CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the disappearance and suspected death of Liam D'Arcy
Hearing date:	25 August 2020
Date of findings:	25 August 2020
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – disappearance of Liam D'Arcy on 23 June 2019 – has Liam D'Arcy died? - if so what is the manner, cause, time and place of his death?
File number:	2019/232386
Representation:	Coronial Advocate assisting the inquest: Sgt Simone Kelly. Northern Sydney Local Health District: K Kumar of Counsel i/b Hicksons Lawyers. The D'Arcy family.

Findings:	**Identity** The person who died is Liam D'Arcy. **Date of death**: Liam D'Arcy died on or about 23 June 2019. **Place of death**: Liam D'Arcy died in the area of The Gap Lookout at Watson's Bay, Vaucluse NSW 2030. **Manner of death:** Liam D'Arcy died when he intentionally jumped from a cliff in the area of The Gap. **Cause of death:** The precise cause of Liam D'Arcy's death is unknown.

Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] 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 disappearance and suspected death of Liam D'Arcy.

Introduction

1. Liam D'Arcy aged 36 years was last seen alive at about 7.45pm on 23 June 2019, when his image was captured on CCTV footage. He was seen walking along a cliff side path at The Gap at Watson's Bay in Eastern Sydney. He has not been seen since then, and his body has never been found.

2. Section 27(1)(c) of the Act requires that an inquest must be held where it appears that it has not been sufficiently disclosed whether a person has died, or what the cause, manner, time and place of the person's death was.

Issues examined at the inquest

3. Liam was much loved by his family, and his disappearance has been devastating for them. Adding to their deep sadness is the lack of certainty as to what exactly happened to him that night. The purpose of this inquest was to ascertain if possible if he has died, and if so the time, place, cause and manner of his death.

   At the close of the evidence Liam's mother, father and brother provided their loving statements of how much Liam meant to them. They spoke of his intelligence, his sweet nature, and above all his sense of humour. They miss him very deeply.

Liam D'Arcy's life

4. Liam was born on 20 September 1982. He grew up in West Killara, Sydney with his parents Patricia and John D'Arcy and his younger brother Kieran.

5. When Liam was in his late teens his parents learnt that he had been diagnosed with schizophrenia, with moderate to severe functional deficits. He came under the community care of the Hornsby Mental Health Team, and received his medication by means of tablets and at one stage, depot injections. According to Liam's mother Patricia, these medications left Liam feeling numb and sedated.

6. In her statement to the inquest, Patricia D'Arcy reported that when he was in his twenties things began to improve for Liam. His medication was changed to the antipsychotic drug clozapine and he began studying computer business at TAFE. He undertook casual work and moved into a granny flat at the back of his parents' home. Towards the end of 2010 Liam moved into his own accommodation, an apartment at Eastwood. He commenced a permanent part-time job performing reception and filing work.

7. During this time Liam saw his parents regularly, and met up with his brother Kieran with whom he had a close relationship. His mental health care was transferred to his local service, the Ryde Mental Health Team.

8. From late 2017 onwards Patricia noticed that Liam was becoming more withdrawn. Liam told her of certain side effects of his clozapine medication, including nocturnal enuresis, which is excessive urination at night time. As a result, on the recommendation of his mental health team he agreed to incrementally reduce the dosage of his clozapine. This process commenced in February 2019 and by April 2019 he had ceased use of it. Liam's clinicians asked Patricia to monitor any behavioural changes.

9. By June 2019 Patricia had become increasingly worried about Liam's emotional state. He was not sleeping well and was feeling tired and stressed. He seemed depressed on the weekend when he visited his parents. At his mother's suggestion he took a week off from work to get some rest, but this didn't seem to help. His brother Kieran reported that on 15 June he'd had a phone call with Liam where Liam sounded highly agitated and angry.

10. Although Liam seemed calmer over the following week, his mother continued to worry that he appeared depressed and very flat in mood. She made contact with his mental health case manager, as will be described further below.

11. On the evening of 23 June 2019 Keiran D'Arcy noticed an alarming message from Liam on Facebook, and immediately rang his mother. The post stated: '*Goodbye everybody. (I left notes for my family the rest of you get this Facebook post)'*. Patricia contacted NSW Police who went to Liam's apartment at Eastwood. It was empty and secured, and Liam's car was

missing. Neighbours reported seeing Liam drive away at around 7.30am that morning. Police made attempts to triangulate Liam's phone but it was either switched off or unable to give a signal.

12. Inside the apartment police officers found three very sad letters on a desk, addressed to Liam's parents and brother. In the letters Liam wrote that he had taken his life and that he had wanted this '*for a long time'*. He expressed love for his family and urged them not to be sad or upset.

The search for Liam.

