CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Michael Joyce
Hearing dates:	24 October 2018
Date of findings:	24 October 2018
Place of findings:	State Coroners Court, Glebe
Findings of:	**Deputy State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Cause and manner of death
File number:	2017/76969
Representation:	**Advocate Assisting the Coroner** Mr Dalla-Pozza, Crown Solicitor's Office instructed by Ms Leung of the Crown Solicitor's Office **Counsel for NSW Commissioner of Police** Ms Hopper **Counsel for NSW Ambulance** Mr Woods

Findings:	**Identity of deceased**: The deceased person was Michael Joyce. **Date of death**: Mr Joyce died on 12 March 2017. **Place of death**: He died at Dunningham Reserve, Coogee in NSW. **Manner of death:** Mr Joyce died when he stumbled and fell from a cliff when he was experiencing an episode of mental disturbance. **Cause of death:** The medical cause of his death was multiple injuries.

Table of Contents

The Coroners Act 2009 (NSW) *in s81(1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of Mr Michael Joyce.

Introduction:

1. This is a mandatory inquest into the tragic death of Mr Michael Joyce.

2. Mr Joyce's death is a huge loss to his family, friends and colleagues. I would like to extend my condolences to them for their loss.

3. This is a mandatory inquest by operation of s23 of the *Coroners Act 2009*, as in force at the relevant time.[1]

The role of the coroner

4. My role, as set out in s81 of the *Coroners Act 2009* ("the Act"), is to make findings as to the:
   a. identity of the deceased;
   b. date and place of the person's death;
   c. physical or medical cause of death; and
   d. manner of death, that is, the circumstances surrounding the death.

5. Pursuant to s82 of the Act, I have the power to make recommendations, including concerning any public health or safety issue arising out of the death in question. For the reasons set out below, I do not consider there is any need for me to make recommendations arising out of the present inquest.

Background

6. Mr Joyce was born on 12 December 1988. He was still a young man, of 28, at the time of his death. His mother is Ms Jennifer Joyce. He has two sisters, Danielle and Kathleen. Statements provided by Ms Jennifer Joyce and Ms Danielle Joyce and, in addition, the tone of the text messages between Ms Danielle Joyce and her brother which are attached to Ms Danielle Joyce's statement, indicate that the relationship between Mr Joyce and his family was a particularly close, loving and supportive one.

7. Although it risks getting lost given the focus of the inquest, the material before me also says a lot about Mr Joyce and the person who he was. In particular,

[1] On 1 July 2017, s. 23 was amended by the Law Enforcement Conduct Commission Act 2016 ("LECC Act") in two respects. First, the words "or in the course of" were omitted from subs. (1)(c). Secondly, a new subs (2) was inserted which defines "police operation" as "any activity engaged in by a police officer while exercising the functions of police officer other than an activity for the purpose of a search and rescue operation".

his family members and their partners, who reside in Brisbane, recall the many attractive elements of Mr Joyce's personality; particularly his intelligence, sense of humour, and larrikin nature.

8. Mr Joyce was actively pursuing his business opportunities (he was developing an App) and, not long before his death, seemed to have had some considerable successes in this regard, in particular, obtaining a lucrative contract from a client).

9. Indeed, Mr Joyce had moved to Sydney from Brisbane in early 2017 to pursue these business opportunities further. He was living with Mr Tang at a flat in Coogee, a location that he liked. During the time that he knew him, Mr Tang records Mr Joyce as having an active social life and as pursuing various interests and hobbies.

10. Although the focus of my reasons will be on the events leading to Mr Joyce's death, I do think it important to record these positive and happy aspects of Mr Joyce's life.

The Evidence:

11. At the hearing of the inquest, a brief of evidence, being a one volume folder containing the written, photographic and video material obtained by the officer in charge of this investigation, A/Inspector Christine McDonald, was tendered.

12. I have referred above to what that evidence in that brief says about who Mr Joyce was and his relationship with his family. I will now deal with what it says about the manner and cause of his death.

The background to the events of 12 March 2017

13. The account of members of his family is that Mr Joyce had been experiencing some mental health issues over a long period of time. In her statement, Ms Jennifer Joyce refers to her son having suffered for a number of years from a sleeping disorder, exacerbated by stress. In 2010, while he was still living in Brisbane with his family, Mr Joyce had been hospitalised at the Royal Brisbane Hospital for a period of around 3 months after suffering psychosis. In 2016, he was admitted to the Princess Alexandra Hospital at Brisbane for sleep deprivation.

