QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Tracy Ann Beale**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Gladstone
FILE NO(s):	2013/246
DELIVERED ON:	28 March 2018
DELIVERED AT:	Mackay
HEARING DATE(s):	13 – 15 March 2018
FINDINGS OF:	Magistrate D O'Connell, Coroner
CATCHWORDS:	CORONERS: Inquest – Neck compression causing death – Medical cause of death – possible asphyxia – possible vaso-vagal inhibition Domestic violence – law reform – consideration of amendment to s. 315A of the *Criminal Code* to encompass vaso-vagal inhibition

REPRESENTATION:

Counsel Assisting	Mr J M Aberdeen
Family of Tracy Beale	Mr M Anderson
Mr Jamie Beale	Mr A Boe and Ms P Morreau
Women's Legal Service	Ms K Hillard

[1]. On 21 January 2013 Mrs Beale was involved in an altercation with her husband late one night where he restrained her in a chokehold, firmly squeezing her neck until she became limp. She was noticed to be unresponsive but he did not provide CPR. He telephoned emergency services. When police arrived they commenced CPR until paramedics arrived. She was unable to be revived.

[2]. The police commenced an investigation into her death. Her autopsy raised significant questions as to the precise mechanism of her death, not that there was doubt that neck compression force had been used on her, but it was whether she died of neck compression or possibly if there was triggered a 'sympathetic'[1] vasovagal episode which led to her death. The police charged her husband over her death, but it did not proceed to trial as the Director of Public Prosecutions eventually withdrew the charge against him.

[3]. This inquest examines the circumstances of her death, particularly the medical mechanism as to how she died, and whether the domestic violence laws in Queensland adequately deal with circumstances such as that which arose in this case.

Tasks to be performed

[4]. My primary task under the *Coroners Act 2003* is to make findings as to who the deceased person is, how, when, where, and what, caused them to die[2]. In Mrs Beale's case there is no real contest as to who, when, where, or how she died, the real issue is directed to the 'what'[3] caused her death.

[5]. Accordingly the list of issues for this inquest are:-

1. The information required by section 45(2) of the *Coroners Act 2003*, namely, when, where, and how Mrs Beale died, and what caused her death?

2. Was Mrs Beale's death due to (a) asphyxia, (b) vasovagal attack (or reflex cardiac arrest?), (c) a combination of (a) and (b), or (d) other cause, or causes?

3. What is the probability that (a) dilated cardiomyopathy, and/or (b) consumption of alcohol, contributed, in some degree, to Mrs Beale's death?

4. Is there a need for a program of education to raise public awareness as to the dangers inherent in some forms of neck compression or restraint? and

5. Should a recommendation be made to the Attorney-General that consideration be given to:-

[1] Sympathetic is simply my layman term
[2] Coroners Act 2003 s. 45(2)(a) – (e) inclusive
[3] 'what' is the medical reason in everyday language

(a) Whether neck compression or restraint which causes death should receive legislative attention in the same or a similar way as 'one punch' strikes to the head or neck? (cf section 314A Criminal Code)?

(b) Whether neck compression, in and of itself, in a domestic setting, should receive legislative attention (cf section 315A Criminal Code?)

[6]. The second task in any inquest is for the coroner to make comments on anything connected with the death investigated at an inquest that relate to public health or safety, the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future.[4]

[7]. The third task is that if I reasonably suspect a person has committed an offence[5], committed official misconduct[6], or contravened a person's professional or trade, standard or obligation[7], then I may refer that information to the appropriate disciplinary body for them to take any action they deem appropriate[8].

Factual background & evidence

[8]. The incident occurred at a little after midnight although the precise time is uncertain. Stated in brief Mr Beale advised police on the night that he was asleep in the main bedroom after earlier having a verbal disagreement with his wife. Mrs Beale, who had been consuming alcohol, woke[9] him when she began to hit[10] him in the face or head. Mr Beale got up from the bed and placed his hands up near his face to prevent a further assault, he also pushed his wife out of the bedroom. She went down the hallway and he followed her into the lounge room area. Mrs Beale then again assaulted him by punching him[11]. He then placed her in a chokehold with her neck in the 'V' formed by his left arm. He did this in an attempt to 'calm her down'. He squeezed her in this chokehold until she became limp and they fell to the floor. He only released her after they were on the floor and she was no longer struggling. He said he only held her for a few seconds before she became limp. When he released his hold he noticed she was not breathing and appeared to be unconscious. He then rang 000 at 12.20am and spoke to the police. He did not attempt CPR.

