



# MAGISTRATES COURT *of* TASMANIA

## CORONIAL DIVISION

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### **Record of Investigation into Death (Without Inquest)**

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Olivia McTaggart, Coroner, having investigated the death of Judith Anne Emery

**Find, pursuant to Section 28(1) of the Coroners Act 1995, that:**

- a) The identity of the deceased is Judith Anne Emery;
- b) Ms Emery died as a result of falling from a cliff in unascertained circumstances;
- c) The cause of death is chest and abdominal injuries or drowning; and
- d) Ms Emery died between 24 and 26 September 2016 at Claremont, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Ms Emery's death. The evidence includes the Police Report of Death for the Coroner, an opinion of the forensic pathologist who conducted the autopsy, toxicological evidence, police and witness affidavits, medical records and forensic evidence.

Ms Judith Anne Emery was born on 17 November 1941 and was aged 74 years at her death. She lived alone at Derwent Waters retirement village in Cadbury Road, Claremont and had done so for the last three years of her life. Ms Emery's partner of 35 years was Mr Yogi Bruce Marriott. Mr Marriott was 85 years of age at the death of Ms Emery and suffered from severe dementia. Mr Marriott is now deceased. He had left Derwent Waters before Ms Emery's death to reside at Barossa Park Lodge in Glenorchy where he received a high level of care.

Derwent Waters is an independent residential facility run by the Aveo Company and is a facility for non-dependent older persons who purchase their individual living quarters or units. In return for the purchase, the residents receive their meals, a cleaning service and laundry service. Staff are present on site for 24 hours per day but are not medically trained and do not administer medicines, nor cater for the residents' needs. Residents of the facility are free to leave the premises at will and without the requirement to notify staff.

Ms Emery was described by Ms Kirby Cross, a staff member at Derwent Waters, as a person who kept to herself. Ms Cross, in her affidavit for the investigation, said that Ms Emery was a "strong, stubborn woman who knew what she wanted and would not compromise". Ms Cross said

that she did not appear to suffer dementia. Generally, the evidence in the investigation indicated that Ms Emery was healthy, alert and fully capable of living independently.

It is asserted by the investigating officer in his report to me that, based upon police discussions with staff of the facility, Ms Emery would often walk to the nearest bus stop located on Cadbury Road, Claremont and catch Metro buses to visit Mr Marriott at Glenorchy. It is further reported by the investigating officer that Ms Emery would normally visit Mr Marriott only on week days. Unfortunately, there were no affidavits gathered of key staff members regarding this information, despite my ongoing requests. The affidavit of Ms Cross, the last staff member to see Ms Emery, was sworn on 27 January 2020 as a result of repeated requests for further investigations.

I note that the waterfront area near Derwent Waters comprises a rocky foreshore below cliffs which are under 10 metres in height. Moreton Crescent runs along the line of these cliffs.

It is asserted in the investigating officer's report that the retirement home manager, Mr Stephen Stone, told investigators that Ms Emery often walked along the waterfront surrounding the retirement complex, to which residents had full access. No affidavit of Mr Stone was taken by investigators, forming the view that no further useful information would be gained.

The general habits, movements and disposition of Ms Emery are very important matters in this investigation, given the circumstances of her death. I am confident that the investigating officer has accurately related the contents of discussions by police with staff of the facility in his report. However, the lack of direct affidavit material and detail has hampered this investigation considerably. In any event, I am satisfied that Ms Emery was mobile and independent, and was in the habit of catching the bus to visit Mr Marriott on regular occasions. It appears that the distance to the closest bus stop on Somerdale Road (adjoining Cadbury Road) was a distance of 250 metres from the rear of her unit. Walking to this bus stop would not involve walking along the waterfront cliffs. It would seem unlikely that she would take a circuitous route via the waterfront cliffs to a bus stop a greater distance away from her residence.

