



MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

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MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record Of Investigation Into Death (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Madeleine Wilson, Coroner, having investigated the death of Céline Aline Cremer

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

- a) The identity of the deceased is Céline Aline Cremer, date of birth 13 June 1992.
- b) The manner and circumstances of Ms Cremer's death are set out below.
- c) Ms Cremer's cause of death was by accident.
- d) Ms Cremer died at Arthur River, Waratah in Tasmania between 17 June 2023 and 21 June 2023.

In making the above findings, I have had regard to the evidence gained in the investigation into Céline Aline Cremer's death which is contained in appendix A of this document.

Background

1. Céline Aline Cremer, 31, was born in Liège, Belgium on 13 June 1992.¹ Her father passed away in 2011. She is survived by her mother and younger sister. Ms Cremer attended secondary school at Athénée Royal de Chênée a Liège and completed one year at the University of Liège.²
2. Between 2020 and June 2021, Ms Cremer worked for a manufacturer and distributor of medical grade devices in Belgium. She was multilingual and spoke

¹ C16 Photo 42 Photograph of passport.

² C19 Affidavit of Jean Lambion; correspondence from Ariane Mathieu.

French, Spanish and English.³ Ms Cremer had no known mental or physical illnesses.⁴

3. During 2020 Ms Cremer began planning to travel to Australia for a working holiday. She applied for a working visa to enable her to stay in the country and work for 12 months. She told friends she intended to work until she had saved enough money to buy a four-wheel drive vehicle and then she intended to drive around Australia and travel.
4. In June 2022, Ms Cremer travelled from Belgium to Sydney, Australia for a working holiday.⁵ She stayed with a friend, Jean Lambion in Freshman on the Northern Beaches of Sydney for two months and worked as a waitress in various hotels and cafes in Sydney before moving into a share house nearby.⁶ In September or October 2022, Ms Cremer purchased a light grey Honda CRV and removed the backseat so that a bed could be made in the back. In mid-November 2022, Ms Cremer drove herself from Sydney to Melbourne.
5. On 17 January 2023, Ms Cremer travelled from Melbourne to Tasmania on the Spirit of Tasmania⁷ to take up employment as a waitress at a restaurant in Coles Bay.⁸ On her days off she enjoyed exploring the region and camping in her car.⁹ In March 2023, Ms Cremer was involved in a car accident, and her car was written off.
6. In May 2023, she purchased a white Honda CRV registered number E40TF.¹⁰ Ms Cremer remained working at the restaurant until late May 2023 when she resigned and commenced travelling around Tasmania. She attended the “Dark Mofo” festival in Hobart between 10-13 June 2023 with friends she had met in Coles Bay¹¹ and told them she planned to travel to the West Coast and visit Strahan and Cradle Mountain.

³ C19 Affidavit of Jean Lambion.

⁴ Ibid.

⁵ C20 Affidavit of Justine Ropet.

⁶ C20 Affidavit of Justine Ropet; C19 Affidavit of Jean Lambion.

⁷ C6 Affidavit of Senior Sergeant James Scicluna; C18 Affidavit of First Class Constable Dean Wotherspoon.

⁸ C19 Affidavit of Jean Lambion.

⁹ C22 Affidavit of Melissa Lancaster.

¹⁰ C7 Affidavit of Wayne Bradford.

¹¹ C20 Affidavit of Justine Ropet.

7. Ms Cremer booked a fare on the Spirit of Tasmania, departing Devonport and returning to the mainland on 21 June 2023.¹² Ms Cremer had made plans to meet a childhood friend from Belgium, Justine Ropet, later in the year in the Northern Territory.¹³
8. On 20 June 2023, Ms Ropet tried to contact Ms Cremer but was unable to reach her. After a few days Ms Ropet contacted Mr Lambion and asked if he had heard from her. He had not. It was ascertained that Ms Cremer had last spoken to her mother on 17 June 2023.
9. A missing persons report was made to Tasmania Police on 26 June 2023.¹⁴ The response was initially run from Hobart. A “Concern for Welfare” was published on the Tasmania Police Facebook site that day, seeking the location of Céline Cremer. The post included an image of Ms Cremer, a description of her vehicle and information that she was last seen in Hobart but was believed to have been heading to the West Coast.¹⁵

Last known sitings

10. Initial investigations, commenced on 26 June 2023, involved a triangulation of Ms Cremer’s mobile phone which established her mobile phone had last “pinged”¹⁶ off the Telstra base station at Waratah on 20 June 2023. Enquiries were made of the Waratah Roadhouse who confirmed they had CCTV recordings of a female matching Ms Cremer’s description attending the roadhouse approximately two weeks earlier.¹⁷
11. The CCTV footage obtained from the Waratah Roadhouse confirmed that Ms Cremer drove her Honda CRV to the Waratah Roadhouse on 17 June 2023 and obtained petrol. CCTV footage from the Roadhouse showed that at 1.15pm Ms Cremer entered the store and ordered a coffee and something to eat. The proprietor of the Roadhouse, Candice Mason, spoke with Ms Cremer who told her that she was getting the boat back to the mainland “on the 21st”¹⁸ and was

¹² C19 Affidavit of Jean Lambion; C23 Affidavit of Gabrielle Patterson.

¹³ C19 Affidavit of Jean Lambion; C22 Affidavit of Melissa Lancaster.

¹⁴ C18 Affidavit of First Class Constable Dean Wotherspoon.

¹⁵ C6 Affidavit of Senior Sergeant James Scicluna.

¹⁶ Mobile network pinging: A telecommunications provider checks which cell towers a phone is communicating with. By comparing signal data from nearby towers, they can estimate the phone’s location.

¹⁷ C6 Affidavit of Senior Sergeant James Scicluna.

¹⁸ i.e. 21 June 2023.

touring around before she went back. Ms Cremer told her that she wasn't sure if she was going to go via Corinna or Cradle Mountain. Ms Mason suggested Philosopher Falls and Waratah Falls as places of interest. Ms Cremer was observed to go to her car, where she drank her coffee and scrolled through her phone before leaving in the direction of Waratah Falls.

12. A short time later she was seen to drive towards Philosopher Falls.

Waratah and Philosopher Falls

13. The town of Waratah is located at the edge of the Tarkine Wilderness/Takayna in North West Tasmania, approximately 356 kilometres north west of Hobart and 70 kilometres south west of Burnie. The town was originally constructed to support a tin mine at Mount Bischoff. It has a population of 235 people, with a median age of 55 years.¹⁹
14. Prospectors were active in the area and Philosopher Falls, located about a 10 minute drive from Waratah was named after the prospector James "Philosopher" Smith, who is credited with discovering tin in the area in 1871. A water race was built to divert water from the Arthur River to supply water to the nearby town of Magnet.
15. While the broader area has been subjected to prospecting, mining and logging, the area around the falls is heavy rainforest, with a plant known as "*horizontal*" prolific in the area. Horizontal is endemic to Tasmania and is common to the Tasmania's cool temperate rainforests. It is commonly known as horizontal scrub due to its slender trunk bending down horizontally under its own weight. This fallen stem sends vertical branches up its length, which in turn bend down forming an impenetrable horizontal scrub.
16. The small car park to the falls is accessed via a dirt road and is about 500 metres from Waratah Road. The track to the falls and lookout is located amongst the dense rainforest. The track itself is wide, gravel and easy to follow. It crosses the Arthur River upstream of the falls and then follows the water race until a set of over 200 stairs descends to the lookout. The falls are multi-tiered and fall around 40 metres.

¹⁹ Australian Bureau of Statistics Census 2021 data.

17. A pamphlet on Waratah, produced by the Waratah Wynyard Council describes the walk to Philosopher Falls as a three kilometre return walk, graded “*short, easy*”, of one and a half hours duration, allowing for breaks and photo opportunities.

Tasmania Police investigation

18. In June 2023, Waratah came within Tasmania Police Western District, Queenstown Division, which included stations at Queenstown, Strahan, Zeehan and Rosebery. The area was serviced by a Senior Sergeant, Sergeant and six constables. At the time, the Rosebery station was partially closed for maintenance and operations were being run out of Strahan, approximately two hours’ drive from Waratah. The Waratah police station had not been manned for several years.²⁰
19. On 27 June 2023, Senior Sergeant James Scicluna, the Officer in Charge of Rosebery, assumed carriage of the missing persons investigation.²¹
20. During the morning of 27 June 2023, a Waratah Wynyard Council employee was undertaking duties at Philosopher Falls when he located Ms Cremer’s Honda CRV at the car park. He noted that he had seen the vehicle parked in the same spot on 23 June 2023 when he had last checked the area.²²
21. Police officers were dispatched to Philosopher Falls and conducted registration checks which confirmed that the vehicle belonged to Ms Cremer. Officers commenced walking the Philosopher Falls track at approximately 12.30pm.²³
22. At approximately 3.10pm additional police arrived and conducted a search of the immediate area surrounding the falls, before returning to the carpark. During the return journey, officers observed the track became rapidly obscured by darkness beneath the dense canopy and, after daylight faded, required the use of mobile phone torches to navigate.²⁴ One officer unintentionally veered off track and police observed that it was easy to lose the defined sections of the track in the

²⁰ C6 Affidavit of Senior Sergeant James Scicluna.

²¹ C6 Affidavit of Senior Sergeant James Scicluna. (Senior Sergeant Scicluna had charge in the initial stages from 27 June – 4 July 2023. Inspector Jackson later assumed carriage of the investigation).

²² C28 Affidavit of Ingrid Ekman; C30 Affidavit of Jon Oliver.

²³ C6 Affidavit of Senior Sergeant James Scicluna.

²⁴ C18 Affidavit of First Class Constable Dean Wotherspoon. Sunset at Waratah was at 4.57pm.

darkness. Officers returned to the car park at 5.09pm. Police observations of Ms Cremer's vehicle continued overnight.²⁵

23. Authorisation was obtained on 27 June 2023 for the deployment of a drone and helicopter, however, the helicopter was unable to attend the area due to low cloud cover and returned to Hobart. The drone operator also advised that approaching darkness, limited GPS coverage and the dense forest canopy prevented the safe operation of the drone, either remotely or manually.²⁶
24. Early telecommunications data available to police was limited to triangulation of Ms Cremer's mobile phone. An analysis of the data revealed Ms Cremer's mobile phone had connected to the Telstra base stations servicing areas on either side of Philosopher Falls, namely Waratah and Mt Cleveland towers, between approximately 2.00pm on 17 June 2023 and the cessation of service on 20 June 2023.
25. Of particular note, the mobile phone changed from Mt Cleveland base station to Waratah base station on 17 June 2023 at 4.07pm and thereafter received exclusive service from the Waratah base station from around 4.08pm until 8.13am on 20 June 2023, suggesting that the mobile phone was still moving at around 4.07pm to 4.08pm but had likely remained stationary thereafter.²⁷
26. Australian Federal Police (AFP) provided Tasmania Police with computer generated maps of the expected mobile coverage areas of the Telstra mobile cells Mt Cleveland 3G, Waratah 3G and Waratah 4G, which indicated that there were pockets of incomplete mobile coverage at Philosopher Falls and the surrounding area.
27. An examination of call charge records identified that no outgoing calls were placed by the mobile phone during the period 17 June to 20 June 2023.
28. On Wednesday 28 June 2023, at first light, police officers, including members of Western District Search and Rescue, commenced search operations. A drone was launched from the viewing platform above the waterfall, however, it was only able to obtain limited coverage due to dense foliage.²⁸

²⁵ C6 Affidavit of Senior Sergeant James Scicluna.

²⁶ C6 Affidavit of Senior Sergeant James Scicluna.

²⁷ Ibid.

²⁸ Ibid.

29. A police helicopter was deployed and conducted aerial observations of Philosopher Falls and the surrounding area. Land searches included areas near the waterfall and within the river and continued for approximately seven and a half hours.
30. At the time, weather conditions were adverse, comprising light snow and rain, with an average temperature of 2°C. Despite extensive search efforts conducted that day, no trace of Ms Cremer was located. Drone footage likewise failed to identify any sightings of Ms Cremer or provide additional investigative leads.²⁹
31. On 28 June 2023 members of the Western District Search and Rescue Squad conducted an abseil search of the waterfall area using a Single Rope Technique (SRT). The officers secured themselves to the base of the lookout descending to the waterfall and entered the water, scanning the surrounding vegetation and foliage, however nothing was located.³⁰
32. Subsequently, officers entered the Arthur River below the waterfall and conducted their search from the water. At the time the water current was strong and required steady controlled movements against the flow due to the rocky riverbed and fallen trees in the area. The search did not locate any items of interest.³¹
33. Search efforts also included the areas adjacent to the walking track leading to the falls lookout, the lookout area itself and an unformed track to the Arthur River below the falls.³²
34. While the police investigation remained focused on search and rescue efforts, a parallel criminal investigation was initiated to eliminate the possibility that criminal involvement contributed to the disappearance of Ms Cremer. During the investigation, extensive CCTV footage was reviewed and information provided by members of the public was assessed and triaged.³³
35. A review of Ms Cremer's bank records confirmed her presence on the West Coast between 14 and 17 June 2023, culminating in the confirmed sighting at

²⁹ C6 Affidavit of Senior Sergeant James Scicluna.

³⁰ C11 Affidavit of Constable Daniel Dellar.

³¹ Ibid.

³² C18 Affidavit of First Class Constable Dean Wotherspoon.

³³ C6 Affidavit of Senior Sergeant James Scicluna.

Waratah on 17 June 2023. Additional intelligence confirmed numerous sightings of her vehicle at the Philosopher Falls carpark from 18 June 2023.³⁴

36. As part of the search operation, Dr Paul Scott was consulted to provide an expert opinion regarding survivability.³⁵
37. Dr Scott advised police that in his opinion the prevailing weather conditions would more than likely cause an injured or lost lightly clothed person to succumb to hypothermia after three to four nights outdoors. He further advised that, as of 28 June 2023, it would be extremely unlikely to find Ms Cremer alive.
38. Dr Scott considered the possible scenarios to be:
 - that Ms Cremer was alive and intentionally avoiding detection, which he considered extremely unlikely given her mental state and future plans;
 - that Ms Cremer had been injured but was out of sight of the trail and subsequently succumbed to hypothermia;
 - that Ms Cremer had fallen from the waterfall and succumbed to injuries and/or hypothermia; or
 - that Ms Cremer had fallen into water and drowned or succumbed to hypothermia.³⁶
39. Police Search and Rescue and State Emergency Service volunteers continued their search efforts on 29 June 2023. They attended the area and conducted line searches adjacent to and parallel to the track from Waratah Road to the carpark and from the car park to the lookout overlooking Philosopher Falls.³⁷
40. Due to a decline in weather conditions a swift water search planned for 30 June 2023 was postponed and instead a rope-access search was conducted of the

³⁴ C6 Affidavit of Senior Sergeant James Scicluna.