[9]. About four minutes later the police arrived at the scene. They were the first to commence CPR. When police arrived Mrs Beale displayed no signs of life. Paramedics arrived shortly after the police. Extensive CPR was continued until 1.06am, when it was declared life was extinct.

---

[4] ibid s.46(1)
[5] Ibid s.48(2)
[6] Ibid s.48(3)
[7] Ibid s.48(4)
[8] In these findings I address these three tasks in their usual order, s.45 Findings, s.46 Coroners Comments, and then s.48 Reporting Offences or Misconduct. I have used headings, for convenience only, for each of these in my findings.
[9] She had been coming in and out of the bedroom earlier
[10] He was unclear whether it was a slap or a punch, but it was repeated blows
[11] He testified that these were punches, not slaps.

Investigations into the incident

[10]. Mr Beale attended at the police station and the police conducted an interview. In the interview the police established that on that evening Mr Beale and his wife had had an argument regarding his unilateral decision to lend his father money[12] *just to help out with a few things and to buy a motor car*.[13] Mrs Beale had been drinking alcohol that day and because he thought she was drunk he did not wish to continue the argument, rather he bathed the children and they put them to bed in the main bedroom. He joined them in the parents' large bed which was a usual arrangement.

[11]. Whilst he was trying to sleep Mrs Beale would enter the bedroom, yell at him, and then go out. When the fatal incident occurred he recounts that he was punched in the face, or hit in the face, first in the bedroom, then out in the lounge room (as they had both walked out there) and *then I put her in a headlock just to calm her down and try and hold her in a position to stop her from hitting me and I held her there for a bit and then let her go and I realised she wasn't moving and I thought, Oh…I rung you guys straightaway and rung the ambulance*.

[12]. Later he elaborates on this to explain that the headlock he placed her in was with him standing behind her and his right arm around her, with his elbow, or the 'V' of his bent arm, at the front of her throat.[14] Incidentally he could not precisely recall how he came to be behind her, but I find that likely at that time they were in very close quarters and she was engaged in hitting him.[15] As to how long she went limp he described that she went limp for 'a little bit' and he just held her and said 'Righto. That's enough' and it seemed like 'just a few seconds'.[16] As to the strength with which he held her he described it as 'fairly firm'.[17] He also described that after she stopped moving and thrashing around he held her there for a second, then thought of calling the police. He described in his interview of how when she stopped struggling they were both laying on the floor which suggests to me that he maintained his headlock, and with firm pressure, from when they were both standing through when they fell. Significantly, in my view, he maintained it after she went limp which is likely the time when she lost consciousness. He also maintained it through to when they were both laying on the floor as he never says he let her go at any stage. Indeed he confirmed in the interview that he still had her in a headlock when they were both on the floor.[18]

[13]. In evidence at the inquest there was explored more fully the nature of the restraint Mr Beale used and the sequence of events. After hearing the evidence it is apparent that Mr Beale who is a large man approximately 185cm in height and, as I observed from photos taken at the time by police and

[12] $15,000.00
[13] Exhibit C2, page 6 about line 11
[14] Exhibit C2, page 14
[15] The punches by Mrs Beale must have been minor in force as she displayed no offensive injuries to her knuckles (see exhibit A.4). Mr Beale also had no 'offensive injuries' to his knuckles.
[16] Exhibit C2, page 15
[17] Exhibit C2, page 15, line 12
[18] Exhibit C2, page 16, line 4

viewing him at the inquest, is of a physically large build (some 100-110kg was his evidence). He restrained his wife who was 170cm[19] in height and of moderate build (79kg and BMI 27.3)[20] by applying an arm around her throat where he stood behind her and his right arm formed a 'V' around her throat with his elbow roughly in the front at her larynx. With his left hand he applied force to his right wrist to maintain his hold around her neck (he demonstrated this hold in the witness box in his evidence). The duration he did this for was only seconds, and in addition there was clearly an element of a struggle as they both fell to the floor after Mrs Beale went limp (whilst still standing) and whilst Mr Beale maintained his restraint hold.