Mr Marriott's son, William Marriott (William), and his partner, Therese Karpathy (Therese), arrived in Tasmania from New South Wales, where they lived, at 1.00pm on Sunday 25 September. This was a planned visit to Tasmania to see Mr Marriott at his residence at Barossa Park Lodge and to travel to other parts of Tasmania. William had spoken to Ms Emery by telephone on 16 September to advise of their impending visit. He told Ms Emery that he and Therese would come from the airport, collect her from her residence and then they would all go to visit Mr Marriott.

Once arriving in Tasmania on 25 September, William and Therese attempted to call Ms Emery twice to offer her a lift to Barossa Park, as arranged, but she did not respond. These calls were made at 1.35pm and 2.54pm. They assumed that she had made her own way to Mr Marriott and so they went to visit him. Ms Emery was not present at Barossa Park Lodge.

At approximately 5.00pm that day William and Therese, after visiting Mr Marriott, drove to Ms Emery's unit at Derwent Waters, expecting her to be there. She was not in her unit and the night manager advised them that she had not seen Ms Emery since the day before when she had "checked herself out" for lunch and dinner on Saturday. The manager further advised that Ms Emery had been acting a little strangely in recent times and that she believed she did not wish to attend the main dining room for lunch or dinner due to embarrassment because she had tried to dye her hair and it had not been successful.

Incident sheets obtained from Derwent Waters in the investigation note that staff had last seen Ms Emery on Saturday 24 September when she ordered lunch in her room by telephone. In her recent affidavit, Ms Cross stated:

*"I recall on that Saturday that my manager at the time, Steven, came to me and asked me to take a meal to Judith. She had rung the office and stated that she couldn't attend the dining room as she had just used a hair treatment and that she wasn't looking appropriate and didn't want people to see her that way. I had never known her to miss a meal before in the dining area.*

*Judith would have rung a short time before 12.30pm lunch, maybe around 12.00pm.*

*The kitchen staff prepared a tray of food for Judith and I walked it to her door. Typically I would let myself into the rooms, but not Judith's room. I knocked and she answered the door. I stood in the doorway and passed the tray of food. I can recall that her hair appeared wet. I also recall that I couldn't smell any hair treatment, dye or chemicals.*

*I have to say that on this occasion she was so nice to me in a way that she hadn't been before. She said something like, "thank you so much Kirby, I really appreciate it" when she would never usually say my name.*

*I remained at her doorway for a short while and did not enter her room before she closed the door and I returned to my day. Judy didn't appear upset, emotional or at all unwell.*

*I can't remember what Judith was wearing that day when I delivered her the meal. It may have been an older type jumper. She didn't tell me when I took her the meal that she was going anywhere. As I said before, I was surprised to find out from other staff that Judith often left the*

*building. The side exit door near the entrance to the building side of Judith's room has a push button to open and a sensor in the garden to reopen. The sensor door is turned off around 8.30pm at night. I do not know if Judith left a key outside to unlock the sliding door from outside."*

Upon the available evidence, Miss Emery was not seen after Ms Kirby's visit. Notably, on Sunday 25 September, Ms Emery did not attend lunch at Derwent Waters.

At about 5.00pm on Sunday 25 September, William and Therese spoke to staff at Derwent Waters as they were concerned for Ms Emery's welfare and could not contact her by telephone. At about 6.00pm staff members, together with William and Therese, entered Ms Emery's locked unit but she was not there. Her wallet, containing cash, was present as was her identification cards and handbag. William stated in his affidavit that there did not appear to be anything out of place or disturbed in the unit apart from the fact that the bed was not made. No affidavits of the staff members involved in opening Ms Emery's unit were taken for the coronial investigation.

At 6.00pm a staff member telephoned police to advise that Ms Emery was missing from her residence. Police officers attended and spoke with staff who confirmed that Ms Emery had not been seen since about 2.00pm on Saturday 24 September when her lunch was delivered.

