QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of John Raymond Ainsworth**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Townsville
FILE NO(s):	2021/185
DELIVERED ON:	18 October 2024
DELIVERED AT:	Townsville
HEARING DATE(s):	18 October 2024
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, natural causes, death in custody.

REPRESENTATION:

Counsel Assisting:	Ms N Macregeorgos
Queensland Corrective Services	Ms A Scales, QCS Legal Strategy & Services

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Introduction

1. John Raymond Ainsworth was sixty-eight years of age when he passed away in the Townsville University Hospital (TUH) Palliative Care Unit on the afternoon of 12 January 2021. Mr Ainsworth had been transferred from the Townsville Men's Correctional Centre (TMCC), where he had been serving a term of imprisonment for sexual offences against children, to the TUH on 25 November 2020. Mr Ainsworth died of natural causes as a result of Cerebrovascular Disease. Diabetes was also determined to be a significant condition contributing to his death but not related to the underlying cause.

Coronial jurisdiction

2. At the time of his death, Mr Ainsworth was a prisoner in custody as defined in Schedule 4 of the *Corrective Services Act 2006* (Qld). As such, Mr Ainsworth's death is a reportable death under section 8(3)(g) of the *Coroners Act 2003* (Qld) as it is a '*death in custody*'.

3. *Death in custody* is defined in section 10 of the Act.

4. In cases such as this, an inquest is mandatory pursuant to s27(1)(a)(i) of the Act. An inquest is intended to provide the public and, most importantly, the family of the deceased, with transparency regarding the circumstances of the death, and to answer any questions which may have been raised following the death.

5. The role of the coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death, and the circumstances surrounding the death – how the person died. Those circumstances are limited to events which are sufficiently connected to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. Those are matters for other courts.

6. The relevant standard of proof is that of the balance of probabilities, with reference to the *Briginshaw*[1] standard. Accordingly, the more significant the issue for determination, the clearer and more persuasive the evidence must be for the coroner to be sufficiently satisfied on the balance of probabilities that the issue has been proven:

> *But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer…In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.*[2]

7. In adjudicating the significance of the evidence, the impact of hindsight bias and affected bias must also be considered.[3] As outlined in 'The Australasian Coroners Manual':

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[1] *Briginshaw v Briginshaw* (138) 60 CLR 336.
[2] *Briginshaw v Briginshaw* (138) 60 CLR 336, 362 – 363 (Dixon J).
[3] Findings of the inquest into the death of Pasquale Roasario Giorgio, [140] – [142].

> *Hindsight bias is the tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact…It is an obvious point, but one that nonetheless bears repeating, particularly when coroners are considering assigning blame or making adverse comments that may damage a person's reputation.*
> *…*
> *Coroners should attempt first to understand the circumstances as they appeared at the relevant time to the people who were there.*
> *…*
> *Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. This distinction needs to be understood and rigorously applied.*[4]

The investigation

8. The investigation into Mr Ainsworth's death was led by Detective Sergeant Mark Tunny of the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

9. After being notified of the passing on 12 January 2021, QPS officers from Stuart Police Station and Kirwan Criminal Investigation Branch, being Constables Felicity Day and Christopher Fenton, as well as Detective Sergeant Brett McLucas, attended the TUH Palliative Care Unit. The QPS officers met with nursing staff and were escorted to Mr Ainsworth's room, where they met Mrs Ainsworth and QCS staff, CCOs Liam Norton, Justin Corbett and Deputy General Manager of TMCC, Bradley Jones.

10. Police observed Mr Ainsworth laying on the bed, with a blanket pulled up on his chest; no injuries or marks inconsistent with medical treatment were identified. Photographs were taken of Mr Ainsworth in situ and he was then conveyed to the Townsville Morgue.

11. On 14 January 2021, the Deputy State Coroner made a direction for a full police investigation to occur. A Coronial Investigation Report was prepared and provided to the Coroners Court on 11 November 2022.

12. Detective Sergeant Tunny conducted a thorough investigation in response to the direction. He concluded that there were no suspicious circumstances surrounding Mr Ainsworth's death, and Mr Ainsworth was provided with appropriate care and treatment while incarcerated. Detective Sergeant Tunny also concluded that the death was not preventable.