[14]. What this demonstrates is that the entire incident was not momentary but slightly, but not by much, prolonged after she lost consciousness. With the force being used by Mr Beale to maintain his arm restraint, and in view of his size and build, it is clearly very reasonable to conclude that his arm was tight around her neck. This is confirmed by the bruising seen on her neck, and is of interest when considered with the autopsy findings.

[15]. I should add that evidence was given at the inquest of disagreements throughout the relationship usually about financial issues, and certainly to me it is very apparent that Mr Beale restricted his wife accessing funds with the arrangements he had in place where his wages were paid to his sole account, and a limited amount of monies transferred from that primary bank account to an account Mrs Beale had access to. There is no police recorded, nor court recorded, formal history of domestic violence in the relationship, but I accept that there were certainly a number of instances of domestic violence within the relationship. Clearly no person considered them[21] of a nature or severity that either sought any of the protections available under the Domestic Violence laws.

Resolution of the medical opinion

[16]. The autopsy was conducted by Dr Alex Olumbe an experienced and accredited forensic pathologist. In very short compass his finding were that her death was due to neck compression with a possible vasovagal attack element. He found a relatively lack of bruising on the right side of the neck but there was the presence of marks or bruises on the left side of the neck consistent with neck compression in a chokehold, which is a form of neck compression leading to asphyxia. He was of the opinion that the hold was consistent with an arm being used, rather than by fingers, due to the nature of the bruising. This supports Mr Beale's account that he used his arm in the restraint, rather than his hands or fingers. Dr Olumbe was of the opinion that the force required to cause the injuries he saw[22] was 'mild to moderate', based on a scale of mild/moderate/severe.

[19] Exhibit A.4
[20] Exhibit A.4
[21] And the evidence was that possibly a lack of understanding or education of what constitutes domestic violence is why no action was ever taken.
[22] And Dr Olumbe had the benefit of external and internal examination

[17]. Comment was also made that at autopsy that there was a lack of petechial haemorrhages which suggested to the pathologist a possible scenario of a vasovagal attack occurring, which is certain pressure on a nerve in the neck which causes the interruption to a regular heart beat and a decrease in blood pressure leading to inadequate circulation to the brain, resulting in loss of consciousness and death. Dr Olumbe also considered that her vitreous alcohol concentration of 0.208 per cent[23] together with an underlying dilated cardiomyopathy could have contributed to her death by potentially causing dysfunction of the heart rhythm. These were considered an underlying significant condition, rather than a primary cause of death.[24] Dr Olumbe's evidence as to her cause of death was more definite at inquest than he initially considered in his autopsy report. No doubt that is due to further consideration, and experience, of the circumstances that presented in this case.

[18]. Dr Buxton, an experienced and accredited forensic pathologist, also gave his opinion after reviewing the autopsy results including photographs. His opinion was very similar but concluded that his determination of the cause of death would be neck compression (asphyxia) and vasovagal reflex, with underlying conditions of a dilated cardiomyopathy and alcohol intoxication.

Determining the controversial issues

[19]. Essentially there needed to be resolved on the evidence precisely, if I was able to, how Mrs Beale was restrained and the medical cause of her death.

[20]. I have no doubt that Mr Beale was sleeping in bed when his wife, very significantly affected by alcohol, confronted him. Likely she assaulted him whilst he was in the bed, she using an open hand, but he was not seriously assaulted. He then got up from the bed and protected himself from a further assault she was then attempting. He then pushed her out of the room.[25] She then walked off down the hallway, and he followed her.

[21]. When they reached the lounge room area the argument continued and escalated. A more heated verbal exchange occurred and Mrs Beale then further assaulted him by a series of small punches. It is clear from his injuries that the assault on him occurred, leaving him with some slight but visible abrasions, one of which bled. Mr Beale then restrained her by placing her in a chokehold. He says he did this to calm her down, which is a possible explanation, but hardly appropriate.