Police then commenced immediate action to try and locate Ms Emery, including searching the area, contacting the Royal Hobart Hospital and Metro bus service, and issuing media releases to broadcast Ms Emery as a missing person. Throughout the night, further searches around the area, including parts of the foreshore, took place and numerous other enquiries were made by police. This response by police to the situation was thorough and appropriate.

At approximately 7.30am on Monday 26 September, whilst police were still attempting to locate Ms Emery, a group of young boys located a deceased person lying on the rocky shoreline below the cliffs in the vicinity of Moreton Crescent. They reported this to their mother who contacted police. A police officer, Constable John Rowbottom, who was already searching for Ms Emery a short distance away on the foreshore, quickly attended the scene after being advised of the report by police radio. He observed the body, later positively identified by William as Ms Emery, laying on her side and clearly deceased.

The area of cliff where Ms Emery was located is behind houses in Moreton Crescent a distance of approximately 300 metres from Derwent Waters. The area directly above the location of Ms Emery's body has no fencing and the cliff face is approximately six metres in height, with rocky foreshore below. The top of the cliff area was flat and grassy with some shrubbery on

the downhill side of the cliff so that the drop from the top to the bottom is not altogether sheer. Further, there are two indented logs on the ground, providing a very small barrier for a person standing to look at the water and which mark the cliff face.

Numerous police officers, including CIB detectives and forensics officers, attended the scene and recorded their observations. They noted that Ms Emery was fully dressed but not wearing her shoes. She was wet from head to toe. She was lying on her back with her head near the high tide line facing the cliff face. Her legs were turned to one side with her left hand partially in her jacket pocket. She was dressed in blue track pants, a grey hooded jacket and wearing long socks. She was not wearing a watch. Two matching shoes were located on the shoreline 20 metres and 50 metres away respectively. Investigators were of the view that tidal movements may explain the location of the shoes away from Ms Emery.

On the cliff above where Ms Emery was found, a purple handkerchief was located in the vegetation on the cliff face. It appeared that the vegetation had been recently disturbed, especially near the cliff's edge, suggesting that Ms Emery had either walked or fallen through this part of the vegetation. DNA testing upon the handkerchief was conducted by comparing samples taken from that item with Ms Emery's blood sample. The forensic scientist indicated that the DNA on the handkerchief matched Ms Emery's sample. For reasons that are unexplained, I was not provided with this DNA profiling report by the investigator until 2 March 2020.

An autopsy was conducted by forensic pathologist, Dr Christopher Lawrence. In his report, Dr Lawrence stated:

*“This 74 year old woman, Judith Anne Emery, died as a result of chest and abdominal injuries following a fall from a height. There may have been terminal drowning based on the appearances of the lungs and the wet clothing. The exact circumstances surrounding the death are still not entirely clear. It appears that Ms Emery may have been walking at the top of a cliff and fell. The circumstances surrounding the fall are not clear and I don't believe that I can tell whether she slipped or jumped.*

*Examination reveals traumatic injuries consistent with a fall from a height probably landing feet first. She does have a substantial haemorrhage into the pelvis and she would be unable to move due to the fractures of the pelvis and of the left ankle. There is no clear indication of hypothermia however there are also over-expanded lungs and she may have terminally drowned”.*

I accept Dr Lawrence's opinion regarding the final medical causes of Ms Emery's death. That is, she died as a result of her injuries from the fall as well as possible drowning. However, the reason for her drop from the cliff face is far from clear.

As part of the investigation, I have considered Ms Emery's medical records from her treating general practitioner, Dr Donald McLeod, at the Glenorchy Medical Centre. The records show that she was not suffering any serious or debilitating illness. Her only medications prescribed were for reflux and cholesterol.

In his affidavit for the investigation, William stated that he believed Ms Emery's mental state had declined over the last year before her death and that she was anxious about his visit. He said that his father had told him of an argument he (his father) had had with Ms Emery about their impending visit. However, there is no evidence at all that Ms Emery was in a depressed state of mind or that she was cognitively impaired. There is no evidence that she had ever expressed suicidal ideation, nor was there any note or other clue in her residence that she intended to end her life. The fact that her handbag and wallet were in her residence may be consistent with her leaving to go for a short walk along the grassed, and relatively flat, waterfront track. Leaving these items in her residence would not be consistent with her intention to leave to catch a bus to Barossa Lodge. The path taken by Ms Emery is also inconsistent with walking to the closest bus stop.

