at the next case conference meeting and for probable discharge[41].

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35 The MoCA is used to detect mild cognitive impairment. It was developed to distinguish clients with mild cognitive impairment from normal elderly clients. It is intended for clients with memory problems who score within the normal range on the Standardised Mini Mental State Examination. The total possible score is 30 points, a score of 26 or above is considered normal. In the initial study data establishing the MoCA, normal controls had an average score of 27.4, compared with 22.1 in people with mild cognitive impairment (MCI) and 16.2 in people with Alzheimer's disease.

36 Statement of Dr Antonia Planinic dated 6 May 2021.

37 Eastern Palliative Care medical records page 2.

38 Eastern Palliative Care medical records page 2.

39 Eastern Palliative Care medical records page 2.

40 Eastern Palliative Care medical records page 2.

41 Statement of Dr Antonia Planinic dated 6 May 2021.

56. On 10 December 2019, an EPC Manager spoke with David on the phone who reported all was settled, that he was visiting and preparing goulash. David said he would speak with his father again about supports for his mother but that the My Aged Care paperwork was extensive.

**FINDINGS AND CONCLUSION**

57. Pursuant to section 67(1) of the Act I make the following findings:

    a) the identity of the deceased was Emma Gertrude Weidemann, born 5 June 1943;

    b) the death occurred on 11 December 2019 at 29 Templeton Street, Wantirna, Victoria, 3152, from the effects of fire in a woman with head and neck injuries; and

    c) the death occurred in the circumstances described above.

58. The available evidence supports a finding that Mr Weidemann was facing a number of significant life significant at the time of the fatal incident, including significant mental health issues and a recent cancer diagnosis.

59. While I have made comments below that appear appropriate to me as they arise from the coronial investigation into Mrs Weidemann's death, the available evidence does not support a finding that there is any causal connection or contribution between the circumstances highlighted in the comments and Mrs Weidemann's death.

**COMMENTS**

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

*Appropriateness of proximate mental health treatment provided to Mr Weidemann*

60. The Director of Clinical Operations, Clinical Governance, Safety and Quality at Eastern Health provided a statement to the Court regarding an In-Depth Case Review (IDCR) completed by the Adult Acute Mental Health Program.[42] The IDCR found that:

    a) There was a lack of recognition of Mr Weidemann's mental illness which may have been contributed to by the circumstances in which he presented to hospital, his physical health

[42] Statement of the Director of Clinical Operations, Clinical Governance, Safety and Quality (Eastern Health) dated 24 May 2021, 1

issues and potentially the focus on Mr Weidemann's capacity to make decisions in this context.

a) Collateral information should have been considered.

b) Mr Weidemann may have benefited from a review by a consultant psychiatrist.

61. Eastern Health confirm that the following actions in the IDCR management plan which have all been implemented:[43]

a) To identify how to provide learning opportunities from the results of an IDCR, a root cause analysis (RCA) or mortality and morbidity (M&M) complaints review rather than the process to be punitive.

b) To work to ensure staff have time for collateral information collection and time for reflection to develop formulation of actions.

c) To develop expectation for timeframes and frequency of family care and meetings in all streams. To ensure family and carers given opportunity to provide collateral information including expectations for creating opportunities, providing information independently of consumers.

d) To create an expectation of support by senior staff to assist in gathering collateral information and problem-solving to do with collateral information.

62. The available evidence supports CL clinicians' position that even if Mr Weidemann's symptoms were assessed as more severe, it would not have met the requirements for compulsory treatment, that he had decision-making capacity regards his refusal for cancer treatment and he had agreed to engagement with APATT after discharge.

63. Mr Weidemann's son David has confirmed with the Court that there is dissatisfaction with practitioner assessments of his father's cognition and competency. The Eastern Health guidelines specify capacity is situation specific as a person may have the capacity to carry out some tasks, but not the capacity to carry out others and that a person's capacity may also vary at different times in different circumstances. [44]

[43] Ibid, 4-5

[44] Eastern Health Capacity Assessment for Patients in Relation to Making Legal Documents Guideline reviewed in June 2019.