³⁵ Dr Scott is a qualified Emergency Medicine Physician and at that time was the Assistant Director of the Emergency Department at the Royal Hobart Hospital. He has extensive experience in the fields of search and rescue and medical retrieval, including as a trauma consultant with the Ambulance Tasmania helicopter response team, a field training officer in Antarctica and a member of the Australian Antarctic Division Aeromedical and Retrieval Evacuation team.

³⁶ C37 Report of Dr Paul Scott.

³⁷ C18 Affidavit of First Class Constable Dean Wotherspoon.

viewing platform and the steep terrain surrounding the falls and river.³⁸ Additional searching was conducted from the carpark north to the Arthur River (not following the track), and following the water race to the north, part way to the Magnet Dam.³⁹

41. On 30 June 2023 members of Western Search and Rescue Squad returned to the area to search the area between the trail and the water's edge to the top of the water fall and around to the lookout. No items of interest were recovered.⁴⁰
42. On 1 July 2023, SES personnel conducted searches using All Terrain Vehicles along Magnet Road, Butlers Road and the old overgrown track access to Philosopher Falls which "*faded to nothing*".⁴¹
43. The search and rescue response was conducted according to standard search planning methodologies; (i) theoretical methodology focuses on determining the maximum distance the missing person can travel in the given timeframe; (ii) statistical methodology is based on the application of Lost Person Behaviour (LPB) and (iii) subjective methodology involves an assessment of the topography, including natural barriers and aids to navigation to reduce the search area to the area that the missing person is most likely to be located.⁴² The application of that planning and the analysis of available mobile phone data informed the parameters of a probable search area bounded by the water race to the east and north, the Arthur River to the south and the vegetation to the west.
44. On 3 July 2023, a review was conducted of the investigation to date to ensure nothing had been overlooked.⁴³ The review failed to identify any shortcomings and confirmed that Ms Cremer's time-frame for survivability had well passed.⁴⁴ A dedicated task force was set up to continue the investigation.
45. On 4 July 2023, owing to the reduced water levels, members of Search and Rescue, searched the river, above and below the falls, including pools, strainers and any other areas of possible entrapment.⁴⁵

³⁸ C6 Affidavit of Senior Sergeant James Scicluna.

³⁹ C18 Affidavit of First Class Constable Dean Wotherspoon.

⁴⁰ C11 Affidavit of Detective First Class Constable Daniel Della.

⁴¹ C18 Affidavit of First Class Constable Dean Wotherspoon.

⁴² Ibid.

⁴³ C6 Affidavit of First Class Sergeant James Scicluna.

⁴⁴ C18 Affidavit of First Class Constable Dean Wotherspoon.

⁴⁵ Ibid.

46. At the end of searching on 7 July 2023 the search effort was formally suspended.
47. The criminal investigation did not identify any evidence of the involvement of an unknown person.

Telecommunications and digital evidence

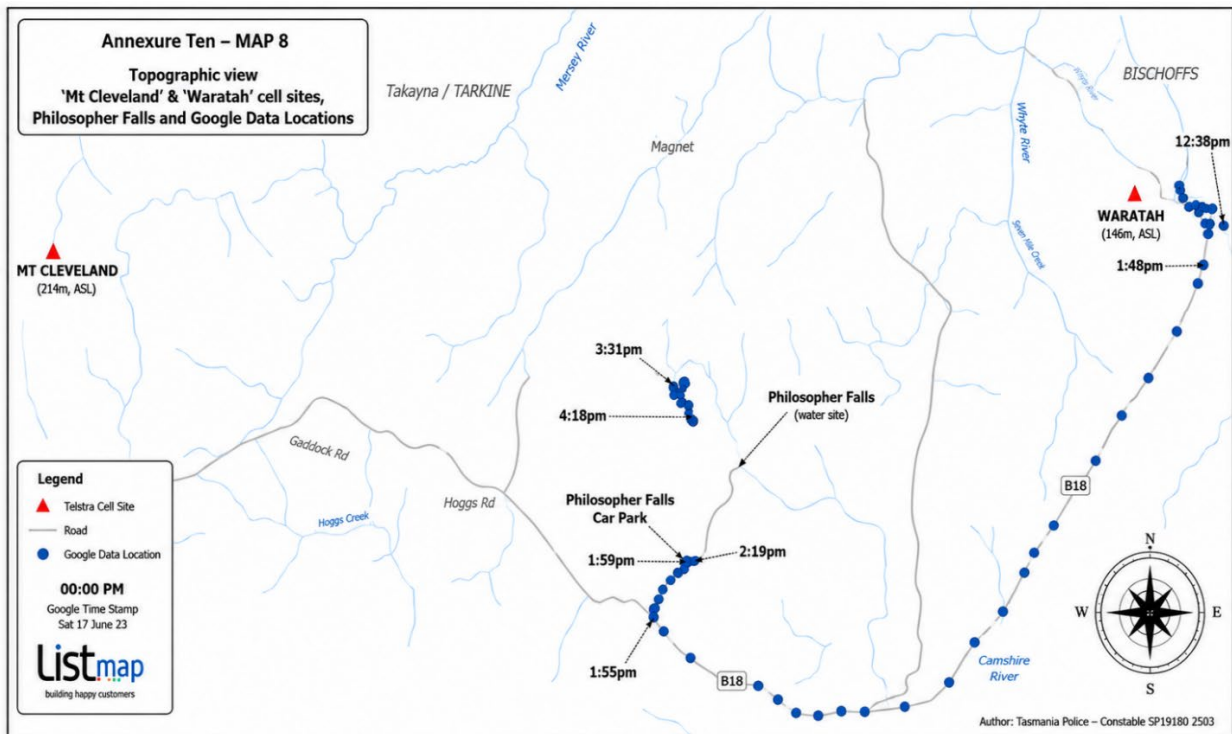
48. Despite the suspension of the search efforts, investigations continued into the mapping and analysis of the available phone data.
49. In mid-July 2023 one of Ms Cremer's close friends gained access to her online Google accounts and social media accounts. With the approval of Ms Cremer's mother, access to Ms Cremer's Google Timeline data was provided to Tasmania Police.⁴⁶
50. Constable Benjamin Shepherd, an intelligence analyst employed by Tasmania Police received the Google location data records on 22 July 2023 and undertook a telecommunications analysis of the data which included recorded coordinates and time stamps from 2017 until 20 June 2023.
51. The data confirmed that Ms Cremer had travelled from the town of Waratah to the Philosopher Falls car park and commenced walking on the track towards the Philosopher Falls lookout.
52. From midday to 2.19pm on Saturday 17 June 2023 Google location data was recorded at frequent intervals. Between 2.19pm and 3.31pm, no Google location data was captured. Constable Shepherd opined that this was most likely due to Ms Cremer's mobile phone being outside satellite reception during that period.
53. Between 3.31pm and 4.18pm on Saturday 17 June 2023 frequent location captures again occurred. The final GPS record contained within the Google data was recorded at 4.18pm. The coordinates associated with that record correspond with a location at the top of what police referred to as "Hill A".⁴⁷

⁴⁶ Timeline data records the movements of a device associated with the account holder and the duration spent at particular locations. Raw data may be extracted to identify GPS coordinates associated with the device. The accuracy of the data may vary in areas with poor cellular coverage.

⁴⁷ C17 Affidavit of Constable Shepherd – Referred to as "Fall A" on Annexure 10 Map 8.

54. Constable Shepherd extracted the GPS coordinates recorded in the Waratah and Philosopher Falls area, captured between noon and 4.18pm on 17 June 2023 and mapped this data.

55. Constable Shepherd's map is set out below.

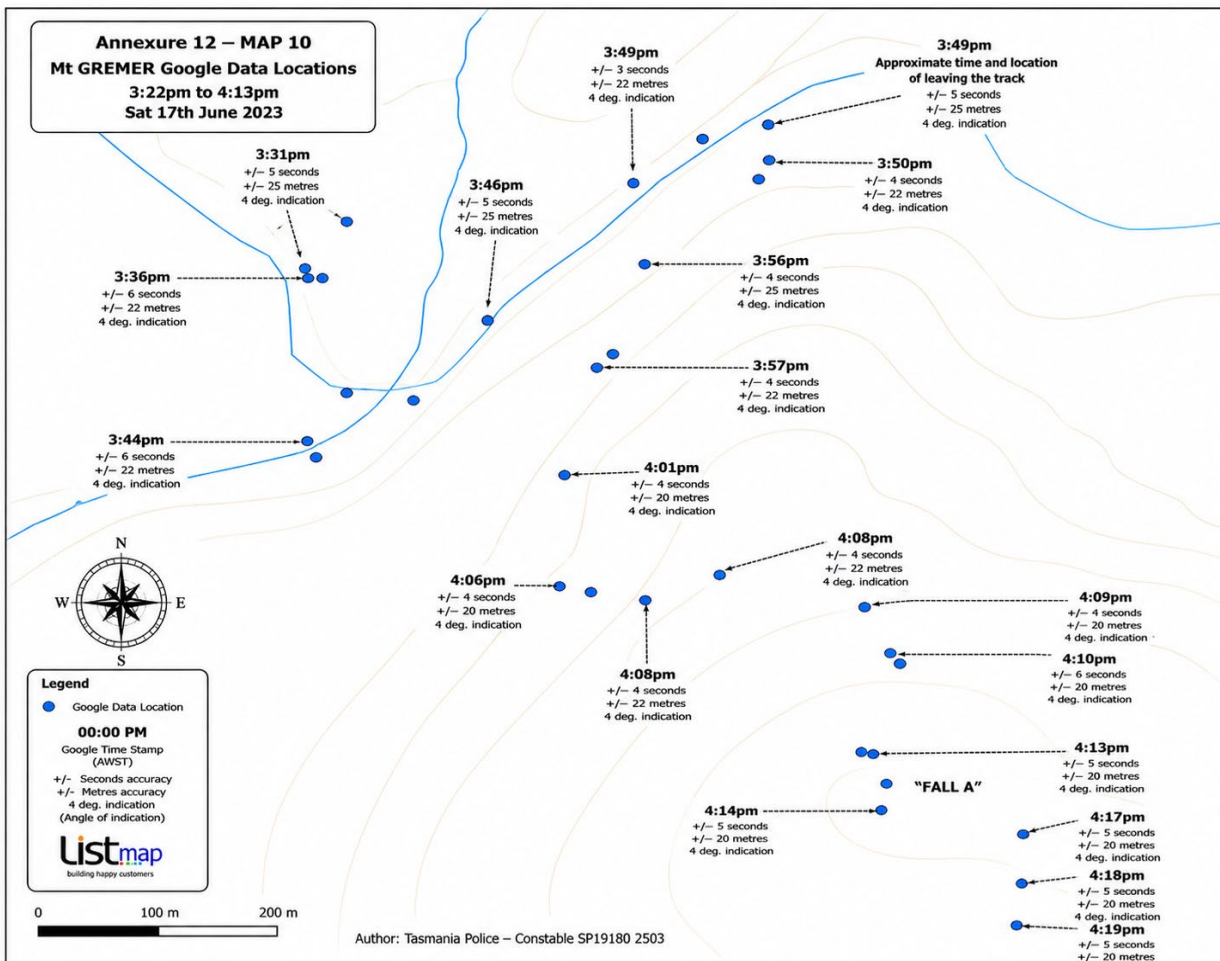


48

56. From 4.18pm onwards the Google data was unable to capture the precise coordinates of the mobile phone and returned approximate coordinates for the Waratah township and surrounding area. In Constable Shepherd's opinion, this suggested that Ms Cremer's mobile phone had become shielded from the satellite coverage it had received whilst elevated on Hill A prior to 4.18pm.

57. Next, Constable Shepherd extracted the GPS coordinates in the Philosopher Falls area between 3.22pm and 4.19pm on 17 June 2023 and mapped this data. "Fall A" in this map is "Hill A" referred to earlier in this decision.

58. This map is set out as below.



49

59. The analysis of the Google Timeline data brought focus to the investigation and sparked further searches by Tasmania Police on several days in late July 2023.
60. Searchers reported the search efforts were significantly hindered by dense vegetation, particularly horizontal scrub, and in some areas, drops of up to five metres.⁵⁰
61. Unfortunately, these searches yielded no further results of evidentiary value, and the search efforts were subsequently suspended. A report of death was submitted to the Coroner's office.
62. Despite the formal suspension of search operations, Tasmania Police utilised allocated training days to conduct additional searches of the area between the

⁴⁹ C17 Affidavit of Constable Shepherd Annexure 12 Map 10.

⁵⁰ C18 Affidavit of First Class Constable Dean Wotherspoon.

car park and the last known mobile phone location, however nothing of significance was located.⁵¹

63. On various occasions, items located by members of the public were provided to police and subjected to forensic testing and DNA analysis. None of the items provided any evidentiary link to Ms Cremer.