The inquest

13. The inquest was held at Townsville on 18 October 2024. All statements, records of interview, medical records, photographs and materials gathered during the investigation were admitted into evidence. No witnesses were called to give oral evidence. Counsel Assisting proceeded to submissions on the investigation material in lieu of any oral evidence.

[4] Hugh Dillon and Marie Hadley, *The Australasian Coroner's Manual* (The Federation Press, 2015) 10.

14. The issues considered at the inquest were the issues required by s 45(2) of the Act, and whether Mr Ainsworth had access to, and received appropriate medical care, while he was in custody.

15. I am satisfied that all material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Social and Medical History

16. Mr Ainsworth was born on 13 June 1952 in Wollongong, New South Wales and was the eldest of two children. Mr Ainsworth had a younger sister but did not maintain a close relationship with her during his adult life.

17. Mr Ainsworth was married to Deborah Ainsworth for approximately thirty years. They lived together in Woodstock, a small rural town in the locality of Townsville, prior to his incarceration. Mr Ainsworth had two adult sons from a previous marriage, although contact with them was sporadic.

18. Mr Ainsworth worked a number of jobs over his lifetime, including as a cleaner and storeman. He worked for the railways and undertook an apprenticeship in engine refurbishment before commencing employment at the Mareeba Shire Council and then the Queensland Ambulance Service (QAS). Mr Ainsworth had volunteered for the State Emergency Service (SES) for twelve years, reaching the role of group leader and training officer. His last job was working at the Sandy Creek Mine in Ravenswood.

19. Sometime in the early 2000s, Mr Ainsworth was diagnosed with Type II Diabetes and managed his condition with daily insulin injections. He also had a history of high blood pressure and high cholesterol and was known to smoke between thirty to fifty cigarettes per day. He was prescribed the following medications:

    a. Metformin extended release 1000mg twice daily;
    b. Lantus 34 units nocte;
    c. Atorvastatin 80mg daily;
    d. Aspirin 100mg daily;
    e. Amlodipine 10mg daily;
    f. Perindopril 10mg daily;
    g. Hydrochlorothiazide 25mg daily; and
    h. Amitriptyline 25mg nocte.

20. On 28 November 2017, Mr Ainsworth was charged with a number of sexual offences against children. He appeared in the Townsville Magistrates Court and was released on bail. Mr Ainsworth had no criminal history in Queensland prior to being charged with these offences.

21. On 4 February 2020, Mr Ainsworth pleaded guilty in the Townsville District Court to ten child sex offences involving two different complainants.

22. Mr Ainsworth's pleas of guilty were not timely and only occurred on the second day of trial. The jury was discharged after day one, due to one juror advising that, after viewing a recorded interview of the principal complainant, they had previously had dealings with and knew her. Prior to the empanelling of a second jury, Mr Ainsworth entered pleas of guilty in respect of the eight charges. Nolle prosequis were entered in respect of the two remaining counts on the indictment.

23. On 6 March 2020, Mr Ainsworth was taken into custody at the TMCC and on 12 March 2020, he was sentenced to a head sentence of ten years imprisonment for two counts of maintaining an unlawful relationship with a child. Mr Ainsworth was sentenced to further periods of imprisonment (to be served concurrently) in relation to the remaining six offences, ranging from twelve months to six years. Despite his pleas of guilty, Mr Ainsworth had maintained his innocence.

24. On 6 November 2020, Mr Ainsworth plead guilty to two further charges of indecent treatment of child under sixteen years of age. Mr Ainsworth was due to be sentenced for these offences on 9 December 2020, however, due to his declining health and inability to provide further instructions to his solicitors, the sentencing hearing was ultimately de-listed.

25. On 19 January 2021, the Crown entered a nolle prosequi in relation to both charges as Mr Ainsworth had passed away.

26. By the afternoon of 7 January 2021, Mr Ainsworth had further declined; his rapid breathing was worsening, his elevated heart rate was ongoing, he was observed to be excessively sweating and was suffering from a low-grade temperature. Mr Ainsworth's medical records note that he also suffered a further aspiration event, and it was likely that his clinical deterioration was a result of this. Intravenous Gentamicin was added to Mr Ainsworth's antibiotic regime at this stage.