64. The Palliative Care Team initially required a psychiatry review and a neuropsychology assessment however it is not clearly documented why the neuropsychology assessment was not completed. According to the available medical records, Mr Weidemann was competent and therefore had decision-making capacity. The assessment appears to have been completed through ongoing reviews and not in a formal process. [45]

65. CL psychiatric registrar Dr Stella noted Mr Weidemann had decision-making capacity[46] in the absence of depressive symptoms regarding his refusal for cancer treatment only. It is however unclear why the discharge summary included advice to prescribe an antidepressant and for this to be followed up with the treating GP. [47] Dr Stella noted Mr Weidemann's paranoid ideation was likely secondary to cognitive impairment and may result in impulsivity.

66. Mr Weidemann's capacity to make decisions regards his refusal to have treatment was established and documented, however as noted in the Eastern Health guidelines, this cannot be assumed to apply to his decision-making capacity to other aspects of his life. There is an absence of any documented discussion in the medical records provided to the Court about Mr Weidemann's ability to make decisions for his wife and to regard her best interests.

67. The available assessments conducted on 30 November 2019, 2 December 2019 and 3 December 2019 noted that clinicians were reassured by the involvement of David in the care of his parents, and that he had been assessed as having decision-making capacity (in his refusal of treatment). The additional needs of Mr Weidemann and his wife were left with their son David and acknowledging David was accepting of the risks, his decision was made in the context of

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45 If an Eastern Health clinician agrees to formally assess a patient's capacity, the following procedure should be followed: (i) Only qualified medical practitioners or clinical neuropsychologists employed by Eastern Health are authorised to undertake capacity assessments for patients. If available, a medical practitioner should refer the capacity assessment to a neuropsychologist. (ii) Capacity assessments should only be carried out by these authorised clinicians who have an understanding of the relevant legal concepts and clinical experience in such assessments. (iii) An Eastern Health clinician should only provide an opinion in relation to a patient's capacity after completing a specific clinical assessment of the patient's medical and psychological state. Medical evidence will draw on a consideration of the patient's full clinical history, physical findings, and observations at the time in question, any relevant drugs being administered and results of formal mental state examinations including standardised examinations such as the Mini Mental State Examination (MMSE). (iv) All capacity assessments should be situation specific as general opinions in relation to capacity may not be sufficient if later challenged in a court or tribunal. Accordingly, specific reference should be made to the document or decision to be made. All assessments made in relation to a patient's capacity must be fully documented in the clinical notes and stored on the Clinical Patient Folder (CPF).

Statement of Dr Margaret Lee dated 6 May 2021.

46 Decision-Making Capacity' means, in relation to a particular decision, being able to: (a) Understand the information about the decision and its effect; (b) Retain enough of that information to make the decision; (c) Use or weigh that information to make the decision; and (d) Communicate the decision, and any views and needs regarding the decision, e.g. by speech, in writing or by gestures. Eastern Health - *Medical Treatment –Consent, Refusal, Advance Care Directives Standard*.

47 Eastern Health medical records page 5.

minimal alternatives. Although EPC did in fact accept the post-discharge referral (despite concerns noted below) and they may have engaged with other services as they developed relationships with the family, it doesn't change the fact David was left with the sole responsibility for his mother's care.

*Mr Weidemann's discharge from Box Hill Hospital on 3 December 2019 and consideration of family violence risk*

68. The available evidence suggests that there was a significant history of unreported family violence in the form of verbal abuse, intimidation, threats of self-harm and coercive control between Mr and Mrs Weidemann particularly in the two to three years prior to the fatal incident.

69. Whilst Mr Weidemann's sons reported being subjected to many incidents of verbal abuse and threats of self-harm in the past neither affirmed any recent concerns about specific family violence risk between their father and mother.[48]

70. Furthermore, assessments performed by clinicians at Box Hill Hospital on 29 November 2019, 2 December 2019 and 3 December 2019 noted no reports of Mr Weidemann harming his wife, no reported concerns for her direct safety from her sons and notes that Mr Weidemann was instead '*protective'* of his wife.[49]

71. Upon Mr Weidemann's release from hospital on 3 December 2019, David was offered limited supports for the responsibility of looking after his parents. The indications of Mr Weidemann's cognitive impairment and likely impulsivity were recorded in medical records provided to the Court but there is no evidence this influenced the assessment of Mr Weidemann's capacity to continue to care for and make decisions for his wife. The emphasis on discharge approval appears to be focused on Mr Weidemann's decision-making capacity to refuse treatment but not the limitations of his capacity to continue to care for and make decisions for Mrs Weidemann.