Privately coordinated search operations

64. In early 2024, Ms Cremer's family engaged IFW Global Investments Pty Ltd (IFW Global) as private investigators to assist in locating Ms Cremer. Mr Kenneth Gamble, Executive Chairman of IFW Global, a licensed private investigator with extensive experience in investigations, intelligence operations, complex search and recovery matters and missing persons investigations, coordinated the investigation.⁵²
65. As part of his preliminary investigations, Mr Gamble attended Waratah on several occasions during 2024. In May 2024 he attended the Waratah Roadhouse and viewed the CCTV footage of Ms Cremer's attendance there on 17 June 2023. Mr Gamble took note of Ms Cremer's clothing, which included a fleece type pullover with a zip at the front, worn beneath a cream or light coloured "*Ghanda*" brand jacket, black tights/pants, black and white Nike runners and a cream-coloured beanie.
66. Mr Gamble subsequently returned to conduct reconnaissance visits of the Philosopher Falls region. He observed the terrain consisted of steep rainforest slopes, dense undergrowth, water races and river systems. He considered that the terrain presented significant physical and navigational challenges.⁵³ At the site of the Magnet Dam walking trail he observed that it was in poor condition and became invisible to the naked eye in some sections.⁵⁴
67. Mr Gamble analysed the GPS coordinates that had been obtained from the Google Timeline. He formed the view that Ms Cremer commenced walking the Philosopher Falls track shortly before 2.19pm, at which time her phone lost contact with nearby telephone towers. The device was next detected at 3.32pm near Magnet Dam. Mr Gamble noted that the distance to Magnet Dam is

⁵¹ C18 Affidavit of First Class Constable Dean Wotherspoon.

⁵² C33 Affidavit of Kenneth Gamble.

⁵³ C33 Affidavit of Kenneth Gamble.

⁵⁴ Ibid.

approximately 2.5 kilometres and would typically take around one hour to walk at a normal pace.

68. Based on the location data, Mr Gamble concluded that Ms Cremer had returned from the vicinity of Magnet Dam, crossing Seven Mile Creek via the walking trail. She then turned left (north) and proceeded for approximately 100 metres before abruptly changing direction, turning right and heading northeast off the trail. She ascended an embankment and subsequently turned south towards the Philosopher Falls carpark where her vehicle was parked, approximately two kilometres away.⁵⁵
69. As she continued uphill and over the embankment, Ms Cremer's mobile phone recorded multiple GPS points indicating a southerly direction of travel. After crossing the hill, she began descending into a lower area, at which point the device appears to have lost signal and ceased recording GPS data at 4.18pm.
70. In October 2025 IFW Global liaised with Constable Dean Wotherspoon, Tasmania Police in relation to planning a privately organised search at Philosopher Falls, scheduled for December 2025.⁵⁶
71. Mr Gamble acted in a private investigative capacity and did not exercise any law enforcement powers.⁵⁷
72. As Ms Cremer's death had been reported to the Coroner's office, the Coroner⁵⁸ approved the provision of information by Tasmania Police to IFW Global in order to support and assist the investigators in their search.
73. IFW Global initiated an expression of interest process to recruit suitably qualified volunteers for an independent, structured search operation. Background checks were conducted to ensure volunteers possessed appropriate skills.⁵⁹
74. The search team included former military personnel, Parks and Wildlife rangers, experienced bushwalkers, mapping specialists and environmental professionals.⁶⁰

⁵⁵ Refer Annexure B.

⁵⁶ C38 Affidavit of First Class Constable Dean Wotherspoon.

⁵⁷ Ibid.

⁵⁸ At that time, Coroner Cooper (now retired) had carriage of the investigation into the death of Ms Cremer.

⁵⁹ C7 Affidavit of Wayne Bradford.

⁶⁰ C33 Affidavit of Kenneth Gamble.

75. On Friday 12 December 2025 a briefing, attended by all searchers, was held at the Waratah Men's Shed. The briefing was arranged in consultation with Tasmania Police. First Class Constable Wotherspoon provided the searchers with background information and informed them of the procedure to be followed if items were found.
76. A coordinated search was conducted between 13 and 17 December 2025 using structured search methodology consistent with recognised incident management principles. Search areas were divided into 50 metre x 50 metre grid squares. Geo-referenced portable document format (PDF) maps were prepared and uploaded to the Avenza mapping application for tracking a walker's movements. Searchers were required to record track logs during their assigned grid searches. These logs were compiled daily to ensure coverage accountability and minimise duplication. Searches were systematically planned and conducted in coordinated lines, to methodically clear 50 metre x 50 metre grid sections using the recorded tracking data.

Discovery of mobile phone handset

77. The private search commenced on Saturday 13 December 2025 and involved about 25 volunteers. A zoned line search was conducted in the last known location of Ms Cremer's phone. The search group progressed from south to north. Amongst the searchers was Mr Anthony Hage, a member of Northwest Search and Rescue.⁶¹ As Mr Hage stepped over a fallen horizontal tree, he observed a blue mobile phone cover partially obscured by leaf matter. Mr Hage photographed the phone in situ and recorded the GPS co-ordinates of the location. In accordance with the agreed protocols, the phone was subsequently transferred into police custody for forensic examination.⁶²
78. First Class Constable Wotherspoon attended the site of the discovery. He noted that the location was within myrtle rainforest, with horizontal scrub adjacent to the location. The phone was a mauve coloured Samsung. The IMEI⁶³ matched records held by Tasmania Police linking the mobile phone to Ms Cremer. The phone appeared water damaged, the USB-C port appeared corroded, the screen was delaminating, and condensation was evident in the camera lenses. A

⁶¹ A division of Tasmania State Emergency Service (SES).

⁶² C33 Affidavit of Kenneth Gamble.

⁶³ International Mobile Equipment Identity; a unique 15 digit number specific to a particular mobile device.

subsequent fingerprint examination of the phone failed to detect any fingerprints.⁶⁴ The phone was sent to Victoria Police to try to extract relevant data.

79. Following the discovery of the phone, the formal police search was reactivated. Tasmania Police and State Emergency Service personnel joined the independent search effort and worked collaboratively by providing advice and personnel to assist with the coordinated grid search.
80. Due to extreme weather conditions forecast for 14 December 2025, searching was suspended. The search resumed on 15 December 2025.
81. During the search a glass bottle, a small black plastic bag and a large black plastic bag which appeared to have been cut, (possibly to create a makeshift poncho) were located. The location of the items was recorded and photographed and the items seized for forensic testing.
82. The IFW Global search was suspended at the conclusion of searching on 17 December 2025, pending the outcome of the forensic testing of the located items.

DNA results of items located in private search

83. A DNA profile was obtained from a swab from the steering wheel of Ms Cremer's recovered car. The profile was compared to a DNA sample obtained from Ariane Mathieu, the mother of Céline Cremer. The results provided very strong support that the major profile from the steering wheel originated from a child of Ariane Mathieu. This DNA profile was used by scientists as a reference sample for Céline Cremer.⁶⁵
84. DNA testing of the glass bottle did not detect Ms Cremer's DNA. A male profile was recovered from the thread and opening of the bottle.⁶⁶
85. Swabs were taken from the outer and inner surfaces of both plastic bags as well as areas near the knots on each of the bags and submitted for DNA analysis. A swab of the outer surface of the large plastic bag contained a mixed profile from

⁶⁴ C38 Affidavit of First Class Constable Dean Wotherspoon.

⁶⁵ C5 Forensic Biology Report of Jane Devenish-Mearns and Rebecca Wilson. I accept Ms Devenish-Mearns as an expert biology examiner and Ms Wilson as an expert in the field of DNA science.

⁶⁶ C38 Affidavit of First Class Constable Dean Wotherspoon.

two contributors. Male DNA was detected, but it was inconclusive with regard to female DNA. A full profile for the male was obtained.

86. Only one other result was returned when compared to Ms Cremer's DNA profile. This was on the swab from the areas adjacent to a tear on the smaller of the two black plastic bags. Forensic testing detected three contributors to the DNA profile obtained. Male DNA was detected. The profile was inconclusive in regard to female DNA. The results are 24 times more likely if Ms Cremer contributed to the DNA than if she did not (and an unrelated female did). Caution must be taken in respect of these results. These represent a very low statistical weighting. For context, the results mean that over 23,000 people in Tasmania could not be excluded from the result.⁶⁷
87. First Class Constable Wotherspoon sought clarification of these results from Forensic Science Service Tasmania (FSST). He was advised that the profile came from a very small amount of DNA and it had multiple people contributing to it; profiles at that level, particularly with multiple contributors can be unreliable and a lot of information was missing from the profile (due to the very small amounts of DNA) and some parts of the DNA was shared between contributors.⁶⁸
88. Consequently, the results of the DNA profile obtained from the swab of the areas adjacent to a tear on the smaller of the two black plastic bags have very limited evidentiary value.

Extent of private search operations

89. A total of 141.5 grid squares of 50 metre x 50 metre⁶⁹ were searched between 13 and 17 December 2025. Mr Gamble described the terrain as mostly sloping and at times very steep rainforest, which often included thick areas of dense tangled fallen trees and thick horizontal growth. Plans were made for further searches on both sides of the Arthur River to take place in early 2026.
90. Thereafter, a number of individuals and small groups conducted sporadic private searches concentrating on the area between the water race and Arthur River.

⁶⁷ C38 Affidavit of First Class Constable Dean Wotherspoon; C5 FSST report.

⁶⁸ C38 Affidavit of First Class Constable Dean Wotherspoon.

⁶⁹ Approximately 35 hectares.

Discovery of unidentified human remains

91. On 28 January 2026, Jarrod Boys attended Philosopher Falls to conduct an independent search of the area. Mr Boys had conducted a number of previous searches of the area and had also been selected to join the IFW Global search in December 2025.
92. Mr Boys departed the Philosopher Falls carpark, followed the track and continued onto the water race. Acting on a theory that Ms Cremer had descended a gully, crossed the water race and reached the Arthur River, he followed that route to the river. He intended to look at the log jams⁷⁰ along the river and the banks on each side.⁷¹
93. At one point, Mr Boys stopped briefly and looked down. Approximately one metre from his feet, he observed what he believed to be a human lower jaw, which was mostly intact but was missing a number of teeth. He observed that the bone was smooth and not too weathered. Located nearby was a long slender bone.
94. Mr Boys took photos of the bones and left them in situ. He ran back to the carpark and reported the discovery to Tasmania Police and IFW Global.
95. The photographs were forwarded to the State Forensic Pathologist, Dr Andrew Reid, who confirmed that the remains were human. As a result, First Class Constable Wotherspoon made arrangements to be flown into the location by rescue helicopter. First Class Constable Wotherspoon and other officers attended the scene at 2.30pm that day.
96. The location was approximately 2.8 kilometres downstream of Philosopher Falls river right⁷² and was a steep bank, with river left being a flat area of rocks and shale. River flow was very low at the time of attendance.
97. Further searching located a long narrow bone situated river left and about two metres upstream from the lower jaw. It was just above the water's edge. Both bones were weathered and appeared to have been in that position for some time. The lower jaw was partly adhered to the river silt. Five teeth remained in the

⁷⁰ A "log jam" is a mass of logs forming a wedge across a current, behind which logs are trapped.

⁷¹ C32 Affidavit of Jarrod Boys

⁷² The terms river right and river left describe the sides of the river relative to the direction of flow: C38 Affidavit of First Class Constable Dean Wotherspoon.

lower jaw. These bones were later identified as a human left radius and mandible.

98. Approximately 10 metres further downstream and just above a log jam/strainer⁷³ was another long bone, which was later identified as a human left ulna.
99. Approximately eight metres further downstream, just above the log jam/strainer, was another long bone, approximately mid-stream. The bone was later identified as a human right humerus.
100. Additional searching recovered a long narrow sliver of what appeared to be bone located partially under a rock, midstream about 20 metres upstream from the mandible location. This bone was later identified as having features of a human fibula.
101. About 12 metres further upstream on an island of small rocks, mid-stream and partly covered by rocks and debris were two long bones. These were later identified as a human right femur and right tibia.
102. All items were photographed in situ and collected and packaged in accordance with recognised forensic protocols. The items were then flown to the Waratah football oval where they were transferred to the mortuary ambulance for transport to the mortuary for forensic examination.⁷⁴
103. On 30 January 2026 First Class Constable Wotherspoon led a group of five additional Police Search and Rescue personnel into the area. The officers entered the Arthur River downstream from the previous location and commenced searching upstream. The search area was a 2.5 kilometre stretch of the Arthur River. At the time water flow was very low and there were a number of significant log jams/strainers.
104. During the search the following items were located:
 - a jacket partially buried in a log jam;
 - two human spinal column vertebrae and human sacrum on the riverbank above the current water level;

⁷³ A log strainer is an obstruction in a river that allows water to pass through it but can trap larger objects. In this instance they were natural and made from fallen timber: C38 Affidavit of First Class Constable Dean Wotherspoon.

⁷⁴ C38 Affidavit of First Class Constable Dean Wotherspoon.

- a bra partially buried in a log jam;
- part of a human pelvis and long sleeve top located centrally in the river. The top had been snagged on sticks and the bone was on the riverbed, within debris; and
- human skull located high in a log jam.

105. The base of the skull was quite fragile. The maxilla contained four teeth but was attached to the skull by vegetation. Upon moving, the maxilla broke away.
106. All items were located within a 350 metres section of the river. The skull was the only item located upstream of the original site and relatively close to the femur and tibia.
107. All items were recovered, seized, packaged and labelled in accordance with the usual police protocols. The unidentified human remains were transferred to the Mortuary Ambulance driver at the Philosopher Falls car park that evening.
108. First Class Constable Wotherspoon noted that the northern side (river left) of the river in the upstream reach was very steep for about 500 metres from the site where the human skull was located. The searchers formed the view that this area was the most probable location that the source body entered the water.
109. On 31 January 2026 First Class Constable Wotherspoon again led a team of five additional Police Search and Rescue personnel in the Arthur River area, returning to the location of the previous days' search. The team commenced searching downstream, however no further human remains were recovered.⁷⁵
110. Subsequent forensic examinations were conducted on the clothing. Of relevance, it was ascertained that the jacket that had been recovered was a tan coloured (although now discoloured) polar fleece pullover with a half zip and hand warmer pockets. A tag indicated that it was "Shein" brand, and a small size.⁷⁶ Due to their prolonged exposure to the elements, these items were not forwarded to FSST for examination.

⁷⁵ C38 Affidavit of First Class Constable Dean Wotherspoon.

⁷⁶ EU 36, US4.