14. Medical records obtained through the Randwick Medical Centre record that Mr Joyce had been prescribed Temazepam as a sleeping aid. However, approximately 2 weeks prior to his death, Mr Tang records Mr Joyce saying to him that his sleeping pills were no longer working.

15. During the last few weeks of his life, Ms Jennifer Joyce had a number of conversations with her son. From them, she took the view that her son was troubled and may have been “slipping in and out of reality”.

16. I am satisfied that, in the weeks leading to his death, Mr Joyce had experienced an unfortunate relapse of the chronic insomnia which had precipitated his mental health issues in the past.

The events of 12 March 2017:

17. Relevantly for present purposes, the material in the brief indicates that, on 12 March 2017, Mr Joyce had made his way to Dunningham Reserve, located in Coogee. The reserve adjoins a cliff overlooking the sea. There is a look out area at the top of the cliff and a small path leading to the look out. A fence separates the lookout from the cliff’s edge.

18. Records from the NSW Ambulance Service indicate that Mr Joyce requested an ambulance from that location. In a conversation which took place at 13:17 Mr Joyce indicated to the telephonist that he was “feeling a little insane”. The telephonist asked Mr Joyce whether he was feeling violent towards anybody at which point Mr Joyce said no and hung up.

19. As is explained in the statement provided by Mr Gately (an employee of the NSW Ambulance Service), the telephonist was asking a question that had been prompted to her by a software program (the ProQA system) deployed by the NSW Ambulance Service to assist in triaging and prioritising the available resources to respond. In light of this explanation, I am satisfied that the telephonist’s response to Mr Joyce was appropriate.

20. As Mr Gately explains, based on the information Mr Joyce had provided, the ProQA system allocated a response code of a priority 2 immediate response. Ambulance unit 1446 was assigned to that job and was dispatched at 13:18. It was cancelled, however, to attend to a higher priority case (a patient who experiencing breathing difficulties, a case which, as Mr Gately says, would generally be classified as at least a 1C urgent response). I am satisfied that this course was necessary and that it was appropriate for the finite resources of the NSW Ambulance Service to be deployed to prioritise a patient experiencing urgent symptoms such as breathing difficulties.

21. At 13:22, a further unit, Ambulance 1536, was assigned to the job and was similarly re-assigned due to a higher priority incident (again, a case involving breathing difficulties). Again, I am satisfied that this course was necessary and appropriate.

22. The NSW Police Force was copied in on the calls that had been received at 13:18.

23. Mr Joyce telephoned his mother Ms Jennifer Joyce at around 13:20 that day (in her statement, Ms Joyce says that this occurred at 12:20 but that is easily explained due to daylight savings being in operation in New South Wales and not in Queensland). As a result of this conversation, Ms Joyce expressed the

opinion that her son was “not in reality” at that time because he was afraid of heights and would never contemplate going near a cliff’s edge if he had been in a well state of mind.

24. Computer Aided dispatch records obtained by the NSW Police Force indicate that Ms Jennifer Joyce then telephoned Police at 13:29 because she was concerned for her son’s welfare. Based on what the information that Ms Jennifer Joyce provided, the matter was appropriately treated by Police as requiring an urgent response. Three police units responded: EB 10 (Inspector Wunderlich); EB 14 (Sergeant Badger) and EB 17 (Senior Constable Belinda Jones and Constable Rainin).

25. Meanwhile, Ambulance unit 1423 continued proceeding to the scene but became delayed by heavy traffic. Consistently with usual procedure, a supervisor unit, unit 1049, was allocated at 13:35. Neither ambulance was ultimately able to arrive at Dunningham reserve before Mr Joyce’s death.

26. Sergeant Badger was the first of the police to arrive at Dunningham reserve (at 13:38) followed a minute later by Inspector Wunderlich. Sergeant Badger proceeded directly to the footpath leading to the lookout area. He called Polair to assist in locating Mr Joyce.