There was some suggestion on the evidence that staff indicated that Ms Emery had left her watch in the residence, something that was highly unusual for her. However the forensics photos and affidavits regarding the unit do not depict or refer to a watch. The observation of the forensics officer examining the residence was that it was clean, locked, no apparent property out of place and no signs of a disturbance. Her keys to the unit were inside. On the main bed were travel itineraries for William's flight from Sydney to Hobart on 25 September boarding at 10.40am.

On the evidence in the investigation, Ms Emery's death may have occurred between 2.00pm on Saturday 24 September 2016 and 7.00am on Monday 26 September 2016. It seems, logically, that it is more likely that she passed away on the evening of Saturday 24 September or some time on Sunday 25 September. An analysis of Ms Emery's telephone calls for the relevant period indicated that there were no calls made from her only telephone line, her landline in her unit, on Saturday 24 September or subsequently. This contradicts the evidence that she telephoned reception at Derwent Waters to cancel her lunch and dinner. The information concerning her telephone activity was provided to me only recently but should have been an essential part of the original investigation.

It is plausible to consider that Ms Emery may have decided to walk along the waterfront grassed path and stopped at the small lookout area about 300 m from her residence. Having attended the scene myself, it is not easy to see why she, or anyone there intending to simply look out at the water, would have deliberately stepped over the very small log markers of the lookout point, as they act as natural barriers. It is also difficult to understand how, if she did lose her footing as she was standing at that point, the foliage and shrubbery on the cliff face would not have prevented her fall. It is possible that she was walking in the dark, possibly in an agitated state, and accidentally fell through the foliage to the rocky shore below. She may have been attempting to retrieve her handkerchief. Nevertheless, she was a person who was spritely on her feet and was accustomed to walking.

It is also plausible to consider that Ms Emery may have deliberately jumped from the cliff with an intention of ending her life. Although she had not expressed suicidal ideation, her very reserved disposition may have prevented her from revealing the extent of any distress she may have been suffering.

Although there is no evidence to cause me to suspect homicide, I also cannot rule out that possibility. This possibility is less likely than Ms Emery's death being an accident or suicide. There are houses on the waterfront close to the grassed track but there are no witnesses to Ms Emery's movements or evidence as to whether any other person was in the vicinity. It is unclear as to the extent to which, if any, of the occupants of these houses were spoken to by police in the search for Ms Emery before she was found.

## **Comments**

This investigation has, unfortunately, been prolonged and unsatisfactory. The subject report and evidentiary material from the investigating officer was submitted to the Coroner's Office on 27 June 2018, just short of two years after Ms Emery's death. This delay is undesirable. It is well-recognised that delay will in many cases exacerbate the grief felt by the family. Upon receipt of the report and evidence, I found the chronology of events difficult to understand and the evidence inadequate. There was confusion as to dates in the subject report and, as discussed in this finding, no reliable evidence from staff of Derwent Waters regarding Ms Emery's movements before her death. In November 2018, the coroner's associate, on my behalf, requested the investigating officer to attend to providing further evidence to assist me to determine why Ms Emery died. The additional available evidence and further report by the investigating officer in response to this request was finally received into the Coroner's Office on 2 March 2020.

Despite the deficiencies in the investigation, and my inability to determine the reason for Ms Emery's death, I do not consider that the holding of a public inquest would elicit any further evidence that could reasonably assist me shed further light on Ms Emery's tragic death.

The circumstances of Ms Emery's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act 1995*.

**Dated:** 8 April 2020 at Hobart Coroners Court in the State of Tasmania.

**Olivia McTaggart**  
Coroner