111. The colours and material of the jacket was consistent with the mid layer of clothing worn under a large jacket by Ms Cremer, as seen in the CCTV footage from the Waratah Roadhouse on 17 June 2023.⁷⁷
112. On 8 and 9 February 2026, First Class Constable Wotherspoon led a team of six additional police Search and Rescue personnel and two Ambulance Tasmania wilderness paramedics on a detailed search of the 350 metres section of the Arthur River, in which the previous human remains and clothing had been located.
113. Searching required in water searching, up to waist deep and included the use of bathyscopes (an underwater viewer). The search included raking the leaf litter and other debris which had accumulated on the riverbed and then searching it on the riverbank. Searching was then conducted of the cleared riverbed, which resulted in the detection of additional bones at the original site.
114. Some removal of soil and vegetation occurred at various suitable locations, resulting in the discovery of additional vertebrae near the site that the jacket had been found.
115. For maximum search effectiveness, riverbed searches were conducted from downstream, progressing upstream. This approach allowed personnel to search into clear water, with any disturbed silt and debris flowing into areas that had already been searched.
116. Three distinct river flow levels were detected at the site: the current flow, which was very low; a minor flood level a short height above the current level and a major flood level which was evident higher up the banks. It was not possible to ascertain when the most recent flooding event had occurred, however searching was conducted up to the highest observable flood level.
117. During the search the following items were located:
- Vertebra located near where the jacket was found;
 - A small bone located at the skull location;
 - Two teeth located under the skull location;

⁷⁷ C38 Affidavit of First Class Constable Dean Wotherspoon.

- Humerus located near the original site (exposed after raking debris on the riverbed);
- Right clavicle (also exposed after raking debris on the riverbed);
- Long bone (also exposed after raking debris on the riverbed); and
- Honda key and tags (including a rectangular Supercheap Autos tag) located between the original site and where the femur and skull were located.⁷⁸

118. First Class Constable Wotherspoon later plotted the location of some of the items onto a map.⁷⁹

119. First Class Constable Wotherspoon's map is set out below.

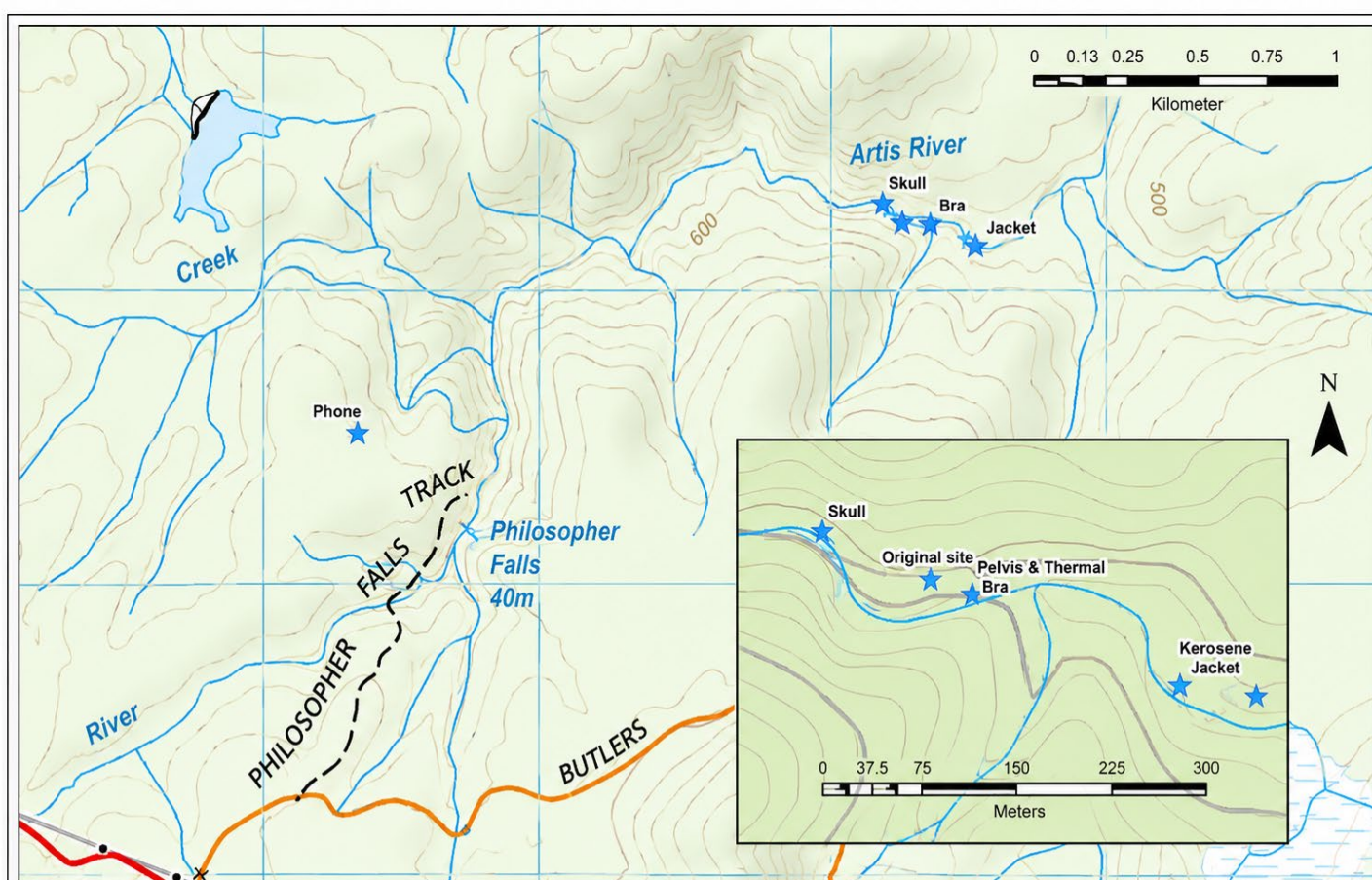


Figure X. Topographic map showing Philosopher Falls, the walking track, and locations of items located during the search.

Source: Tasmania Police – Map provided in exhibit

⁷⁸ C38 Affidavit of First Class Constable Dean Wotherspoon.

⁷⁹ Ibid – Figure X Topographic map showing Philosopher Falls, the walking track and locations items located during the search.

120. The unidentified human remains were transferred to the Mortuary Ambulance at the Waratah Football oval on 9 February 2026.
121. The Honda key was transferred to the Ulverstone police station where it was checked in the locks and ignition of Ms Cremer's car. The key was confirmed as fitting the car.
122. Of note, a still CCTV image taken of Ms Cremer at the Waratah Roadhouse shows her holding car keys with the Supercheap Autos rectangular tag visible.⁸⁰

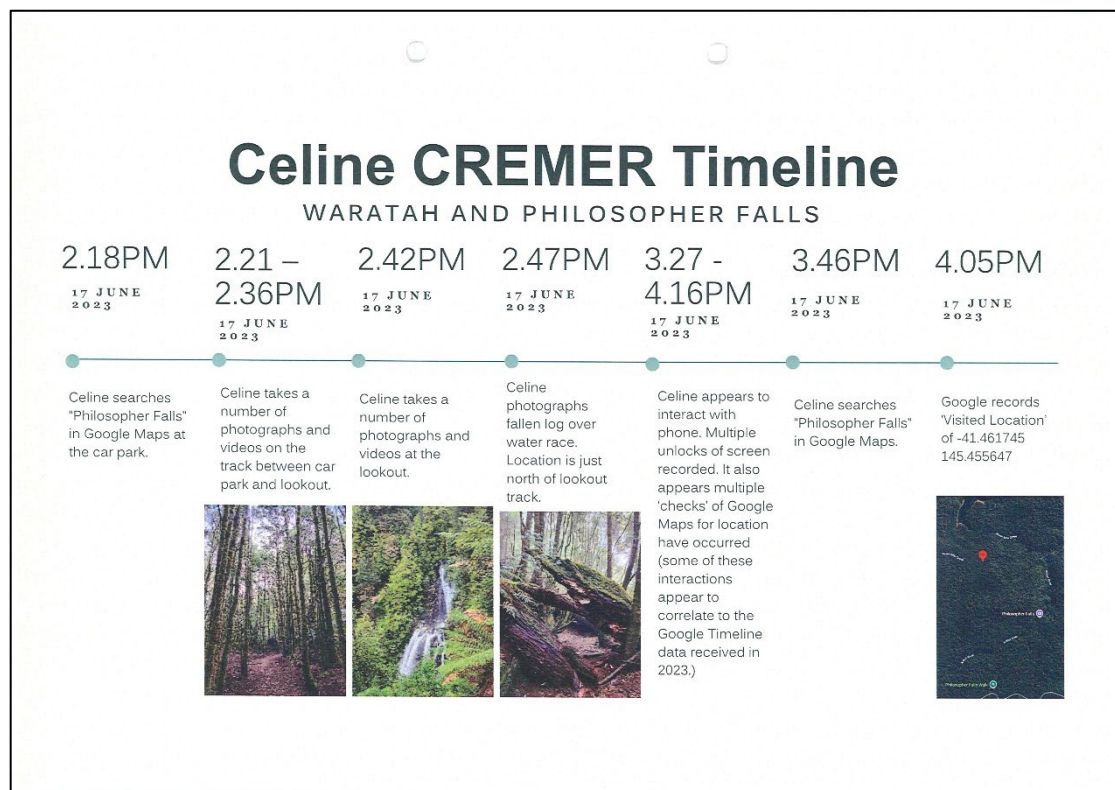
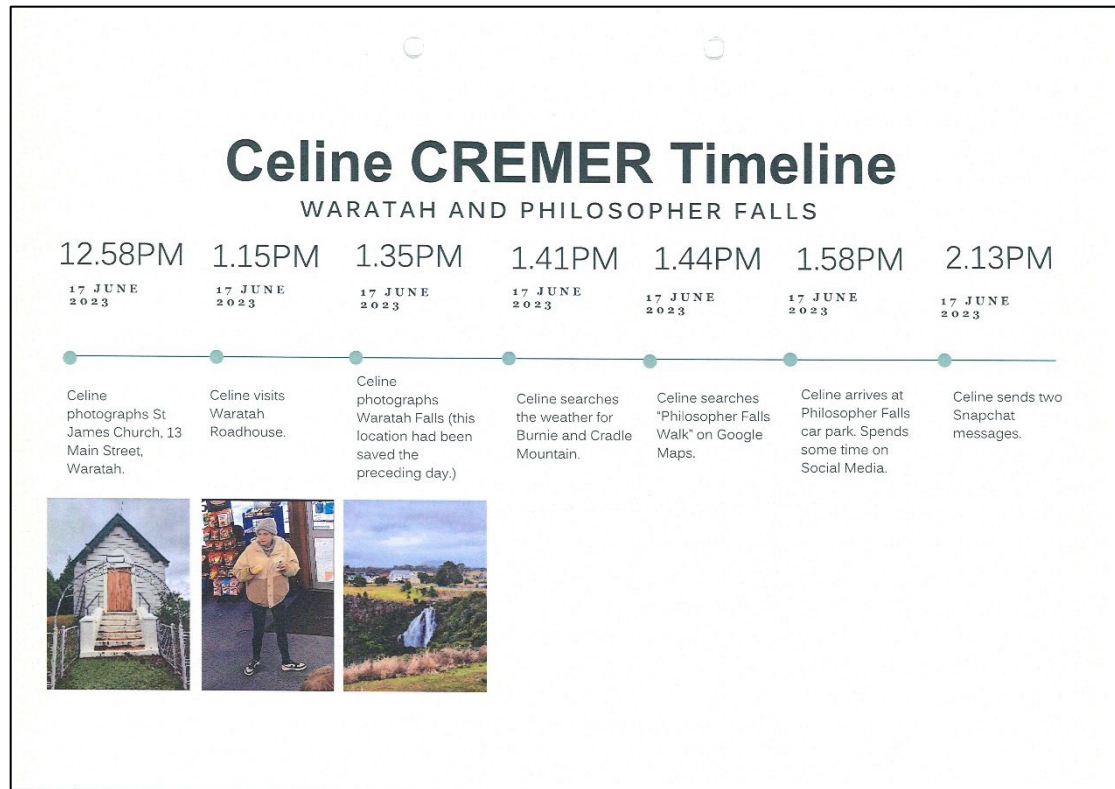
Data extracted from mobile phone