27. On 8 January 2021, the medical treating team consulted Mrs Ainsworth, and it was determined that her husband's treatment should transition to end of life cares. As a result, Mr Ainsworth was transferred to the Palliative Care Centre where palliative treatment was provided for a further four days.

28. Mr Ainsworth was well liked amongst his fellow inmates at the TMCC and was regarded as "*friendly*" and "*down to earth*".[5] Mr Ainsworth was an avid painter and would often spend time teaching other inmates. He would make cards for other inmates to send to their loved ones for special occasions, such as birthdays. Mr Ainsworth also spent his time working in the prison tailor shop and had been promoted in that role.

29. Mr Ainsworth's Type II Diabetes, high blood pressure and cholesterol were managed by the Prisoner Health Service (PHS) whilst at the TMCC. Mr Ainsworth was seen daily in the prison's medical centre in order to monitor his blood glucose levels and his blood pressure was also monitored regularly.

30. On 11 April 2020, Mr Ainsworth was reviewed by Dr Nicholas Milns after nursing staff notified him of Mr Ainsworth's significantly elevated blood pressure that was asymptomatic. Dr Milns prescribed Mr Ainsworth 10mg of amlodipine to lower his blood pressure, ordered blood tests and formulated a management plan where Mr Ainsworth's blood pressure would be reviewed twice per week. The amlodipine was also added to Mr Ainsworth's daily medication regime.

[5] Exhibit C3 – Precis of Prisoner Interviews, p 2.

31. On 13 May 2020, Dr Milns conducted a full medical assessment of Mr Ainsworth. On this occasion, Mr Ainsworth complained that his blood pressure had been less well-controlled despite his usual medications remaining the same. He attributed this to the significant anxiety he was experiencing about being in prison. Mr Ainsworth was also suffering from a common side-effect of amlodipine, being ankle swelling. As a result, Dr Milns ceased amlodipine and commenced Mr Ainsworth on 25mg of hydrochlorothiazide daily. Dr Milns also prescribed 25mg of amitriptyline daily for Mr Ainsworth's anxiety.

32. Mr Ainsworth was seen in the clinic regularly by Nurse Practitioner Candidate (NPC) Sruthy Raju until he was hospitalised on 25 November 2020. During this time, NPC Raju reviewed Mr Ainsworth on a number of occasions and discussed Mr Ainsworth's presentations with Dr Milns.

33. On 28 May 2020, Mr Ainsworth presented to NPC Raju with further elevated blood pressure (220/80) and Dr Milns was contacted. Mr Ainsworth was re-commenced on 10mg of amlodipine daily and was to undergo daily blood pressure monitoring.

34. In his statement, Dr Milns noted that Mr Ainsworth's blood pressure was difficult to control, but improved over the period of May 2020 to October 2020.

35. In October and early November 2020 nursing staff and other inmates observed him to become increasingly forgetful, unsteady on his feet and lethargic. A referral was made to the TUH Outpatients Department on 22 October 2020 for Mr Ainsworth to be assessed by an occupational therapist.

25 November 2020 Admission

36. On 25 November 2020, a Code Blue was called at approximately 19:05 hours when Mr Ainsworth's cellmate and carer alerted prison staff that Mr Ainsworth had fallen after getting up off the toilet. Nursing staff attended Mr Ainsworth's cell and observed him to be slumped on the bed with an obvious right-sided facial droop. Mr Ainsworth displayed severe right-sided weakness in both his arm and his leg, and was unable to verbalise. The QAS were called and lights and sirens were requested, and Mr Ainsworth was subsequently transferred to the medical unit by wheelchair.