13. Although there were grave concerns for Liam's welfare, there was as yet no information as to where he might be. However on the morning of 24 June 2019 the following events took place:

- at about 9.22am a walker found items belonging to Liam at the Gap Bluff Lookout. These were a baseball cap and a driver's licence in his name, as well as a set of car keys
- on the cliff edge beyond the fence line, police found a green jacket which was identified as Liam's
- at 10.00 am Liam's car was located in the car park nearby. It contained Liam's wallet.

14. A search involving Polair, Water Police and Eastern Beaches Police commenced. It covered an extensive area between North and South Head, including the cliff and water edges and a 500 metre radius out to sea.

15. On the evening of 24 June 2019 police checked footage which had been captured by CCTV cameras located at The Gap and its surrounds. They found footage time-stamped 7.43pm the previous evening, which showed a male believed to be Liam walking up the stairs to the The Gap viewing platform. Once there he raised both hands and waved, before walking down a path leading to the HMAS Watson lookout. He was not seen thereafter. It is noted that this path returns to the roadway on a route that is not covered by CCTV cameras.

16. The police search of the area continued the next day, but no trace of Liam was found.

Subsequent inquiries

17. In the following weeks police conducted a number of checks to try to ascertain if Liam was still alive. There were no records of him having left Australia. Liam owned a bank account with the Commonwealth Bank. The final transaction on this account was a withdrawal at The Star Casino at 1.08am on 23 June 2019. There is no record of his death having occurred in any of the States or Territories of Australia.

18. A sample of DNA extracted from Liam's toothbrush has not matched any items on the missing persons DNA database.

19. The officer in charge of the coronial investigation spoke with Mr Eric Hains, Liam's employer. Liam was extremely well liked at his workplace. Mr Hains said that in the week before he disappeared Liam had spoken of feeling very fatigued. He had last seen Liam on the afternoon of Friday 21 June 2019 when Liam completed his shift. Mr Hains searched his own emails and found this message from Liam sent at 7.32pm on 23 June:

    '*Dear Eric and Deb, I am sorry but I will be unable to return to work. I have taken my life. I appreciate the opportunity you have given me and have enjoyed working with you. All the best. Please pass on my best wishes to all. Thanks. Liam.'*

Is Liam deceased?

20. Adding to the deep sadness that Liam's family feel at his loss, is the absence of certainty that he has in fact died. Liam's parents and brother can no longer feel hope that he is alive. However since his body has never been found they have not been able to say their final farewells. Nor can they be sure what exactly happened to him that night.

21. One of the purposes of an inquest is to consider whether the evidence can establish that a missing person has in fact died. Having carefully considered the evidence in this inquest, in my view it does enable the conclusion that Liam is no longer alive. For the reasons given below, my opinion is that he lost his life not long after his image was captured on CCTV on the night of 23 June 2019.

22. Liam has not been seen since that date. Nor has there been any activity on his mobile phone or bank account. There is no record that he has left Australia. His family has received no contact from him, which in itself is compelling given that Liam knew they loved him and cared deeply about him.

23. There is in addition strong evidence that on 23 June 2019 Liam was intent on ending his own life. This is made clear in the letters he left his family, the email to his employer, and the Facebook message he posted that evening.

24. This evidence is sufficient to find that Liam has in fact died, and that he died on or around 23 June 2019.

What was the cause and manner of Liam's death?

25. It is not always possible to establish the cause of a person's death. This is particularly the case where, as here, the person's body has not been found. Where that is the case there is limited scope to know the circumstances of the person's death, or to have the benefit of a medical examination of his or her body.

26. The known facts about Liam's death strongly indicate that he died in the area of The Gap at Watson's Bay. That is the location of his last known sighting. In addition his belongings and car were found at that location.

27. As indicated above at paragraphs 12 and 19, the circumstances also strongly suggest that Liam's death was the result of an intentional act on his part to end his own life.

28. The precise cause of Liam's death cannot be known. No known person observed his actions that night in The Gap area. Nor did Liam's letters and emails point to any specific method he would use to take his own life. However the evidence strongly suggests that he did this by jumping from a height in The Gap area. This conclusion is based on the following:

- the last known sighting of him was in the area of The Gap Lookout
- his car was found at The Gap car park
- his car keys, licence and baseball cap were found at the Gap Bluff Lookout
- significantly, his jacket was located on the cliff side of the fence at that lookout.

29. Although the evidence enables the conclusion that Liam took his life by jumping from one of the lookouts in The Gap area, it is not possible to establish the exact cause of his death. It is almost certain that he died either as a result of unsurviveable injuries or drowning, but since his body has never been found it is impossible to say which.