[22]. I find that in this chokehold he was standing behind her[26], and with the use of his right arm he held her tightly around the neck. He then squeezed her neck tightly with his arm supported by his left hand arm holding his right wrist. The evidence from the pathologist was clear that the injuries showed that the

[23] Obtained from the vitreous humour, and considered a more reliable indicator than blood (0.171%) or urine (0.236%) samples. He stated in his autopsy report that blood alcohol concentrations above 0.15% can cause considerable depression of the Central Nervous System.
[24] See Exhibit A.5 Autopsy Certificate which lists the direct and the contributing causes of death
[25] Which explains fingertip indicative bruising to her upper arms detailed in the autopsy report exhibit A.4
[26] Likely this happened as Mrs Beale was punching him, so in very close proximity to each other

restraint used was of a mild-to-moderate force, on a scale of mild/moderate/severe. I accept the pathologist's observations in this regard.[27] Significantly I find that he held her only for a short period of time, the duration likely to be just a few seconds, and then she went limp whilst standing and then they fell to the floor whilst he still restrained her in the chokehold. Why she went limp was likely the combination of a number of factors which medically was the neck compression, which caused a level of asphyxia, and significantly likely triggered a vasovagal reflex or attack, to which Mrs Beale was more susceptible to the fatal effects of due to her underlying medical condition of a dilated cardiomyopathy and her very significant alcohol intoxication at the time.

[23]. The medical evidence was that likely her primary cause death was asphyxia and a possible vasovagal reflex. As one pathologist said in his evidence sometimes medical evidence conclusions are not entirely black and white, which is what is so sought in legal proceedings. What I am able to conclude is that the medical evidence makes clear that the force of the restraint was not severe, and the duration of the restraint was not prolonged. What that highlights is that there is a very real danger in any form of neck compression as it can lead to sudden, and fatal consequences.

List of inquest issues answers

Coroners Act s. 45(2): 'Findings'

[24]. Dealing with the list of issues for this inquest the answers are as follows:-

[25]. **Issue 1.** My primary task is the information required by section 45(2) of the *Coroners Act 2003*, namely:

a. Who the deceased person is – Tracy Ann Beale[28],
b. How the person died – Mrs Beale died due to fatal injuries received when restrained by her husband in a chokehold in a domestic violence setting,
c. When the person died – 21 January 2013[29],
d. Where the person died – 109 Philip Street, Gladstone, Queensland, and
e. What caused the person to die – neck compression (and likely vasovagal attack), with the noted significant underlying conditions of a dilated cardiomyopathy and alcohol intoxication.

[26]. **Issue 2**. Was Mrs Beales's death due to:-

(a) Asphyxia;
(b) Vasovagal attack (or reflex cardiac arrest);
(c) A combination of (a) and (b); or
(d) Other cause, or causes?

[27] Particularly as the pathologist had the benefit of external and internal examination to determine injury severity
[28] See exhibit A1 QPS Form 1
[29] See exhibit A1

[27]. The cause of death was neck compression, which has led to asphyxia, with a likely vasovagal attack.

[28]. **Issue 3.** What is the probability that –

(a) Dilated cardiomyopathy, and/or
(b) Consumption of alcohol,
Contributed, in some degree, to Mrs Beale's death?

[29]. It is considered[30] likely that both conditions have contributed to her death, but each is an underlying significant condition, they did not directly contribute to her cause of death.

[30]. **Issue 4.** Is there a need for a program of education to raise public awareness as to the dangers inherent in some forms of neck compression or restraint?

[31]. I address this in the Recommendations.

[32]. **Issue 5.** Should a recommendation be made to the Attorney-General that consideration be given to –

(a) Whether neck compression or restraint which causes death should receive legislative attention in the same or a similar way as 'one punch' strikes to the head or neck? (cf section 314A Criminal Code)?
(b) Whether neck compression, in and of itself, in a domestic setting, should receive legislative attention (cf section 315A Criminal Code?)

[33]. In this regard see my Coroner Comments (Recommendations) below.