37. At 19:30 hours, QAS arrived at the TMCC and assessed Mr Ainsworth. Advanced Care Paramedics (ACPs) Sarah Gregory and Matthew Brooks observed that Mr Ainsworth had *"full right-side hemiplegia with loss of the ability to communicate in both words or nodding*".[6] ACP Gregory further observed Mr Ainsworth making repeated chewing motions and upon prying Mr Ainsworth's mouth, removed soggy bread. ACP Gregory then checked Mr Ainsworth's airway to ensure that it was clear. Staff at the TMCC were unable to provide ACP Gregory with information as to when Mr Ainsworth had last eaten and were unaware that he had food in his mouth the entire time. Mr Ainsworth was subsequently conveyed by ambulance under lights and sirens to the TUH suffering from a suspected stroke. He was placed on continuous cardiac monitoring and neurological assessments completed as per QAS's stroke protocols.

[6] Exhibit B7 – Statement of Sarah Gregory, para 13.

38. At 19:57 hours, Mr Ainsworth arrived at the TUH Emergency Department where he immediately underwent a CT scan of his brain and a perfusion. It was established that he had suffered a severe stroke due to an occlusion of the left middle cerebral artery, with irreversible brain injury. Mr Ainsworth was treated with intravenous thrombolysis and subsequently transferred to the acute stroke unit.

39. Despite the administration of thrombolysis, Mr Ainsworth's condition did not significantly improve. As Mr Ainsworth had lost the ability to swallow and was suffering from severe aphasia and dysphagia, a Nasogastric Tube (NGT) was inserted for alternative nutrition and hydration to be provided to him. He was also prescribed aspirin and atorvastatin, as well as other medications to control his hypertension and diabetes that were administered through the NGT. Mr Ainsworth was also reviewed at various times by the Acute Stroke Allied Health team comprising of speech pathologists, physiotherapists and occupational therapists.

40. On 14 December 2020, Mr Ainsworth indicated to the reviewing medical officer that he had chest pain (by pointing to his chest when asked if he was in pain). Soon after, an Adult Medical Emergency Team (MET) call was activated due to Mr Ainsworth vomiting dried blood and experiencing high blood pressure and a rapid heart rate. Mr Ainsworth underwent a gastroscopy on 17 December 2020 which found that he had erosive oesophagitis and was subsequently treated with proton pump inhibitors.

Transfer to Rehabilitation Unit – 21 December 2020

41. On 21 December 2020, Mr Ainsworth was transferred to the Rehabilitation Unit within the TUH, where he remained until 4 January 2021. However, Mr Ainsworth showed little functional improvement and his acute medical issues hampered his ability to participate.

42. On 25 December 2020, Mr Ainsworth was diagnosed with hospital acquired pneumonia or aspiration pneumonia in the setting of severe dysphagia. Investigations were ordered and Mr Ainsworth was commenced on the antibiotic, Augmentin.

43. As Mr Ainsworth had repeatedly dislodged his NGT, he was referred to the Gastroenterology team and a Percutaneous Endoscopic Gastronomy (PEG) tube was inserted and the NGT tube removed.

44. On 1 January 2021, Mr Ainsworth experienced a sudden clinical decline; he became hypertensive and his oxygen saturation levels had decreased to 88%. The MET Registrar immediately reviewed Mr Ainsworth, his Acute Resuscitation Plan (ARP) was consulted by the treating team and investigations ordered. Mrs Ainsworth was consulted and maintained that Mr Ainsworth's ARP be respected, in that:

    a. He did not want to be resuscitated if his heart stopped;
    b. He did not want to be intubated or mechanically ventilated;
    c. The MET could be called if his condition deteriorated in order to assist any reversible causes of deterioration; and
    d. He wanted to be provided with antibiotics and ward-based treatments.

Transfer to Medical Unit – 4 January 2021

45. On 4 January 2021, Mr Ainsworth was referred to the neurology and medical teams as he presented as generally unwell, was drowsy, breathing rapidly and had an elevated heart rate. Mr Ainsworth also had an increase in oral secretions that required suctioning. Diagnoses of subcapsular fluid collection (fluid deep in the liver capsule) and sepsis were considered, and Mr Ainsworth was subsequently accepted into the care of the medical team.