Liam's psychiatric care

30. Given Liam's history of schizophrenia, after his death an internal review took place to examine whether any improvements might be identified in the care which he received from the Ryde Community Mental Health Care Team. Specific questions were whether it had been appropriate to reduce and eventually cease his use of clozapine, and whether his response to the medication change had been sufficiently monitored. Regarding the latter question, it was known that a 'shared model of care' was intended to be in place for Liam at the Ryde Community Mental Health Centre. This meant that a regular GP would be involved in his care; however Liam had not had a regular GP since August 2017.

31. In response to these concerns, the coronial investigation included an examination of these two issues. As regards the reduction and cessation of Liam's clozapine medication, I accept evidence presented at the inquest that this decision was reasonable. The evidence was that since 2004, Liam's use of clozapine had kept his mental state stable without the reemergence of psychotic symptoms. However the medication had caused distressing side effects including intermittent nocturnal enuresis. After Liam died his parents were provided with a copy of this evidence. Patricia D'Arcy has informed the Court that she had not previously been aware of the extent of Liam's side effects while on clozapine, and felt sad that he had not shared the extent of his distress with them.

32. While there is no basis for adverse comment regarding the decision to cease Liam's use of clozapine, it is relevant to note that the review panel considered that the rate of reduction perhaps ought to have proceeded more slowly given the effect on Liam's sleep and consequent impact on his mental state. It made a recommendation that the Mental Health Centre conduct reflective practice sessions on the importance of care planning for patients withdrawing from long term treatment on antipsychotic medication. These sessions have since been conducted.

33. As regards the question of whether Liam received sufficient monitoring during the process of reducing his clozapine, his records with Ryde Community Mental Health Centre show that he had medication reviews in March and April 2019 with the service's consultant psychiatrist, Dr Atrubi Fukui. Dr Fukui's assessment was that Liam was not suffering any significant adverse issues from the reduction and cessation of clozapine, other than reduced sleeping time at night. Liam's last review took place on 24 April 2019. Liam described less sleep and some consequent irritability. According to Dr Fukui's records, Liam reported feeling otherwise well with no other deterioration in mood.

34. In addition, Liam had meetings with his case worker at Ryde Community Mental Health Centre, Registered Nurse Richard Tippett. RN Tippett generally saw Liam on a monthly basis, with the participation of a medical officer every third review. During the medication reduction process RN Tippett noted concerns about Liam's insomnia, anxiety and depression. In response he arranged for the Ryde Community Mental Health Services' Acute Care Team to contact Liam and offer him an assessment. RN Tippett encouraged Liam to take up the offer but Liam did not want to do this. RN Tippett's last contact with Liam was by phone on 21 June, in which they discussed medication to help with Liam's sleep disturbance.

35. As can be seen, the assessment of Dr Fukui and RN Tippett was that Liam had not suffered any significant changes in mood since the cessation of clozapine. Each noted that Liam was experiencing some insomnia but they were of the view that he was otherwise well, with no signs of psychosis, depression or suicidal ideation.

36. There is no basis to find that Liam was not appropriately reviewed and monitored while his medication was being withdrawn. However the review team noted that during this process Liam's mother and to an extent Liam himself had reported insomnia, work stress, anxiety and depression. The team noted further that a comprehensive mental state examination had not been documented while Liam's treatment was being changed. It recommended that clinical staff be reminded of expectations about documentation and assessment of mental state for patients in the community mental health setting.

37. It was also acknowledged that the absence of an established relationship with a GP did not align with the model of care that was intended for Liam. Since

then the ‘shared care’ model has been discontinued, and the Local Health District now employs a specialised Clozapine coordinator.

38. Following Liam’s death his parents have met with Dr Fukui and RN Tippett, and they are aware of the internal review and its recommendations. They have expressed they are satisfied with these processes and they do not express any residual concerns about his mental health care and treatment.

39. As a result of the internal review that has been conducted and its subsequent recommendations, there is no basis for any recommendations to be made arising out of this inquest.

Conclusion

To Liam’s parents and his brother, I express my sincere sympathy for the loss of their beloved son and brother.

I thank Coronial Advocate Sergeant Simone Kelly for her assistance in the preparation and conduct of this inquest. I thank also the Officer in Charge, Leading Sergeant Michael Patane, for his conduct of the coronial investigation.

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.

Identity
The person who died is Liam D’Arcy.

Date of death:
Liam D’Arcy died on or about 23 June 2019.

Place of death:
Liam D’Arcy died in the area of The Gap Lookout at Watson’s Bay, Vaucluse NSW 2030.

Manner of death:
Liam D’Arcy died when he intentionally jumped from a cliff in the area of The Gap.

Cause of death:
The precise cause of Liam D’Arcy’s death is unknown.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe
25 August 2020