27. Inspector Wunderlich went past the path leading to the lookout area with the intention of continuing to move south to clear the area. Once he was in a position to see over the fence line separating the reserve from the edge of the cliff he saw a man (now known to be Mr Joyce) on the far side of the fence and called out to him. Mr Joyce moved away from Inspector Wunderlich, heading north, towards the lookout area where Sergeant Badger was. Inspector Wunderlich called for specialist resources including negotiators and water police. Inspector Wunderlich was not, apparently, a trained negotiator.

28. Sergeant Badger had meanwhile had had some dealings with another group of people who were standing on the cliff side of the fence at the lookout area. Sergeant Badger asked them to return to the reserve side of the fence. One of that group pointed out Mr Joyce to him. Sergeant Badger attempted to engage Mr Joyce telling him to come to the reserve side of the fence, not to jump and that he (Sergeant Badger) was going to back off. Sergeant Badger remained at all times on the reserve side of the fence (the opposite side from Mr Joyce). According to his own directed interview and that of Inspector Wunderlich, Sergeant Badger at no time was closer than 10 metres to where Mr Joyce was standing. Like Inspector Wunderlich, Sergeant Badger was also not apparently a trained negotiator.

29. Inspector Wunderlich then arrived at the lookout area. He too remained on the reserve side of the fence.

30. Senior Constable Jones and Constable Rainin then arrived, in a position out of Mr Joyce’s view and on the reserve side of the fence.

31. The period of time Sergeant Badger had to engage with Mr Joyce before his death was extremely limited (estimated by Inspector Wunderlich to be 30 seconds).

32. From the above, I am satisfied that those police who attended acted in an appropriate and professional manner and did everything in their power to prevent Mr Joyce's death. Their actions displayed an appropriate sensitivity to and awareness of the delicacy of the situation.

33. The final moments of Mr Joyce's life are captured on two video recordings taken by civilian witnesses. They record Mr Joyce approaching the cliff's edge on a number of occasions before he finally went over the edge.

34. In addition, witnesses to the final moments of Mr Joyce's life record him as being "visibly distressed and agitated" and "sweating profusely". More relevantly, they describe Mr Joyce as being unsteady on his feet. Inspector Wunderlich says of the fall:

> "It almost seemed like he stumbled as he got towards the edge… [I]t just didn't look very co-ordinated when [Mr Joyce]… went off the cliff edge. I wouldn't be prepared to say he slipped but it wasn't a clean jump from the cliff edge."

35. In a similar vein, Mr Woodward (one of the group of people located on the cliff side of the fence with whom Sergeant Badger had had dealings with and who witnessed the final moments of Mr Joyce's life) says that as Mr Joyce approached the cliff edge he "hesitated and fell off the cliff edge" (my emphasis).

36. I am satisfied from the above that Mr Joyce did in fact ultimately stumble and fall over the edge of the cliff at Dunningham reserve. This is perhaps as a result of the disorientation and confusion he was suffering as a result of him experiencing an episode of mental disturbance.

Autopsy Report

37. Dr Istvan Szentmariay, Forensic Pathologist, performed an autopsy on Mr Joyce on 14 March 2017. He concluded that Mr Joyce died as a result of multiple injuries.

Conclusion

38. I would like to thank the officer in charge, A/Inspector Christine McDonald, for her thorough investigation. I thank the interested parties and their legal representatives for the co-operative spirit in which they approached this inquest. In particular, I am grateful to NSW Ambulance for arranging a view of their control centre. This view helped me to understand the pressures placed on NSW Ambulance and the complexity of their system for prioritising calls.

39. I thank my counsel assisting, Michael Dalla–Pozza and his instructing solicitor, Elizabeth Leung for their assistance before and during this inquest.

40. Finally, I would like to offer Michael's family my heartfelt condolences. They clearly loved him very much and losing him in this way must have been devastating.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The deceased person was Mr Michael Joyce.

Date of death

Mr Joyce died on 12 March 2017.

Place of death

Mr Joyce died at Dunningham Reserve, Coogee in NSW.

Cause of death

The medical cause of his death was multiple injuries.

Manner of death

Mr Joyce died when he stumbled and fell from a cliff when he was experiencing an episode of mental disturbance.

I close this inquest.

Magistrate Teresa O'Sullivan
Deputy State Coroner

Date 24 October 2018