46. On the same date and in light of Mr Ainsworth's acute clinical deterioration, Mrs Ainsworth was advised that Mr Ainsworth's prognosis looked poor. Mrs Ainsworth was advised that it was likely that Mr Ainsworth was suffering either aspiration pneumonia or hospital acquired pneumonia and that the decrease in his consciousness may represent an extension of stroke. Mrs Ainsworth agreed with the treating doctor the MET should no longer be called in the event of further deterioration.

47. At 17:00hrs, radiology confirmed that CT scan results showed evidence of a new anterior cerebral artery stroke.

48. On the early morning of 12 January 2021, Mr Ainsworth's condition continued to decline, and he had become unresponsive. It was assessed that he had entered the terminal phase of his illness and Mrs Ainsworth was notified.

49. At 15:15 hours on 12 January 2021, Mr Ainsworth was declared life extinct. Mr Ainsworth passed away with his wife by his side. Two Custodial Corrections Officers were also present.

Inmate Concerns

50. During the investigation, Mr Ainsworth's next of kin, Mrs Ainsworth, stated that she did not have any concerns with the care provided to Mr Ainsworth in hospital and that *"he was treated quite well"*.[7]

51. However, some inmates raised concerns regarding Mr Ainsworth's treatment whilst at the TMCC, being:

    a. That the care after the deceased had the stroke was a bit casual;
    b. That the deceased had dried blood coming from his ears on a daily basis and that the deceased tried to get medical attention and a doctor would only come once a month;
    c. That the deceased wasn't getting the medical treatment he required and that the medical staff would fob off the deceased;
    d. That the medical system in the prison system was appalling and that there were not enough staff and too much work that makes treatment unmanageable;
    e. That the deceased felt he wasn't getting good medical support and was frustrated;
    f. That access to medical treatment was very difficult in jail and that the resources are very low; and
    g. That the deceased was trying to get on medication he was on when on the outside, however he couldn't get it.

[7] Exhibit B6 – Statement of Deborah Ainsworth, para 19.

52. Given the concerns raised by the inmates, I obtained an independent review of the adequacy and appropriateness of the medical treatment provided to Mr Ainsworth. Accordingly, on 23 October 2023, Forensic Medicine Queensland (FMQ) was briefed by the Court and on 28 March 2024, the Court received the FMQ report by Dr Gary Hall, Senior Forensic Medical Officer. This report was peer reviewed Dr Katherine Robinson, Senior Forensic Physician.

53. Upon reviewing the medical records obtained during the investigation, the autopsy report and various statements of Mr Ainsworth's treating practitioners, Dr Hall was of the opinion that:

In relation to Mr Ainsworth's initial diagnosis

Dr Hall opined that the diagnosis of stroke was within benchmark parameters. While there was an unexplainable delay of twenty-one minutes between the time Mr Ainsworth's cellmate found him and the call to QAS, he was of the opinion that this did not likely affect the outcome.

In relation to Mr Ainsworth's blood pressure management

Dr Hall commented that Mr Ainsworth's blood pressure was difficult to manage, however, medical documentation demonstrated that consideration was given to the physiological response, "…*and the need to have 'looser' control on blood pressure*".[8] He went on to state that:

> *Attempts were made to appropriately manage his hypertension and control had been improving by the time he was diagnosed with the second stroke in early January. The latter showed no overt symptomatology suggestive of stroke and therefore was not likely to have been considered, although recurrent stroke would be foreseeable. Given his recent large stroke and thrombolysis, Mr AINSWORTH was relatively contraindicated from having further thrombolysis, and given his disability at the time, it is highly unlikely this would have been offered if diagnosis fell within a reasonable therapeutic window. Thus, although there could have been a missed opportunity to diagnose the anterior stroke earlier (highly debatable) there was no likely treatment options and therefore outcome would not have changed.*[9]

In relation to Mr Ainsworth's blood sugar management

Dr Hall opined that Mr Ainsworth's blood sugar levels were difficult to control, and whilst at the TUH, his levels, "…*had been somewhat deranged for days prior to endocrinology involvement*".[10] However, endocrinology involvement was by way of nurse practitioner liaising with the endocrinology team, and, although Dr Hall does not doubt that the exchange of information was anything other than reasonable, he questioned whether this was appropriate management with the difficulties and comorbidities faced by Mr Ainsworth (including nasogastric feeding). He went on to state that:

[8] Exhibit H2 – FMQ Report of Dr Gary Hall, p 15.
[9] Exhibit H2 – FMQ Report of Dr Gary Hall, pp 15 – 16.
[10] Exhibit H2 – FMQ Report of Dr Gary Hall, p 16.