Coroners Act s. 46: 'Coroners comments' (Recommendations)

[34]. There was evidence led at the inquest by Professor Heather Douglas that the specific Criminal Code offence s.315A relating to choking and strangulation in the domestic violence setting possibly overlooks the circumstances of this case, which involves a situation of reflex cardiac arrest or vasovagal reflex, accordingly the legislation is likely deficient in dealing with this certain aspect[31] of the neck compression situation. I agree with her views. Difficult legislation such as this requires not just legal considerations but medical considerations. It is desirable that when conducting a review there is sought submissions from appropriate, interested, entities[32] who can contribute and provide valuable input. This will not only include legal entities but also medical from experienced forensic pathologists, or their representative body. Importantly any review must not be rushed, as rushed legislation inevitably leads to issues and circumstances being overlooked.

[30] On the medical opinion evidence of both pathologists
[31] And certain advice from the department to the Minister needs review as Prof Douglas considered certain aspects of the departmental advice to be worthy of more rigorous examination to determine its reliability
[32] entities are readily come to mind the Queensland Law Society, Bar Association of Queensland, Women's Legal Service, and no doubt there are a number of other entities which specifically deal in this area

[35]. What is concerning to me is that evidence presented to the inquest by the QPS which highlighted that this specific legislative provision results in two persons being charged every day in Queensland. Circumstances such as seen in this inquest are occurring weekly and legislative change is required, and promptly.

[36]. Accordingly, I will refer to the Attorney-General a request to review and determine if any amendment is required to s.315A to address the possible deficiencies identified by Prof Douglas.[33]

[37]. Also raised was whether there is benefit in a wider community education program on the dangers of neck compression. Prof Douglas observed that in a decision of the Queensland Court of Appeal there was comment that the public education campaign in relation to the *one punch can kill* campaign would leave no person in doubt as to the dangers, and consequences, of a strike to the head. Clearly neck compression (however it occurs) carries with it dangers, in fact possible fatal consequences. The government should consider if it is appropriate for there be a similar style community education or awareness program of the dangers of choking or strangulation.[34]

[38]. There was comment made during the inquest of the Director of Public Prosecutions and their level of consultation with the family prior to the charges against Mr Beale being withdrawn. There was evidence presented that the DPP did consult with a family member, but perhaps due to a degree of a fractured family relationship the information was not passed on to other family members. I am not critical of the DPP at all in this regard, and note that the DPP does have a policy to advise family members when charges are to be discontinued. No doubt it is wise for the DPP to ensure that all prosecutors are aware of the policy and to ensure its implementation as practically as circumstances permit. I merely make this observation.

[39]. Accordingly I make the following recommendations:-

a. That the Attorney-General, after allowing submissions from appropriate interested parties, review Criminal Code s.315A to determine if it is adequate to deal with the incidence of so called vasovagal reflex, and whether the types of neck compression specified in the provision should be defined in the legislation;

b. That the Attorney-General determine if an appropriate public awareness campaign should be conducted to educate of the dangers of neck compression (of whatsoever type) in the domestic violence setting.[35]

[33] Indeed rather prophetically identified by the Women's Legal Service in their original submission when the legislation was first proposed, but it appears that was overlooked in the final legislation.
[34] Attacking the neck in any form really, and any campaign should reinforce the specific laws applicable in the domestic setting.
[35] indeed not just in the domestic violence setting, but any situation

Coroners Act s. 48: 'Reporting offences or misconduct'

[40]. The Coroners Act s.48 imposes an obligation to report offences or misconduct. The Queensland Police Service investigated and laid a charge of murder. After being committed to stand trial on a charge of manslaughter the Director of Public Prosecutions elected not to proceed.[36] They have stated their reasons. Coroners Act s.48 states that a referral is mandatory, and so simply out of an abundance of caution based on the additional evidence obtained at the inquest I will refer the matter back to the Director of Public Prosecutions, but I note their stated position previously has been not to proceed.

Magistrate O'Connell
Central Coroner
Gladstone
28 March 2018

[36] There was not expressed any criticism of this at the inquest by any interested party