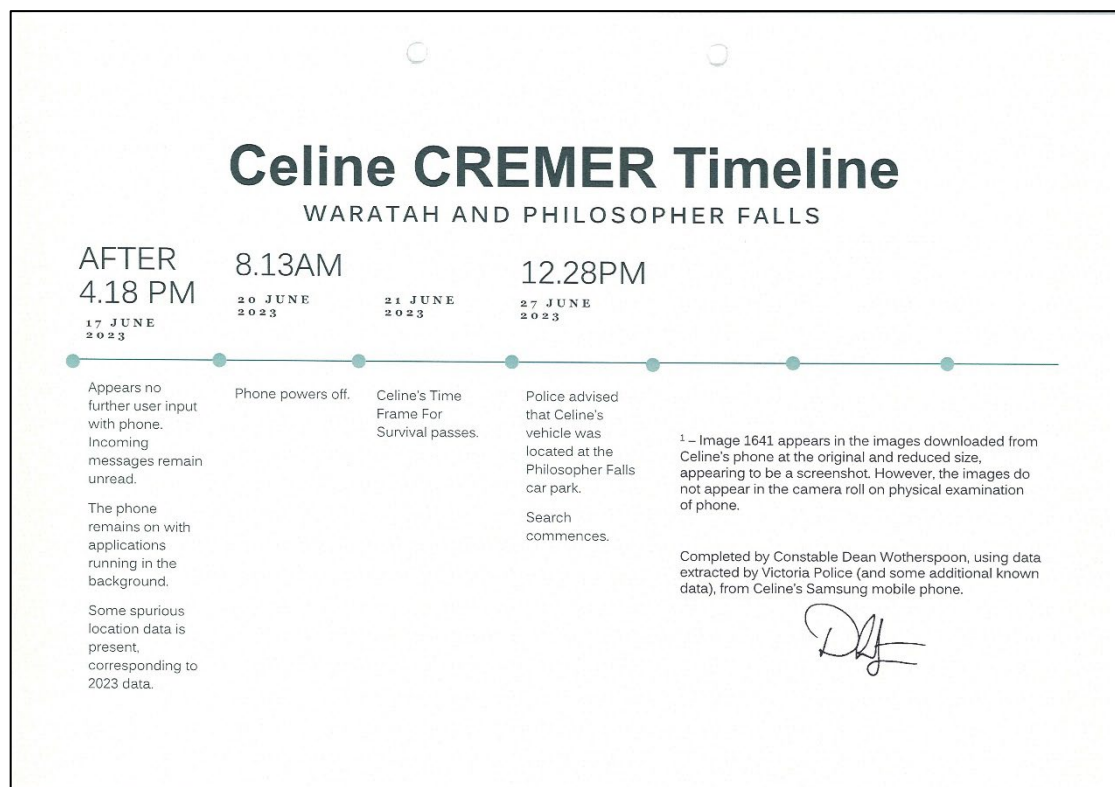
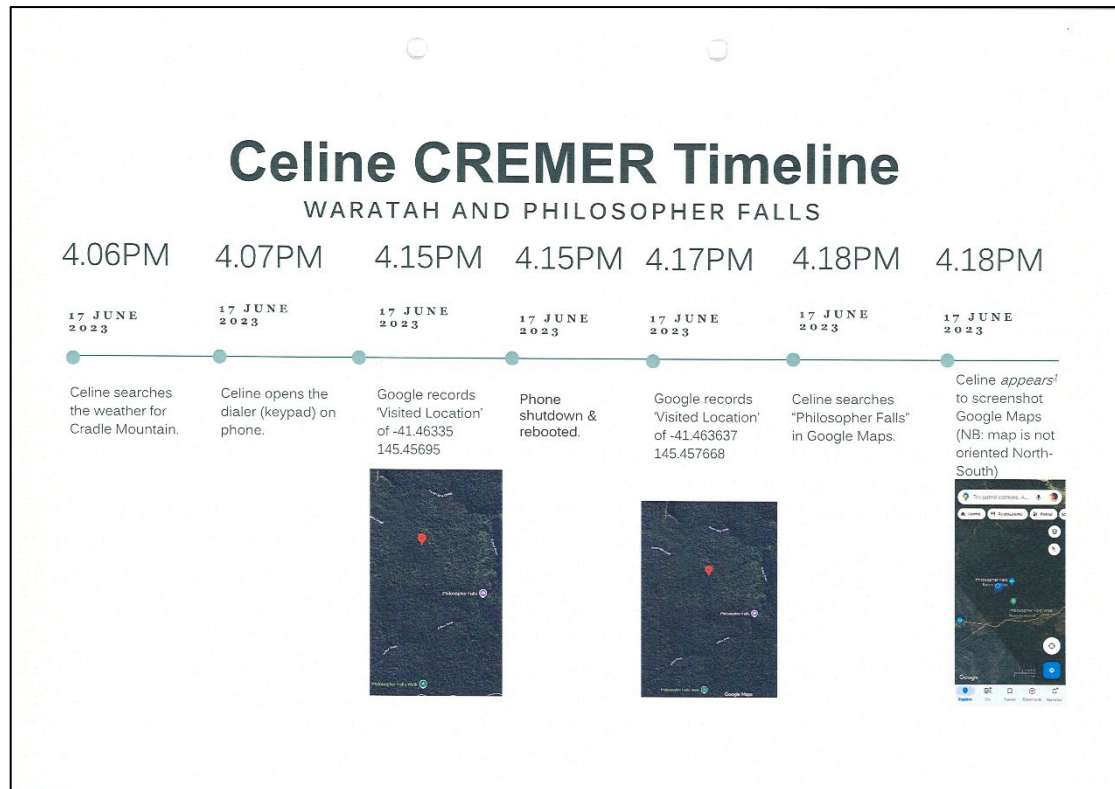
123. Owing to the condition of the mobile phone when it was recovered, it was sent to Victoria Police to undertake the necessary repairs to enable attempts to extract the phone's data using the forensic software platforms Magnet Axiom and Cellebrite. These platforms are capable of accessing smartphone data including text messages, call logs, application data, location history, photos, browser history and, where possible, social media application data.
124. On 4 March 2026, First Class Constable Wotherspoon was provided the login details to a cloud-based storage system containing data generated from the digital forensic examinations of Ms Cremer's phone.
125. Focusing on data from 17 June 2023, First Class Constable Wotherspoon created a timeline of Ms Cremer's movements, cross referenced against other known information (for example, her attendance at the Waratah Roadhouse).
126. Relevant information extracted from the device included the following:
 - At 1.44pm Ms Cremer searched "*Philosopher Falls walk*" in Google Maps.
 - At 1.58pm Ms Cremer arrived at Philosopher Falls car park.
 - At 2.18pm Ms Cremer searched "*Philosopher Falls*" in Google Maps at the car park.

⁸⁰ C38 Affidavit of First Class Constable Dean Wotherspoon.

- Between 2.21pm and 2.42pm Ms Cremer took a number of photos and videos between the car park and lookout, including at the lookout.
- At 2.47pm Ms Cremer photographed a fallen log over the water race. (During a subsequent search, this tree was identified as being located about 25 metres north of the stairs to the Philosopher Falls lookout).
- At 4.07pm the keypad appears to have been opened in an area of limited mobile phone coverage.
- At 4.15pm the phone is shut down and rebooted.
- Between 3.27pm and 4.18pm there is evidence that the screen was unlocked multiple times and that there were multiple checks of Google Maps for location.
- “*Philosopher Falls*” had been searched in Google Maps at 3.46pm and 4.18pm.
- The latitude and longitude at three “*visited*” locations was recorded on the device.
- There appears to be no further user input after 4.18pm on 17 June 2023.
- The phone powered off at 8.13am on 20 June 2023.

127. Below is the timeline prepared by First Class Constable Dean Wotherspoon.





128. On 8 March 2026 First Class Constable Wotherspoon led a small team of Police Search and Rescue personnel back to the Philosopher Falls and Arthur River. The purpose of which was, inter alia, to map the location of the log jams along the Arthur River between Philosopher Falls and the area previously subject to detailed searches on 8 and 9 February 2026, and to assess the previous hypothesis regarding the location at which Ms Cremer may have entered the water.
129. The coordinates of every log jam between the falls and the skull location, of which there were 27, and an additional four log jams below the skull location and lower search boundary were recorded and plotted onto a map.
130. First Class Constable Wotherspoon hypothesised that Ms Cremer had accidentally entered the river a relatively short distance upstream from the skull location due to the number of log jams in the river above that point and the topography. First Class Constable Wotherspoon noted that at the time of his visit, the water flow was approximately 30ML/day (measured at the Hellyer River site). He further observed that between 20 and 24 June 2023 the flow varied from 1200ML/day decreasing to 600ML/day, which would likely have prevented safe access to the riverbed. The searchers found that it was relatively straight forward to travel through the rain forest adjacent to the river, keeping it in sight and using it as a navigational aid. This continued to be the case until a point about 250 metres upstream from the skull site. At that point the topography and vegetation significantly hampered progress and funnelled a walker down towards the river, where the banks were steep and slippery.
131. First Class Constable Wotherspoon also carried out a number of other investigations. These included searching the contents of Ms Cremer's car. Relevant findings included:
- A green and black backpack was on the front seat. This was identified to be of similar appearance to a backpack worn by Ms Cremer in a photograph on her phone.
 - A good quality Gore-Tex raincoat suitable for wet weather conditions was located inside the car.
 - Several items of "*Shein*" branded clothing was recovered from the vehicle.
 - A roll of purple coloured kitchen tidy (plastic) bags was recovered. No plastic bags consistent with those found by searchers on 16 December 2025 were located.

- A Supercheap Auto membership card was located. This had the same membership number as the membership tag recovered with the set of car keys from the Arthur River on 9 February 2026.
- Of note, there was no outer jacket or Nike skate shoes consistent with those seen in the CCTV from the Waratah Roadhouse.
- There were also no empty Mount Ossa glass water bottles in the car.

132. A file was then prepared for the Coroner.

THE ROLE OF THE CORONER

133. In Tasmania a coroner has jurisdiction⁸² to investigate a death if it appears to the coroner that the death is or may be a reportable death.⁸³
134. A reportable death is defined in s3 of the *Coroners Act* 1995 (Tas), (the Act) and includes a death that occurred in Tasmania, being a death that appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury.⁸⁴
135. The coroner's role under the Act in investigating any reportable death is inquisitorial. A coroner must investigate the death and determine the matters required by s28(1) of the Act.⁸⁵ Those matters include the identity of the deceased, how the deceased died, the cause of death and when and where the deceased died.
136. The phrases "*how death occurred*" and "*the cause of death*" were considered in *Re State Coroner; Ex parte Minister for Health* [2009] WASCA 165. The court was considering s25(1) of the *Coroners Act* 1996 (WA) which is virtually identical to s28(1) of the Act.
137. Buss JA, with whom Martin CJ and Miller JA agreed, analysed s25 (1)(b) and (c) in the following terms:

40 The dictionary meaning of the expression '*how death occurred*' is in what way or manner or by what means the death happened or took place. See The Macquarie Dictionary (4th ed, 2005) 694; The Shorter Oxford English Dictionary (5th ed, 2002) 1279.

41 However, '*how death occurred*' in s25(1)(b) of the Act must be construed not merely by reference to its dictionary meaning, but also in the context of the other provisions of s25(1) and the Act as a whole. For example, the Parliament plainly intended that a finding of '*how death occurred*' within s25(1)(b) would be different from a finding of '*the cause of death*' within s25(1)(c).

⁸² Annexure A.

⁸³ Section 21(1).

⁸⁴ Annexure B.

⁸⁵ Annexure C.

42 In my opinion, s25(1)(b) confers on the coroner the jurisdiction and obligation to find, if possible, the manner in which the deceased happened to die. This does not refer only to the means or mechanism by which the death was suffered or inflicted. It extends to the circumstances attending the death. In my opinion, a construction of s25(1)(b) which entitles and requires the coroner to find, if possible, by what means and in what circumstances the death occurred reflects the public interest which is protected and advanced by a coronial investigation (especially an investigation into deaths where one or more of the conditions of s22(1) of the Act are satisfied).

138. Buss JA then considered the phrase “*cause of death*” at [44]- [47]:

44 The coroner, in finding, if possible, ‘*the cause of death*’, is not confined or restricted by concepts such as ‘*direct cause*’, ‘*direct or natural cause*’ ‘*proximate cause*’ or the ‘*real or effective cause*’. Similarly, a coroner is not confined or restricted to a cause that was reasonably foreseeable. See *WRB Transport v Chivell* [1998] SASC 7002; (1998) LSJS 102 [20] (Lander J, Mullighan J agreeing).

45 In *WRB Transport*, Lander J said, in the course of considering the coroner’s jurisdiction under s12 of the *Coroners Act* 1975 (SA) to ascertain ‘*the cause or circumstances of the ...death of any person...*’:

The Coroner... has to carry out an inquiry into the facts surrounding the death of the deceased to determine what, as a matter of common sense, has been the cause of that person’s death. The inquiry will not be limited to those facts which are immediately proximate in time to the deceased’s death. Some of the events immediately proximate in time to the death of the deceased will be relevant to determine the cause of the death of the deceased. But there will be other facts less proximate in time which will be seen to operate, in some fact situations, as a cause of the death of the deceased. That is a factual inquiry which only has, as its boundaries, common sense [21].

His Honour added that the coroner’s jurisdiction to determine the cause of a deceased’s death is in addition to his or her jurisdiction to determine the circumstances of the deceased’s death [22]- [25].

See also *Saraf v Johns* [2008] SASC 166; (2008) 101 SASR 87 [18] – [19] (Debelle J).

46 Section 25(1)(c) does not, however authorise a coroner to undertake a Roving Commission for the purpose of inquiring into any possible causal connection, no matter how tenuous, between an act, omission or circumstance on the one hand and the death of the deceased on the other. See *R v Doogan; Ex parte Lucas-Smith* [2005] ACTSC 74; (2005) 193 FLR 239 (28) (Higgins CJ, Crispin & Bennett JJ).

47 It will be necessary, in any inquest, to delineate those acts, omissions and circumstances which are, at least potentially, to be characterised as causing or a cause of the death of the deceased. This is to be undertaken by applying ordinary common sense and experience to the facts of the particular case. See *March v E & MH Stramare Pty Ltd* [1991] HCA 12; (1991) 171 CLR 506, 515 (Mason CJ), 522 (Deane J); *WRB Transport* [21]; *Saraf* [18]- [19]; *Doogan* [29].

139. The purpose of a coronial investigation is to establish facts, not to cast blame or determine criminal or civil liability. A coroner is expressly precluded from including in their finding any statement or comment that a person is or may be guilty of an offence.⁸⁶

Recommendations and comments

140. The role of the coroner is also critical in identifying matters contributing to or connected with any individual death with a view to making comments and recommendations that would prevent the recurrence of similar deaths or accidents in the future. However, there should be a clear nexus between the comments or recommendations made and the circumstances surrounding the death into which the coroner inquires.⁸⁷ Section 28 of the Act sets out these important functions as follows:

⁸⁶ Section 28(4), *Coroners Act* 1995.

⁸⁷ Ian R Freckelton, *Death Investigation and the Coroner's Inquest* (Oxford University Press, 2006) p619-620.

- (2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.
- (3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.

The standard of proof

141. All coronial findings must be based on proof of relevant facts on the balance of probabilities, and, in determining those matters, the principles enunciated in *Briginshaw v Briginshaw* apply: *Mortimer v Coroners Court of Victoria* [2022] VSC 437 at [89].

DETERMINATION OF THE IDENTITY OF THE DECEASED

142. For identification purposes a multidisciplinary approach was undertaken involving several joint post-mortem examinations by the State Forensic Pathologist and specialists employed by Statewide Forensic Medical Services in forensic anthropology, forensic odontology, forensic pathology and DNA analysis.

Forensic Anthropology

143. Dr Callan Birkmann-Little,⁸⁸ is a Forensic Anthropologist employed by Statewide Forensic Services. Dr Birkmann-Little has a Bachelor of Science (Anatomy and Histology) and Bachelor of Arts (Archaeology) from the University of Sydney and a Doctor of Philosophy (PhD) in Forensic Anthropology from the University of Sydney.

144. Dr Birkmann-Little commenced practice as a forensic anthropologist in 2024, prior to this he assisted the State Forensic Anthropologist (NSW) on case work between 2016-2021. Dr Birkmann-Little provides anthropology services to various agencies. He is a member of the Australian and New Zealand Forensic Science Society (ANZFSS) Tasmania branch, and a member of Australasian Society for Human Biology (ASHB). Dr Birkmann-Little has taught anatomy at University of Tasmania and The University of Sydney.

