



## FINDING OF INQUEST

*An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 16<sup>th</sup> day of March and the 30<sup>th</sup> day of June 2021, by the Coroner's Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Anthea Ryder Mocketarinja .*

*The said Court finds that Anthea Ryder Mocketarinja aged 42 years, late of 35a Gladstone Avenue, Mile End, South Australia died at the Royal Adelaide Hospital, Port Road, Adelaide, South Australia on the 31<sup>st</sup> day of July 2019 as a result of multiple organ failure due to sepsis on a background of pneumonia, spontaneous bacterial peritonitis and end-stage liver disease. The said Court finds that the circumstances of her death were as follows:*

### **1. Introduction and cause of death**

- 1.1. Anthea Ryder Mocketarinja was born on 8 June 1977 and died at the Royal Adelaide Hospital on 31 July 2019 at the age of 42 years.
- 1.2. A pathology review was undertaken by Dr Iain McIntyre of Forensic Science South Australia. In his report he proffered an opinion as to the cause of Ms Mocketarinja's death.<sup>1</sup> I accept that opinion and find the cause of death to have been multiple organ failure due to sepsis on a background of pneumonia, spontaneous bacterial peritonitis and end-stage liver disease.

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<sup>1</sup> Exhibit C2a

## **2. Reason for Inquest**

- 2.1. Ms Mocketarinja was subject to a Level 2 Inpatient Treatment Order (ITO) at the time of her death. At the time the inquest was heard, her death was defined as a death in custody and this was a mandatory inquest.<sup>2</sup>
- 2.2. On 12 July 2019 Ms Mocketarinja was admitted to the Royal Adelaide Hospital (RAH) due to pneumonia complicated by multifactorial delirium on the background of advanced cirrhosis (chronic liver disease).
- 2.3. On 14 July 2019, she was placed on a Level 1 ITO by Dr Seimon. On 15 July 2019, the ITO was confirmed by psychiatrist Dr Georgina Weir.
- 2.4. On 19 July 2019, Dr Weir confirmed the Level 2 ITO citing as reasons impaired attention and orientation, with multifactorial delirium and demonstrating impaired decision-making capacity. The Level 2 ITO was due to expire at 2pm on 30 August 2019.

## **3. Background**

- 3.1. Information as to Ms Mocketarinja's background has been obtained predominately from her brother, Clinton Johnson<sup>3</sup> and the medical case notes. Mr Johnson did not know his sister well as they were growing up, but they became very close as they grew older.
- 3.2. Ms Mocketarinja was an Aboriginal woman born on 8 June 1977 in Alice Springs. She was raised by her mother in Hermannsburg in the Northern Territory. She had other siblings, Derek, Caroline and Barbara Mocketarinja.
- 3.3. Ms Mocketarinja remained in Hermannsburg until the death of her mother and then, in about 2006 or 2007, moved to South Australia to live with Barbara, before moving into a house at 35a Gladstone Avenue, Mile End where she resided until her death.
- 3.4. Ms Mocketarinja never married, but had a daughter Coralee, now in her twenties. Mr Johnson states his sister's relationship with Coralee's father ended long ago, and he was not aware of any other long-term relationships. It must be noted that the SAPOL investigation report refers to RAH medical notes recording that Ms Mocketarinja advised medical staff of a biological son, but no other details are known to the Court.

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<sup>2</sup> From 7 June 2021, following the amendment of section 21 of the Coroners Act 2003, Ms Mocketarinja's death would likely have been certified by a medical practitioner to have been a death due to natural causes, and would not have required a mandatory inquest

<sup>3</sup> Exhibit C5

- 3.5. Mr Johnson saw his sister weekly and last saw her at her house. On that occasion, he provided her with some money for food. Mr Johnson did not see her again before she passed away. He knew his sister as a very heavy drinker, who drank every day from early in the morning. Nevertheless, he remembers her as a mostly happy person who loved spending time with friends and family members.
- 3.6. Mr Johnson was aware that Ms Mocketarinja had some health issues and occasionally went to hospital, usually following one of the family members calling an ambulance. She did not like hospitals and had a history of discharging herself prior to the completion of relevant treatments. Mr Johnson was not aware of any mental health issues. Mr Johnson did not know whether his sister's drinking caused health issues. Her medical history clarifies this.

#### **4. Recent medical history**

- 4.1. Dr Jyothirmayi Bhumireddy was Ms Mocketarinja's main known general practitioner, at Sefton Park Primary Health Care.<sup>4</sup> The doctor first encountered Ms Mocketarinja on 19 June 2018 in relation to a wound infection of the right knee. He states she was difficult to engage with and was a poor historian.
- 4.2. Impaired liver function was first diagnosed on 26 September 2018. Ms Mocketarinja was advised that to treat the liver disease, she would need to control her alcohol intake. However, she did not follow the advice, despite the ramifications. The doctor states that her prognosis was poor. There was no ongoing treatment plan as, despite attempts to contact her, she would not engage with the practice.
- 4.3. On 5 June 2019, Ms Mocketarinja presented to the RAH with a cough, shortness of breath, fever and vomiting. She was diagnosed with atelectasis with loss of lung volume, advanced liver disease, portal hypertension and an E.coli infection. She was deemed to be at a high risk of pneumonia and other infections. Against medical advice, she absconded from hospital after three days, before her treatment and diagnosis was completed.
- 4.4. Dr Bhumireddy last saw Ms Mocketarinja on 19 June 2019, when she was brought in by her family with a blood infection (bacteraemia). He was informed that this illness developed after she self-discharged herself from hospital prematurely, before her treatment was completed. She was sent to the RAH for further treatment, where she

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<sup>4</sup> Exhibit C4

remained for nine days before being discharged. Her health remained poor and she had a persisting lung infection. This was treated using antibiotics but she remained uncooperative.