> *…I would have expected more direct input from the endocrinologists. Poorly controlled diabetes can lead to high risk of infection and increased risk of aspiration secondary to poor gastric mobility. Although these factors could contribute to Mr AINSWORTH's complications they were not likely causative. Of note, his glycaemic control whilst in TCC was also poor.*[11]

In relation to Mr Ainsworth's hospital acquired aspiration pneumonia

Dr Hall commented that the complications of hospital acquired, and recurrent aspiration pneumonia was foreseeable, and this was always going to be difficult to manage. This was amplified in circumstances where Mr Ainsworth's cough and swallow reflexes were so significantly affected by the stroke. He noted that the presence of the nasogastric tube would not prevent aspiration, and Mr Ainsworth either did not tolerate the nasogastric tube or was deliberately dislodging it as an act of potential self-harm.[12]

Dr Hall was of the opinion that Mr Ainsworth's treatment was appropriately changed to PEG feeding, despite similar risks of aspiration. He also opined that the investigation and management of Mr Ainsworth's gastrointestinal bleeding was appropriate and timely.

In relation to supportive therapies and palliative care

Dr Hall opined that Mr Ainsworth received, "…*regular attendance and therapy with physiotherapy, speech pathology and occupational therapy as well as appropriate access to social work support"*.[13] In relation to Mr Ainsworth's carotid artery obstruction, Dr Hall stated that his referral for vascular surgery was appropriate and within a reasonable timeframe. Further, the advice to, *"…await significant functional improvement, extent of vascular disease and high risk of surgery*" was also considered reasonable by Dr Hall.[14] Ultimately, Dr Hall was of the opinion that, "*The decision to transition to comfort cares and palliation was appropriate as it was clear prognosis was poor with considerable discomfort to Mr Ainsworth and his family*".[15]

54. In conclusion, Dr Hall opined:

> *Thus, I have no concerns regarding Mr AINSWORTH's management at TUH (and by QAS). Treatment was timely, according to best practice, and complications were identified and managed appropriately and in a timely fashion. He received the same care as would be expected of any patient whether from the community or from a correctional facility.*
>
> *The medical management at TCC was acceptable and could have been better, particularly his diabetic management, diet, weight gain, and to a lesser extent, blood pressure management. I do not believe these significantly impacted outcome. It was clear Mr AINSWORTH had been gaining significant amount of weight with little advice, input or referral to manage this. His blood glucose levels were also noted to be labile with rising average levels. The adjustments in nightly*

[11] Exhibit H2 – FMQ Report of Dr Gary Hall, p 16.
[12] Exhibit H2 – FMQ Report of Dr Gary Hall, p 16.
[13] Exhibit H2 – FMQ Report of Dr Gary Hall, p 16.
[14] Exhibit H2 – FMQ Report of Dr Gary Hall, p 17.
[15] Exhibit H2 – FMQ Report of Dr Gary Hall, pp 16 - 17.

long-acting insulin levels did not appear to be making much impact and it should have triggered earlier intervention with more frequent testing and referral to dietician with consultation with the prison kitchen.

Mr AINSWORTH's blood pressure was also labile with Dr MILN acknowledging that it was difficult to manage despite three agents and admitting management was "not ideal." He had been a long-term heavy smoker, uncontrolled diabetes and hypertension placing him at high risk of cardiovascular disease and stroke. Although these risks might have been reduced by rigorous treatment and lifestyle interventions, one cannot state with certainty that outcome could have been prevented.