⁸⁸ C3 Report of Dr Birkmann-Little.

145. I accept Dr Birkmann-Little as an expert who is suitably qualified to give opinion evidence about forensic anthropology.

146. Dr Birkmann-Little received three batches of unidentified human remains which had been found during three separate searches of the Arthur River location and which, due to the conditions of the remains, the individual was not visually identifiable. He examined the remains and confirmed that they were human. The remains were identified as follows:

Batch 1

- mandible
- right humerus
- left ulna
- left radius
- right femur
- right tibia

Batch 2

- 1st, 2nd lumbar vertebra
- 5th lumbar vertebra
- Right innominate
- Skull (damaged)

Batch 3

- 12th thoracic/1st lumbar vertebra
- Zygomatic (fragment)
- Left humerus
- Right clavicle
- 2 loose teeth

147. In addition, two long bone shaft fragments were also recovered. Dr Birkmann-Little was of the opinion that each of these shafts, were most likely fibula based on their morphology. Due to the circumstances of recovery, namely their association with other remains, and their condition, he considered it most likely that they were human and formed part of the same set of remains. He observed that the majority of the remains had a dark brown material (a muddy like substance) adhered to them, mainly around the articular surfaces. A decision was made not to clean or remove any material in case soft tissue had been preserved in these areas.

148. Dr Birkmann-Little examined the cranial bones (comprising skull, mandible and zygomatic bone). He made the following observations of the skull:

“The skull recovered was heavily damaged with minimal facial bones and no base remaining. A fragment of the maxilla was recovered containing teeth and a fragment of a zygomatic bone was also recovered. These were not attached to the skull when it was analysed. The cranial vault including the frontal bone, both parietal bones and the occipital bone was intact. The temporal bones were loosely attached but were damaged. The skull appeared stained, mainly around the occipital bone, with a fair amount of mud and sediment adhered to it, this is consistent with the location it was found. The damage appeared to be postmortem.

Many cranial features were either missing or damaged rendering any possible assessment of them impossible, e.g. the mastoid processes were broken off.

The occipital bone retained the nuchal region which appeared gracile and no prominent external occipital protuberance was present. The frontal bone retained the superior orbital margins which were sharp and supraorbital ridges which were gracile with no prominent glabella present. These features suggest that the skull was that of a female. The coronal, sagittal and lambdoid sutures were intact and fused but did not show any signs of obliteration suggesting the individual was not elderly but the individual was of adult age.”

149. Dr Birkmann-Little observed that the mandible was largely intact, appearing predominately white with areas of dark brown staining and green staining on the internal surface, most likely due to algal growth. Both left and right condyles and coronoid processes were absent, with evidence of damage to some areas, which appeared to be postmortem.

150. The gonial angle could not be accurately measured due to damage.

151. He further observed:

“The mandible had a slight “rocker jaw” characteristic and the chin, although prominent, was not square but tended towards a rounder profile. These non-metric traits suggest the mandible may be from a female individual.”

152. Dr Birkmann-Little identified a fragment of bone as being a part of the skull, a fragment of the zygomatic bone. The fragment was heavily damaged, with the damage appearing to be postmortem in nature. It was stained brown in parts with mud adhering to portions of its surface.
153. Dr Birkmann-Little also examined the postcranial skeleton. He observed evidence of similar weathering and staining on many of the bones. The humerus, in particular, was heavily caked with dark brown material which he considered most likely to be mud or sediment. Due to the potential of it being soft tissue, it was not removed. The same dark brown material encapsulated the proximal end of the ulna, while the distal end of the femur was heavily embedded with the same material. Other bones exhibited varying degrees of brown staining, while two lumbar vertebrae recovered in the second batch, together with the sacrum appeared weathered with green moss-like staining.
154. Damage was evident to many of the bones including the humerus, femur, tibia, clavicle and vertebrae. This damage was assessed as postmortem, likely resulting from environmental weathering and/or animal predation.
155. Dr Birkmann-Little examined the humerus, radius, ulna, femur and tibia for evidence of epiphyses, a biological marker for biological age and skeletal maturity. In each case there was evidence that the epiphysis was fused suggesting the individual was above the age of 20-23 years.
156. Dr Birkmann-Little took measurements of the right human humerus but considered that the maximum length and maximum head diameter measurements may have been impacted by the dark brown material. Humeral head diameter has been reported as a reliable method to estimate sex. Dr Birkmann-Little was of the view that the measurements taken provided evidence that it is likely that the humerus belonged to a female.
157. He also observed that the left radius and ulna were able to be aligned together and he determined them to be a match.
158. Dr Birkmann-Little examined the right innominate bone and sacrum. He observed that the innominate was damaged, with the pubic bone largely missing, no rami or pubic symphysis present, a large hole in the iliac blade and a portion of acetabulum missing.

159. He stated:

"The greater sciatic notch was intact and appeared wide with a "U" shape. The overall innominate also appears to have a fairly wide pelvic inlet with the iliac blade showing a wider profile. These features are consistent with a female pelvis. The anterior iliac crest showed signs of incomplete fusion, however this may have been exaggerated by the weathering of the bone around this area. This suggests that the individual was not elderly but a younger adult. Anterior iliac crest is usually close to complete fusion around the age of 23 years.

The sacrum was determined as a human sacrum. It was heavily damaged with the left ala and lower sacral bodies missing... The right ala showed signs of damage with partial damage to the auricular surface...The right auricular surface was matched to the right innominate and appeared to match however due to damage on the sacrum and the dark brown material on the innominate a match could not be completely confirmed. The overall shape of the sacrum, when held in anatomical position appeared to have slight curvature but not overall pronounced, consistent with a female sacrum."

160. Dr Birkmann-Little concluded as follows:

"Based on these observations, the similar patterns of weathering and staining and the location of where the remains were found, it is strongly suggested that all bones found belong to the same individual.

The unknown human remains appear to be from a single individual who is female of adult age but not elderly.

The adult age of the individual is established from the fusion of the epiphyses of the long bones and sutures of the skull. The not elderly status is established from the lack of any obvious osteo-arthritis evidence in the postcranial skeleton and the non-obliteration of the cranial sutures.

The female sex of the remains is established from various features found on the bones. The skull showed gracile features in the nuchal region, supraorbital ridges and sharp superior orbital margins. The

innominate bone showed a wide “U” shaped greater sciatic notch and wide/broad profile.

The measurements of the long bones recovered may not provide accurate results due to the impact of dark material in places. It is determined, however, that the humeral head diameter of 38.7mm, likely to indicate a female, would not be negatively impacted from the material.”

161. I accept Dr Birkmann-Little’s expert opinion that the remains are human and appear to be from a single individual who is female, of adult age but not elderly.

Forensic Odontology

162. Dr Cailin Davies is a Forensic Odontology officer employed by Statewide Forensic Medical Services. Dr Davies has a Bachelor of Dental Surgery from James Cook University and a Master of Forensic Medicine - Specialisation Forensic Odontology (MForMed) from Monash University.
163. Dr Davies practiced as a public dental officer from 2017, began Forensic Odontology practice in 2022, and qualified in 2024. Dr Davies sits on the Medical Sciences Scientific Advisory Group (ANZPAA-NIFS) as the Tasmanian Representative of the Forensic Odontology Scientific Advisory Group and is Vice President of the Australian Society of Forensic Odontology (AuSFO) and a member of the Australian and New Zealand Forensic Science Society (ANZFSS) of Tasmania.
164. I accept Dr Davies as an expert who is suitably qualified to give opinion evidence about forensic odontology.
165. On 29 January 2026, Dr Davies was asked to examine unidentified human remains and to provide an opinion as to the identity of the individual.
166. The remains included a mandible, skull and maxilla and two teeth. The items had been recovered during three separate searches. Dr Davies was also provided with antemortem dental records belonging to Céline Cremer date of birth 13 June 1992.

167. The antemortem dental records included two bitewing radiographs and one orthopantomogram (OPG) radiograph which had been provided by Dr Philippe Mareschal⁸⁹ of “*Dentius Verviers Dental Clinic*”, Heusy, Belgium.
168. Orthodontists identify specific teeth using standardised numbering systems. The mouth is divided into four quadrants.⁹⁰ The system uses two numbers, the first representing the quadrant and the second representing the specific tooth.⁹¹
169. Pulp stones also known as denticles or pulpal calcifications are discrete radiopaque masses found within the dental pulp chamber or root canals. Due to their idiosyncratic patterns, size, number and location in individuals they serve as a valuable marker in identification.⁹²
170. The antemortem records and radiographs revealed a number of relevant features. These included:
- The presence of pulp stones in the pulp chamber of a number of the teeth, namely teeth 16 (one stone), 26 (one stone) 27 (two stones), 36 (two stones) and 46 (two stones);
 - Impacted and partially developed wisdom teeth (18, 28, 38 and 48) were present on the 2008 OPG radiograph;
 - Teeth 13, 23 and 43 were rotated radiographically;
 - Characteristic crown morphology associated with tooth 37; and
 - Characteristic root anatomy associated with teeth 36 and 37.
171. A complete postmortem examination of the dentition of the remains was conducted over three dates. A number of radiographs were taken for comparison with the antemortem dental records.
172. The early postmortem radiographs of the maxilla and mandible revealed the following relevant features:
- Present teeth: 14, 15, 16, 17, 34, 36, 37, 46, 47;

⁸⁹ Master en Médecine Dentaire U Lg. Dentius Oleg.

⁹⁰ Upper right (1), upper left (2), lower left (3) and lower right (4).

⁹¹ Teeth are numbered 1 to 8 commencing at the front and working towards the back teeth.

⁹² C4 Dr Cailin Davies.

- Missing skeletal maxillary fragment Quadrant 2: i.e. Absent teeth 21, 22, 23, 24, 25, 26, 27 and 28;
- Missing teeth postmortem: 11, 12, 13, 31, 32, 33, 35, 41, 42, 43, 44, 45; Teeth 18, 38 and 48 were not present radiographically (these had been present in 2008); and
- Pulp stones present radiographically associated with teeth; 16 (one pulp stone in the pulp chamber), 36 (two stones in the pulp chamber), 46 (two pulp stones in the pulp chamber).

Subsequently, two further teeth were located in the third search, these were confirmed to be teeth 13 and 27. These teeth were whole with no damage to the teeth or roots. Both teeth had previously been identified as missing from the postmortem radiographs.

173. Radiographs were taken of these teeth, however the postmortem radiograph of tooth 27 was insufficiently clear to enable the presence of pulp stones to be confirmed in that tooth.
174. Dr Davies attempted to relocate the loose teeth. Tooth 13 was unable to be completely relocated into the socket of the maxilla. This was attributed to the postmortem changes of the bone resulting in shrinkage of the bony socket.
175. Due to the lack of maxillary alveolar bone and sockets on Quadrant 2 (which had been sheared off), it was not possible to reposition tooth 27 into its associated socket.
176. Further enquiries were made of Ms Ariane Mathieu, who confirmed that Ms Cremer had had surgery to remove her wisdom teeth. This accounts for the absence of teeth 18, 38 and 48 on the postmortem radiograph.
177. Dr Davies compared the antemortem dental radiographs and the postmortem radiographs. She identified the following significant concordant features:
 - Crown morphology associated with tooth 37;
 - Root anatomy and morphology associated with teeth 36 and 37;
 - The presence of pulpal stones, with the same morphology and number, associated with teeth 16, 36 and 46; and

- Rotation and morphology of sockets associated with rotated canines.

178. Dr Davies concluded that based on this dental comparison identification is established.⁹³ I accept Dr Davies's opinion and find that the dental remains associated with the maxilla and mandible are positively identified as Céline Aline Cremer, date of birth 13 June 1992.
179. Given the technical difficulties associated with imaging, and relocating, individual teeth, Dr Davies was unable to identify the two loose teeth, namely teeth 13 and 27. However, given the location of their discovery in the Arthur River and the fact that they were missing from the recovered remains, I am satisfied that teeth 13 and 27 are those of Céline Aline Cremer.

Forensic Pathology

180. Dr Andrew Reid is a medical practitioner specialising in forensic medicine and pathology. Dr Reid holds the following qualifications: Bachelor of Medical Sciences (Honours), University of Nottingham, 1986; Bachelor of Medicine and Bachelor of Surgery (Honours), University of Nottingham, 1988; Foundation Fellow of the Faculty of Forensic and Legal Medicine, Royal College of Physicians, 2006; Fellow of the Royal College of Pathologists of Australasia in Anatomical Pathology, 2018; and Post Fellowship Diploma of the Royal College of Pathologists of Australasia in Forensic Pathology, 2019.
181. Dr Reid is the State Forensic Pathologist under s17 of the Act and employed in the Tasmania State Service as a Staff Specialist Forensic Pathologist and Director of Statewide Forensic Medical Services. He has practised in pathology since 1990.
182. I accept Dr Reid as an expert who is suitably qualified to give opinion evidence about forensic pathology.
183. Each of the human remains recovered in the three searches was examined by Dr Reid for signs of violence or injury. Dr Reid observed that many of the bones recovered were damaged, disrupted and fractured in multiple places. He noted that the defects and fractures of the skull vault (calvarium) were greater on the

⁹³ Definition of Interpol Dental Identification terms define "established" as "*Absolute certainty that the antemortem and postmortem data are from the same person*".

right side than the left, and the distal right leg bones could have been caused by blunt force trauma associated with head injury and/or trip or slip and fall associated with compound fracture and joint dislocation.⁹⁴

184. However, he reasoned that the nature and degree of the fractures, defects or disruptions could equally have been caused by prolonged water immersion, entrapment by and impacts upon, or from hard rocks, timber and other debris in the river.
185. Dr Reid noted that initial images of the head of the right femur showed appearances that may be associated with osteoarthropathy of bone from an older individual. However, on direct examination, he considered that degradation changes in this and other bones were probably caused by a combination of postmortem trauma and environmental conditions. He concluded that the nature of the recovered bones away from the joint surfaces corresponds to those of a younger individual.
186. Dr Reid's examination revealed no evidence of sharp force trauma and none of the bones showed features of projectile injury.
187. Dr Reid reported that the innominate bone was recovered from a shallow pool of water in the riverbed and noted that there was evidence of postmortem animal predation to it, the features of which would correspond to either a small mammal/rodent activity or aquatic animal activity by insect larvae or crustaceans.
188. Specimens from an area of the innominate bone and possible soft tissue were identified, sampled and submitted to FSST for DNA extraction, and comparative profile analysis.
189. Dr Reid was unable to determine a cause of death. However, he expressed his opinion that the differential diagnoses for cause of death, based on the circumstantial and other evidence include:
 - Hypothermia with or without previous trauma;
 - Trauma;
 - Drowning, with or without hypothermia and/or previous trauma or

⁹⁴ C2 Report of State Forensic Pathologist.