- 4.5. On 3 July 2019, Ms Mocketarinja presented to the Murray Bridge Hospital with abdominal pain and a cough with yellow mucus. She was transferred to the RAH. Her symptoms were deemed to be chronic. She remained there for three days before being discharged.

## **5. Last Royal Adelaide Hospital admission**

- 5.1. On 12 July 2019, Ms Mocketarinja was admitted to the RAH due to pneumonia complicated by multifactorial delirium on the background of advanced cirrhosis of the liver.
- 5.2. On 16 July 2019, Dr Christopher Belder, a physician, commenced treating Ms Mocketarinja.<sup>5</sup> He considered her liver disease to be due to alcohol abuse.
- 5.3. Dr Belder states Ms Mocketarinja was difficult to engage with and non-compliant. She was treated for pneumonia with intravenous antibiotics. She had chronic haemolytic anaemia, thought to be a consequence of her advanced liver disease, and was also treated for hepatic encephalopathy. Due to her limited engagement, the doctor found it difficult to assess her mental state and degree of confusion.
- 5.4. Dr Belder states her condition initially appeared to have improved and returned to baseline. However, at her baseline she was still significantly unwell, due to her advanced liver disease, which carried a very poor prognosis.
- 5.5. As already mentioned, on 19 July 2019, psychiatrist Dr Weir imposed a Level 2 ITO, as Ms Mocketarinja continued to demonstrate impaired decision-making capacity with impaired attention and orientation.
- 5.6. Dr Belder states that on 29 July 2019 Ms Mocketarinja became more confused, in his opinion due to the worsening encephalopathy. She had refused several doses of (lactulose) medication.

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<sup>5</sup> Exhibit C1

- 5.7. A CT scan on the same day revealed multiple regions of ongoing lung infection. She was placed back on intravenous antibiotics and was moved to a negative pressure room until tuberculosis could be excluded.
- 5.8. On 30 July 2019, there was a medical emergency team (MET) call for low blood pressure. She was thought to have worsening sepsis due to her lung infection. Antibiotics were escalated and intravenous fluid resuscitation resulted in improved blood pressure. A fluid sample from the abdomen showed infection (spontaneous bacterial peritonitis), for which the antibiotic she was already receiving was providing appropriate cover. Her condition was discussed with infectious disease and gastroenterology teams.
- 5.9. On 30 July 2019 at 1:30pm, there was another MET call for low blood pressure which was again managed using fluid resuscitation. Review by a MET consultant gave an impression of multiple organ failure, secondary to refractory sepsis, likely as the terminal phase of her condition. The plan was for ongoing treatment and to contact the family to advise of her deterioration.
- 5.10. A multi-disciplinary determination was made that, in the setting of Ms Mocketarinja's chronic liver disease, intensive care would not be appropriate, in the circumstances of her significant deterioration.
- 5.11. At 4pm her blood pressure had improved to 97, she was drowsy but appeared comfortable. Dr Belder handed over her care at 4:30pm to Dr Bazzi.
- 5.12. At 9pm, Nurse Priyani Rodrigo commenced working the night shift and was responsible for the care of Ms Mocketarinja.<sup>6</sup>
- 5.13. At 10:10pm the nurse checked vital signs. Blood pressure was low and a MET call was made. Ms Mocketarinja was treated with albumin. Unsuccessful attempts were made to contact commence family members, regarding commencing palliative care. Ms Mocketarinja was stabilised by 11:50pm.
- 5.14. The nurse checked on Ms Mocketarinja every half hour. Her condition deteriorated, resulting in a further MET call. At 12:30am on 31 July 2019, the MET team applied a

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<sup>6</sup> Exhibit C3

non-rebreather mask to give maximum oxygen intake. Ms Moketarinja's condition did not improve and she passed away at around 1:30am.

## **6. Coronial investigation**

- 6.1. Due to the imposition of the Level 2 ITO, a police investigation commenced. Detective Brevet Sergeant Rowen Male from SAPOL Western District Criminal Investigation Branch provided a final investigation report<sup>7</sup>.
- 6.2. The investigation addressed, carefully and in detail, by reference to the statements and medical records obtained:
- whether the care and treatment provided to Ms Moketarinja by Sefton Park Primary Health Care was appropriate;
  - whether the care and treatment provided by the Royal Adelaide Hospital was appropriate; and
  - whether the issue and continuation of an Inpatient Treatment Order was appropriate.
- 6.3. Detective Brevet Sergeant Male concluded that the care and treatment at Sefton Park Primary Health Care Unit was appropriate, the care and treatment provided at the Royal Adelaide Hospital was appropriate and that the ITOs were valid and appropriate. Based on my consideration of the statements and medical records, I agree with these conclusions and I so find.

## **7. Recommendations**

- 7.1. I make no recommendations.

*Key Words: Death in Custody; Inpatient Treatment Order*

*In witness whereof the said Coroner has hereunto set and subscribed his hand and*

*Seal the 30<sup>th</sup> day of June, 2021.*

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*State Coroner*