72. On 6 May 2021, Eastern Health (on behalf of Box Hill Hospital) provided the Court with a copy of current policies and procedures relating to family violence, elder abuse, risk assessment and information sharing. These policies were largely developed in response to recommendations following the Royal Commission in Family Violence (**RCFV**) and the introduction of the Family Violence Multi-Agency Risk Assessment and Management Framework (**MARAM**).

[48] Mr Weidemann's medical records provided to the Court by Eastern Health, 71-72 of 258; 75-76 of 258
[49] Ibid, 72 of 258

The MARAM provides guidance to practitioners across the Victorian service system about family violence, and their responsibilities to undertake family violence risk assessment and management, to share information, and to work collaboratively.[50]

73. Mr Weidemann was 81 years-old and dying of a terminal illness and it is reasonable to accept the focus of the treating teams was on his best interests and his wishes. Nonetheless, there were according to the MARAM, serious risk factors including a previous incident of violence (behaviours prior to and following the engagement of police that resulted in the recent siege),[51] controlling behaviours (not wanting David to arrange services for Ms Weidemann),[52] suicide and self-harm threats,[53] and a mental illness (both for Mr and Mrs Weidemann's dementia),[54] that should have resulted in greater efforts to engage with the family especially in light of both David and Robert having expressed fear of their father[55], to establish risks and how to mitigate them, even using the current Eastern Health 2017 Clinical Practice Guideline.

74. The only planned referral for follow up in home care upon discharge from Box Hill Hospital was for Eastern Palliative Care to make contact with the family.[56] This is despite the fact that on 2 December 2019, in an earlier patient review, clinicians noted concerns about discharge care including:

> *Given involved in 5 hour stand off with knife held to his own chest and negotiations with Victorian Police Special Operations Group culminating in* ***Rudolf being tasered will not be accepted for community palliative care with Eastern Palliative Care***
>
> ***Likely to have similar issues with other community services, and likely Rudolf will not accept given his distrust of others***
>
> *Needs Psychiatric and Neuro-Psychology assessment*
>
> ***Is likely to be high risk for self discharge home with no community supports with family that has grave fears for his safety***[57] *[Bold emphasis added]*

[50] For more details on the MARAM see online resource: https://www.vic.gov.au/maram-practice-guides-and-resources

[51] Mr Weidemann's medical records provided to the Court by Eastern Health, page 115-116 of 258

[52]

[53]

[54] GP references to mental health treatment

[55]

[56] Mr Weidemann's medical records provided to the Court by Eastern Health, 115 of 258

[57] Ibid, 125 of 258

75. It was further noted by clinicians during the 2 December 2019 consultation that:

*David said that Robert told him that he is now afraid to go to his parents place as he is worried that Rudolf might hurt him since he encourage the phone call to Police.*

*David and Robert want their father and mother to be cared for by helpers given they won't be able to support for the foreseeable future, due to Rudolf's decision to not see his sons now.*[58]

76. Part of the treatment plan recorded during the 2 December 2019 consultation was:

*EPC would be very reluctant to be involved given forensic issues detailed above, and will need further psychiatric input given that as Rudolf's functional ability continues to deteriorate his risks are likely to only rise.*[59]

77. The available evidence demonstrates limited exploration of family violence risk factors by treating medical clinicians or discussion with Mr Weidemann's family as to whether his cognitive impairment and associated impulsivity was a risk that the family could manage after his discharge from hospital following a police siege on 29 November 2019.

## RECOMMENDATIONS

Pursuant to section 72(2) of the Act, I make the following recommendations:

To **Eastern Health** I recommend:

1. That a review is conducted into clinician guidelines to ensure clearer communication between the clinician and patient and/or their supporting family members when assessing a patient's decision-making capacity beyond the ability to refuse treatment; and

2. That clinical guidelines provide for any specific request for assessment of decision-making capacity be documented and communicated to relevant supporting family members where appropriate. If the assessment is only relevant to the decision to refuse treatment, it should not be assumed to apply to other decisions or situations. The assessment should be communicated or clarified to relevant supporting family members where appropriate.

[58] Ibid, 126 of 258
[59] Ibid

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

Pursuant to section 73(1A) 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

Jessica Jones, HWL Ebsworth

Dr Yvette Kozielski, Eastern Health

Leading Senior Constable Dimitrios Gogorossis, Coroner's Investigator

Signature:


Coroner Paresa Antoniadis Spanos

Date : 25 May 2023

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.