- Any of the above associated with assault by a third-party or other third-party involvement.

190. Dr Reid maintained that there was no evidence from the nature and pattern of the fractures and other abnormalities to suggest an assault by blunt force trauma inflicted by a third party with a blunt instrument or otherwise.

191. Dr Reid provided the following explanation:

“The fractures and other defects and disruptions were, by definition, caused by blunt force trauma. However, the topographical and circumstantial evidence from the vicinity in which the searches were conducted and the remains recovered is such that the fractures and damage to the skull and other skeletal bones could equally have been caused by post-mortem artefactual “injury”. This could be due to the missing person or body entering the river and then subjected to blunt force inflicted by impacts against or from hard surfaces in the environment such as rocks, wooden trunks, branches and other materials, within or along the course of the river. The body and subsequent disrupted human remains were probably subject to such forces for over 18 months (approximately) between sometime after the person went missing in June 2023 and when the remains were recently discovered.

Further disruption and distribution of human remains will have been caused by a combination of decomposition, river currents and possible post-mortem animal predation, including by freshwater crustaceans.”

192. Dr Reid provided the following explanation in relation to hypothermia:

“If the unknown cause of death was associated with hypothermia, then often there is paradoxical undressing in which clothes are inappropriately shed preceding death. It is not possible to determine whether this occurred in this case. It is equally possible that the person was immersed in the river fully clothed due to an accidental trip or slip and fall, with or without skeletal trauma or head injury. Such a mechanism might have been immediately and intrinsically fatal. Equally, non-fatal injuries might have been followed by drowning.”

Forensic examination and DNA identification of human remains

193. Jane Devenish-Meares is a Forensic Scientist employed by FSST. Ms Devenish-Meares holds a Bachelor of Biological Science. She is an experienced forensic biologist with 25 years' experience in crime scene investigation, examination of evidence and the interpretation and statistical evaluation of DNA profiles.
194. I accept Ms Devenish-Meares as an expert who is suitably qualified to give opinion evidence about forensic biology.
195. Rebecca Wilson is also a Forensic Scientist employed by Forensic Science Service Tasmania (FSST). Ms Wilson holds a Bachelor of Applied Science from Charles Sturt University. She has been employed at FSST for 20 years and has expertise in the interpretation and statistical evaluation of DNA profiles.
196. I accept Ms Wilson as an expert who is suitably qualified to give opinion evidence about DNA profiling results.
197. Ms Devenish-Meares and Ms Wilson co-authored a report addressing forensic testing carried out by the laboratory in respect of items submitted to FSST.
198. As previously stated in this finding, a major profile was obtained from a swab of the steering wheel of Ms Cremer's vehicle, which was used by forensic scientists as a reference sample for Céline Aline Cremer.
199. On 4 February 2026 Ms Devenish-Meares attended the mortuary at the Royal Hobart Hospital and with Dr Andrew Reid, viewed several skeletal remains to assess their viability for DNA profiling.
200. As previously indicated, a portion of the right innominate bone was selected as a potential site for DNA analysis. A sub-sample was taken and swabbed. The remaining bone fragment was cut in half and the inner portion was swabbed. Both swabs were then placed into separate sample tubes, labelled and forwarded for DNA testing. The remaining portion of bone fragment was cleaned and dried overnight in a laminar flow isolation hood, then manually crushed, and the resulting powder was placed in a sample tube for DNA testing.
201. Two samples from the pelvic bone, namely
 - (i) the swab of pink/red staining on the bone; and
 - (ii) crushed bone fragments

were compared to the DNA profile of Céline Cremer contained in the reference sample.

202. A partial DNA profile obtained from sample (i) matched the DNA profile of Céline Cremer. The profile from the stain on the bone is 93 million times more likely to have originated from Céline Cremer than another randomly chosen person within the population.
203. A mixed DNA profile was obtained from (ii) the crushed bone fragments. The profile of Céline Cremer was not excluded from the mixed DNA profile. The profile from the bone is 50 million times more likely to have been contributed to by Céline Cremer than another randomly chosen person within the population. In Ms Devenish-Meares opinion, this provides *“extremely strong support for Céline Cremer to have contributed to the mixed DNA profile from the crushed bone fragments”*.
204. I accept Ms Wilson’s opinion as to this.

Missing persons reports

205. Advice was received from the Missing Persons Unit that there were no persons who had been reported missing in the Waratah area, who remained missing other than Ms Cremer.

FINDINGS PURSUANT TO S28(1) CORONERS ACT 1995

a) Findings regarding identity of unidentified human remains

Based on the expert reports of anthropologist Dr Callan Birkmann-Little, odontologist Dr Cailin Davies, State Forensic Pathologist Dr Andrew Reid and Forensic Scientists Ms Devenish-Meares and Ms Wilson and the opinions they expressed therein, and the fact that there are no other missing persons who have been reported missing in the area of Waratah who remain unaccounted for, I am satisfied to the requisite standard of proof, that the skeletal remains recovered during the searches conducted on 28 January 2026, 30 January 2026 and 9 February 2026 belong to a single adult female, and that the identity of that person is established as being Céline Aline Cremer.

b) How death occurred

I find that on 17 June 2023 sometime after 1.15pm Ms Cremer drove her white Honda CRV registered number E40TF, alone, from the Waratah Roadhouse to the Philosopher Falls carpark, arriving there at 1.58pm. At 2.18pm Ms Cremer searched "*Philosopher Falls walk*" in Google Maps on her phone. Soon thereafter Ms Cremer commenced walking on the marked track to the Philosopher Falls lookout, taking photographs and videos along the way. Ms Cremer's phone was likely out of range of satellite reception between 2.19pm-3.31pm.

Ms Cremer arrived at the lookout, and at 2.42pm took a number of photographs and videos at the lookout. On the return trip, instead of returning directly to the car park, Ms Cremer walked along the less clearly defined track adjacent to the water race towards Magnet Dam, photographing a fallen log at 2.47pm.

Ms Cremer likely reached Magnet Dam and then commenced walking back to the car park. Between 3.27pm and 4.18pm Ms Cremer unlocked her phone several times to check her location.

Ms Cremer's Google Timeline recorded her movements from 3.31pm-4.18pm and indicate that she followed the Magnet Dam walking trail, crossed Seven Mile Creek, then turned north following the trail for

approximately 100 metres. At 3.46pm she searched the location of "*Philosopher Falls*".

I am satisfied from the accounts given, that the track from Magnet Dam was poorly defined and that at approximately 3.49pm, Ms Cremer wandered off track and became lost. At this time, she suddenly turned in a northeasterly direction, leaving the walking trail and walking up an embankment, then turned south in the direction of the Philosopher Falls car park where her car was parked approximately two kilometres away. Ms Cremer continued walking in southerly direction.

Between 4.04pm and 4.14pm Ms Cremer continued walking uphill and reached "*Hill A*". At 4.15pm Ms Cremer shut down her phone and rebooted it, searched "*Philosopher Falls*" in Google Maps again at 4.18pm and took a screenshot before she commenced descent of Hill A, in the direction of the car park.

Given the location at which her mobile phone was retrieved, I find that Ms Cremer became separated from her phone soon after 4.18pm in dense forest terrain and fading light, leaving her without a means of communicating or navigating her way back to the car park.

I have referred to the evidence of the recovery of a glass water bottle and makeshift "*poncho*" made from black plastic bags and the limited evidentiary value of the results of DNA testing conducted on the items.

I am unable to be satisfied on the balance of probabilities that Ms Cremer contributed to the DNA profile obtained from the glass bottle or from the swab of the smaller black plastic bag.

I am therefore unable to find, to the requisite standard that the items located during the search by IFW Global are connected to the disappearance of Céline Cremer. In particular, I am not satisfied that the discovery of the glass bottle and plastic bags are evidence that Ms Cremer had taken shelter at that location in June 2023.

It is not possible to determine the route taken once Ms Cremer lost her mobile phone, to her final resting place in the Arthur River. However, given the location of the human remains recovered, it is likely that she became disoriented and without the benefit of her phone, mistakenly changed direction and began moving towards the Arthur River. Alternatively, she

may have made a conscious decision to find and then follow the Arthur River.

The location of Ms Cremer's remains was concentrated within a 350-metre section of the Arthur River in an area where there was evidence of a major flood level higher up the banks.

Given the wet and cold weather conditions experienced in June 2023, and the significant water flow at the time, the river levels were significantly higher than at the time of the discovery of Ms Cremer's remains, making it difficult, if not impossible for her to access the riverbed in that location.

Given the location of numerous log jams above the location where Ms Cremer's skull was recovered, and relatively few below it, I find that Ms Cremer entered the river a short distance from the final resting place of her skull.

It is not possible to discern the exact mode of entry into the river but given the steep and slippery terrain above the river, one possibility is that she slipped and fell from the banks into the river.

Another possibility is that she slipped and fell trying to cross the river.

There may be other hypotheses open on the evidence. I am not able to ascertain the exact circumstances in which Ms Cremer came to rest in the Arthur River.

I find that after entering the water and before the discovery of Ms Cremer's remains, her body was affected by natural river processes, including movement, entrapment in debris and progressive disarticulation over time.

Tasmania Police conducted a thorough investigation into the disappearance of Ms Cremer and into the location of and subsequent identity of human remains recovered in this matter. I note that the initial investigations included a concurrent criminal investigation. As a result, I am satisfied that the involvement of another person in Ms Cremer's death can be definitively ruled out.

Similarly, I am satisfied that there are no indicators at all that Ms Cremer intentionally took her own life.

I find that death occurred by way of accident.

c) Cause of death

The examination of Ms Cremer's human remains showed multiple signs of damage. I accept the opinion of Dr Reid, State Forensic Pathologist to the effect that many of the defects and fractures were consistent with blunt force trauma associated with head injury and/or a trip or slip and fall. Equally the nature and degrees of fractures, defects and disruptions seen could have been caused by prolonged water immersion, entrapment by and impacts upon or from hard rocks, timber and other river debris.

I accept that there was no evidence of sharp force trauma and none of the bones showed features of projectile injury.

I note the differential diagnoses for cause of death expressed by Dr Reid in his report and reproduced in these reasons. For the reasons stated therein, I find that the cause of death is unable to be determined.

d) When and where death occurred

I accept the evidence of Dr Paul Scott that the likely time frame for survivability in June 2023, based on the clothing that Ms Cremer was seen to be wearing in the CCTV footage at the Waratah Roadhouse on the afternoon of 17 June 2023, the fact that her Gore-Tex waterproof jacket was found in her car, and the weather conditions at the time, that Ms Cremer's time frame for survivability was three to four days.

I find that Céline Aline Cremer died at Arthur River, Waratah in Tasmania between 17 June 2023 and 21 June 2023.

DECISION NOT TO HOLD AN INQUEST

206. The Act mandates the circumstances in which an inquest must be held⁹⁵ and provides a discretionary power to hold an inquest in other cases where the coroner has jurisdiction to investigate if the coroner considers it desirable to do so.⁹⁶ The discretion conferred by the section is a wide and unfettered one.

207. In *Clancy v West* [1996] 2 VR 647 at 653, Tadgell JA, dealing with comparable Victorian legislation, said of the discretion:

⁹⁵ *Coroners Act* 1995 s24(1).

⁹⁶ *Coroners Act* 1995 s24(2).

“A more absolute discretion conferred upon a Coroner to hold or not to hold an inquest in a case not falling within [the mandatory provision] could scarcely be formulated.” [See also Taing and Nuon v The Territory Coroner and Attorney General for the Northern Territory [2011] NTSC 58, [45]–[46].]

208. In exercising the discretion, a factor that has been regarded as significant is “whether there would be any benefit in holding an inquest and whether it would be expected to yield further information that thus far has not come to light”, per Blokland J in *Taing and Nuon v The Territory Coroner* at [53]. Her Honour explained this as follows, at [54]:

“What would make the holding of an inquest ‘desirable’ (in keeping with the over objectives of the Coroners Act (NT))[54] is that there be some practical benefit to the next of kin in terms of better understanding of what occurred to the deceased, or that there be a benefit to the general public, a section of it, or to the overall administration of justice. An inquest should not be held where it would clearly be a futile exercise”.

209. In the present case, I am of the view that there has been a thorough police investigation into the death of Ms Cremer. Unusually, in this case, I also have the benefit of the evidence of investigations carried out by an independent, private investigator and the discovery of crucial evidence by members of the public. While the exact manner and circumstances of Ms Cremer’s death, and the exact cause of death cannot be positively determined, I do not consider that the holding of an inquest would be likely to produce any definitive evidence that could rectify the lacunas in the evidence.

COMMENTS

Adequacy of the police investigation

210. I am satisfied that the initial police response to the missing person report filed on 27 June 2023 was appropriate. Immediate engagement with the public through the Tasmania Police social media sites brought attention to Ms Cremer's status as a missing person.
211. The investigation received large volumes of information from the public which was actioned.
212. A simultaneous criminal investigation was conducted, which eliminated some of the lines of enquiry that had been raised by members of the public. Furthermore, the criminal investigations enabled the involvement of any other person to be definitively ruled out.
213. The search and rescue response was guided by accepted methodologies and informed by the mobile phone data that was available and current at the time. The response was somewhat limited by the prevailing weather conditions, in particular the water levels in the Arthur River during 2023, which were significantly higher than at the time that Ms Cremer's remains were recovered in January and February 2026.
214. It is also important to recognise that the mobile phone data was recovered incrementally. The initial response was based on the triangulation of the mobile phone to determine the approximate geographical location of the device.
215. The search and rescue response was reinvigorated by the subsequent access to Ms Cremer's Google account and retrieval of Google Timeline location data, which allowed more targeted searching of the Philosopher Falls area to be undertaken by Tasmania Police. Finally, the discovery of the physical mobile phone by private searchers in December 2025, provided an opportunity for the phone to be interrogated by Victoria Police and further data extracted, which confirmed police theories about Ms Cremer's movements up until the mobile phone was lost.
216. Tasmania Police engaged with IFW Global and exchanged information to assist the private search. The location of human remains by a member of the public fuelled further searches by Tasmania Police, which led to further significant recoveries of Ms Cremer's remains.