The episodes described by Mr AINSWORTH of feeling like he was having a stroke on 7th October 2020 and subsequent episodes of cognitive decline on 19th October and light headedness on 21st November were not investigated or explained. It is possible that these could have heralded stroke (transient ischaemic attacks or even temporary global amnesia). Thorough investigation may have uncovered evidence of carotid artery occlusion on ultrasound for example, however Mr AINSWORTH was already on aspirin, cholesterol lowering treatment and antihypertensive therapy, so treatment may not have changed. It might have triggered early vascular or neurological referral. It may not have affected outcome as onset of acute ischaemic stroke would not be predictable.[16]

55. I accept the opinion of Dr Hall.

Autopsy results

56. On 20 January 2021, D Paull Botterill conducted an autopsy consisting of an external examination and sampling of body fluids for toxicology, as well as a review of Mr Ainsworth's medical records.

57. Dr Botterill opined that:

> *…appearances along with the review of medical records, including antemortem radiology reports and pathology, were consistent with death consequent to strokes (cerebrovascular disease), but the possibility of inadvertent drug toxicity could not be excluded at that time*.[17]

58. Further investigations were undertaken, and the toxicology results showed:

> *…the presence of pain killer (morphine and metabolite, with no illicit metabolites), a sedative anaesthetic agent (midazolam), and an antidepressant (amitriptyline), all at blood levels below the reported respective potentially toxic or lethal ranges. No other drugs, including alcohol, were detected.*[18]

[16] Exhibit H2 – FMQ Report of Dr Gary Hall, pp 17 – 18.
[17] Exhibit A2 – Autopsy Report, p 7.
[18] Exhibit A2 – Autopsy Report, p 7.

59. Dr Botterill concluded that the cause of death was:

> *Direct Cause*
> *1(a) Cerebrovascular disease*
>
> *Other significant conditions*
> *2 Diabetes mellitus.*[19]

Conclusions

60. After considering the material gathered in the coronial investigation, I am satisfied that Mr Ainsworth died from natural causes. I find that none of the inmates, correctional or health care staff at the TUH or the TMCC caused or contributed to his death. There were no suspicious circumstances.

61. It is an accepted principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community. Mr Ainsworth had been regularly reviewed by health practitioners in the TMCC and had been admitted to the TUH and reviewed by medical staff. His passing was expected and the final stages of his illness were managed in accordance with his ARP.

62. The primary issue for consideration was whether Mr Ainsworth had access to, and received, appropriate medical treatment while he was incarcerated. From the medical records and the statements provided, I am satisfied that Mr Ainsworth received regular, timely and appropriate medical care.

Findings required by s. 45

63. I am required to find, as far as possible, the medical cause of death, who the deceased person was and when, where and how he came to his death. After considering all of the evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – John Raymond Ainsworth

How he died – Mr Ainsworth was serving a term of imprisonment for sexual offences against children. He had a number of comorbidities, including Type II Diabetes, high blood pressure and high cholesterol. In October and November 2020, Mr Ainsworth experienced a decline in his health whereby nursing staff and inmates noticed him to become increasingly forgetful, unsteady on his feet and lethargic.

On 25 November 2020, Mr Ainsworth suffered a severe stroke due to an occlusion of the left middle cerebral artery, with irreversible brain injury. Mr Ainsworth was treated with intravenous thrombolysis and subsequently transferred to the acute stroke unit at the TUH. Despite treatment, Mr Ainsworth's condition did not significantly improve.

[19] Exhibit A2 – Autopsy Report, p 7.

	Mr Ainsworth continued to decline and suffered a further anterior cerebral artery stroke on 4 January 2021. In light of Mr Ainsworth's poor prognosis, a decision was made in consultation with Mrs Ainsworth to commence palliation. Mr Ainsworth died of natural causes.
Place of death –	Townsville University Hospital Angus Smith Drive DOUGLAS QLD 4814 AUSTRALIA
Date of death–	12 January 2021
Cause of death –	1(a) Cerebrovascular disease Other significant conditions 2 Diabetes mellitus.

Comments and recommendations

64. Section 46 of the *Coroners Act* enables a coroner to comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

65. In the circumstances, I accept that there are no comments or recommendations to be made that would assist in preventing similar deaths in the future, or that otherwise relate to public health or safety or the administration of justice.

66. I extend my condolences to Mr Ainsworth's family.

67. I close the inquest.

Terry Ryan
State Coroner
TOWNSVILLE