Private search

217. The private search efforts of IFW Global brought renewed attention to the plight of Ms Cremer and built momentum for a privately arranged search to be conducted in December 2025. The search uncovered vital evidence, namely, the discovery of Ms Cremer's mobile phone.
218. The search effort coordinated and led by IFW Global was well planned and coordinated. Volunteers were vetted to ensure that persons with appropriate skill sets were selected. IFW Global ensured open lines of communication with Tasmania Police and informed them of their plans. IFW Global and Tasmania Police worked collaboratively to ensure that relevant information was shared and to develop protocols related to the discovery, collection and packaging of items of interest, to preserve the integrity of the evidence. Furthermore, IFW Global utilised searcher tracking technology to document and plan their searches, thereby ensuring a thorough, systematic search of areas of interest and those identified in the location data.
219. The private search efforts of IFW Global are to be commended.
220. I note too, the efforts of many volunteers who gave up their time to join the private search and to conduct their own individual searches. Such work ultimately led to the discovery of the first human remains, prompted the recovery of further remains and provided answers to Ms Cremer's predicament.
221. The findings that I have made are the result of the evidence obtained due to the combined efforts of a police investigation, private investigators and individual searchers.
222. However, the success of this case must be tempered by the potential for adverse results arising from private or individual search efforts. These include the potential for compromising the integrity of the scene, contamination of evidence and failures to accurately document discoveries or report them to the relevant authorities so that they can be investigated by trained professionals. Individuals embarking on their own investigations must be mindful that they do not interfere with official investigations.
223. A further consideration is the information that individuals documenting their efforts disseminate, and the need to be mindful that such information may be inaccurate, fuel rumours or cause distress to the family and friends of the missing person.

224. Individuals entering challenging wilderness settings to conduct their own searches must also be cognisant that by doing so, they may place themselves at risk.
225. These investigations highlight the valuable contribution that private citizens can make once official search efforts have been suspended. It is appropriate that consideration is given to formalising arrangements between Tasmania Police and private search groups so that this resource can be harnessed.
226. It is appropriate that Tasmania Police give consideration to:
- Developing protocols to formalise arrangements with private search groups who conduct investigations and searches into missing persons once the official search effort has been suspended;
 - Establish a criteria for eligibility of private search groups to work with Tasmania Police on such investigations into missing persons;
 - Consider the registration of such private search groups with Tasmania Police; and
 - Develop protocols between the parties related to the sharing of information, the recording of the investigations undertaken and the collection of evidence.

CONCLUDING COMMENTS AND RECOMMENDATIONS

227. The death of Ms Cremer was the result of a confluence of errors that commenced when she took the walking track towards Magnet Dam, having visited the Philosopher Falls lookout, instead of returning directly to the car park.
228. The track to Magnet Dam was not well defined and she wandered off track and became lost. The deviation from the track occurred late in the day, four days before the winter solstice, at which time the afternoon light was starting to fade. The weather conditions at the time were cold, with overnight temperatures close to freezing and wet. Ms Cremer had insufficient clothing to ward against the environmental conditions and was not carrying any waterproof clothing.
229. Ms Cremer's only means of communication and navigation was her mobile phone, however the reception in the area was intermittent and she became separated from her phone in the late afternoon.

230. Ms Cremer also failed to follow standard safety precautions.
231. Standard safety messages are published on the Tasmania Police and Parks and Wildlife Services (PWS) websites.⁹⁷
232. This messaging includes:
- being prepared by taking a map, torch, clothing and footwear to suit any conditions, including a waterproof jacket;
 - plan the walk by studying maps and guides;
 - walk within your capabilities;
 - avoid walking alone; and
 - let someone know where you are going.
233. I **comment** that walkers should familiarise themselves with these standard safety messages before embarking on short walks, day walks or multiday hikes, in order to be properly prepared for the terrain and changeable weather conditions.
234. Walkers should also be aware that mobile coverage is often intermittent or unavailable in remote areas of the Tasmanian wilderness and should plan accordingly.
235. A copy of the draft recommendations was circulated to stakeholders including Tasmania Police, Waratah Wynyard Council and PWS, a division of Department of Natural Resources and Environment Tasmania (NRET). A response was received from each stakeholder, which I have considered.
236. I **recommend** that Tasmania Police give consideration to conducting a review into the utilisation of private search groups and the development of protocols governing their use in connection with missing persons investigations.
237. In his response, Deputy Commissioner, Jonathan Higgins APM, on behalf of Tasmania Police has committed to undertaking a review of the use of private

⁹⁷<https://parks.tas.gov.au/safety-in-parks>; <https://www.police.tas.gov.au/news-events/media-releases/bush-walking-safety-advice>.

search groups in missing persons investigations, including consideration of formal protocols, eligibility criteria, potential registration mechanisms and arrangements for information sharing and evidence handling, to ensure any future engagement is effective and appropriately governed.

238. Other proposed comments and recommendations were directed at the safety of the Philosopher Falls and Magnet Dam walking tracks.
239. Responsibility for the Philosopher Falls car park and the walking track to the lookout rests with the Waratah Wynard Council (WWC), under a licence agreement for public recreation.
240. WWC advised that in March 2025, the Council upgraded signage along the walking track to the lookout by installing 50 track markers, with 25 positioned in each direction. A “Danger- Do Not Enter- Walkway Closed” sign was installed at the end of the walking track and a “Footpath Closed” sign placed approximately 15 metres beyond the first sign. An “Exit” directional sign (with arrow pointing left to the car park) was installed at the top of the viewing platform stairs. WWC advised that they undertake regular maintenance of the track to the lookout, including the stairs leading to the viewing platform at the falls. WWC acknowledges that the signs at the entrance to the walking track are outdated. These contain details of Ms Cremer as an active missing person and contain warnings to beware of snakes, falling trees, steep walking tracks and uneven ground.
241. PWS conducted a risk assessment of the Philosopher Falls walking track on 6 July 2026 to inform their response to the draft recommendations.
242. PWS’s risk assessment revealed that the track from Philosopher Falls carpark to the lookout has an even surface and is sufficiently wide for two people to walk side by side. After crossing the Arthur River, the track following the old water race becomes rougher and narrower but remains easy to follow. It is asserted that overall, the track is in good condition. The track then deviates from the water race towards the formal stairway to the viewing platform. PWS reported that beyond the turn, the water race continues towards Magnet Dam and noted the installation of the two warning signs referred to earlier (albeit recent photographs accompanying the submission show the two signs positioned next to each other, not 15 metres apart). PWS advised that the water race alignment beyond the stairs is not, nor has it ever been, a formal walking track.

243. A draft recommendation to urgently upgrade the track from the Philosopher Falls lookout to Magnet Dam was circulated to WWC and PWS for comment.
244. Advice was received from Richard Gilmour, General Manager- Operations, PWS to the effect that the track from the Philosopher Falls lookout to Magnet Dam is on land that is administered by PWS, a division of NRET. That land is designated as Future Potential Production Forest Land (FPPFL) which was established under *Forestry (Rebuilding the Forest Industry) Act* 2014 and is administered in accordance with the *Crown Lands Act* 1976. Approximately 350,000 hectares of land in Tasmania falls within this category. While the land is administered by PWS, infrastructure within FPPFL is not maintained by PWS as it is reserved primarily for future production forestry, not recreation or public access infrastructure. For the track to Magnet Dam to be upgraded, it would need to be transferred to a land manager with a recreation mandate, such as a Council.
245. The WWC advised that even in the event that an extension of the existing licence was granted, or a new licence, or other formal agreement allowing Council to upgrade and maintain the section from the lookout to Magnet Dam was issued, the Council does not have any allocated funding in its budget to make upgrades or maintain the land.
246. PWS stated that *“neither WWC nor the PWS has any appetite for upgrading the water race alignment beyond the stairway to promote as a walking track”*.
247. Constable Dean Wotherspoon videoed the Philosopher Falls track from the carpark to Magnet Dam and return on 23 July 2026. A USB of the edited video showing the track and water race, as well as the point at which Ms Cremer is believed to have deviated from the track and walked uphill, was received as an exhibit in this investigation. The video confirms that the track beyond the stairway to the viewing platform has two signs installed beside each other advising that the walkway is closed. The video of the “closed” track to Magnet Dam and return depicts a reasonably clear trail adjacent to the water race. The video depicted potential navigation obstacles by way of fallen timber, however the water race and nearby track remained a feature that was reasonably obvious when compared to the surrounding scrub. The video showed the vicinity of where Ms Cremer is believed to have turned around from Magnet Dam and showed a fairly

obvious track. In contrast, at the point at which Ms Cremer left the track, the scrub was thick with no defined track. Notwithstanding those observations, the track was not as clear as the Philosopher Falls track from the car park to the look out. As stated earlier in these reasons, anecdotally police officers had found the track difficult to navigate in failing light.

236. In the absence of an authority with a mandate to upgrade or maintain the track⁹⁸ to Magnet Dam, users accessing the track should be mindful that the track surface is degraded, uneven and may be hazardous.

237. I **recommend** that Waratah Wynyard Council erects signs at the entrance to the Philosopher Falls walking track that informs walkers that Council's responsibility for the Philosopher Falls walk track does not extend beyond the junction to the lookout and that the Magnet Dam Trail is situated on Future Potential Production Forest Land and is not managed for recreational use and no maintenance is undertaken on the track. Warnings should include that the trail surface is degraded, uneven and may be hazardous.

I extend my appreciation to Senior Sergeant Julien Puurand, First Class Constable Dean Wotherspoon, IFW Global and all those involved in the search and rescue efforts.

I extend my sincere condolences to the family and loved ones of Ms Cremer.

Dated: 25 August 2026 at Hobart in the State of Tasmania



Madeleine Wilson

Coroner

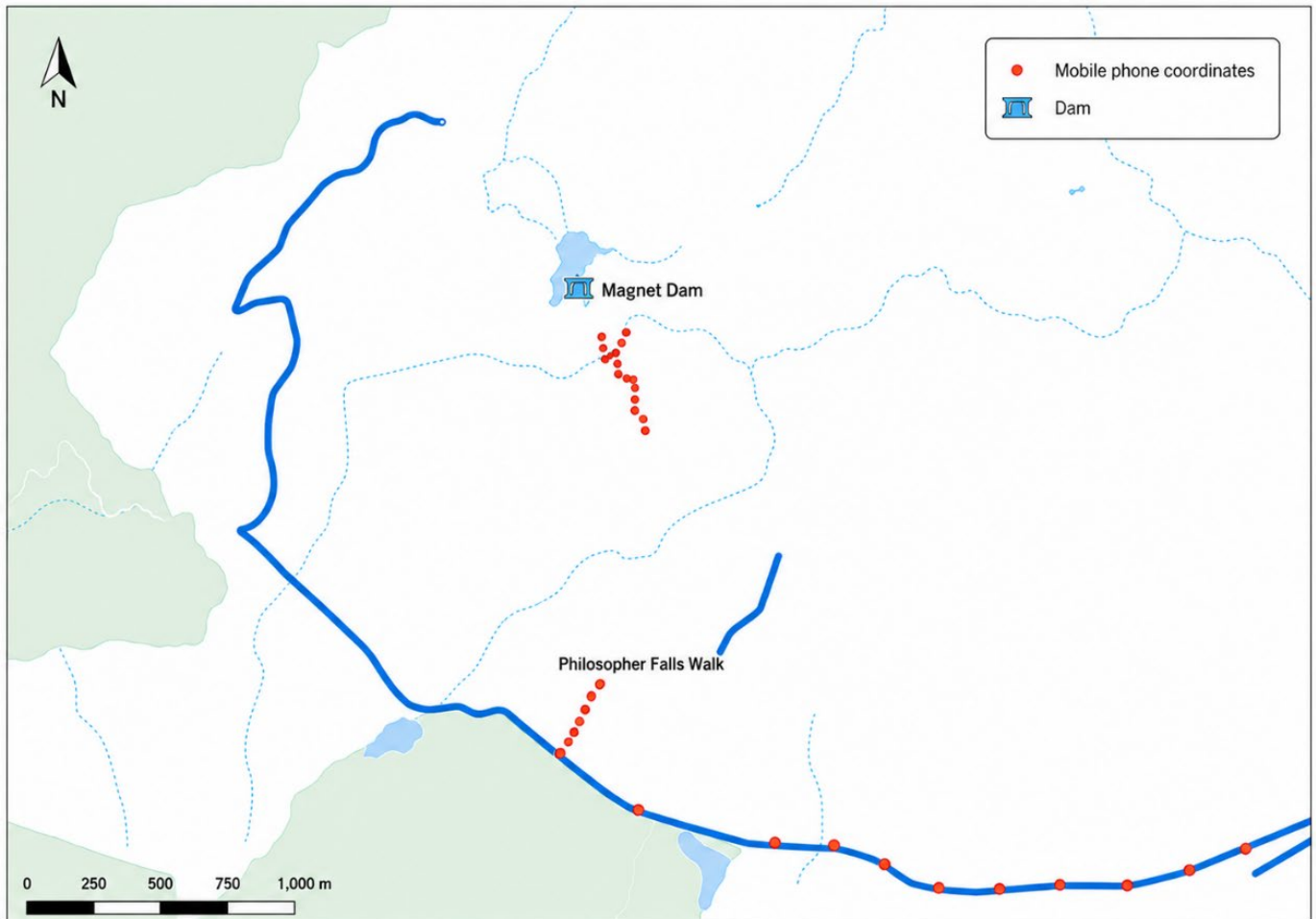
⁹⁸ References to "track" in this context, includes "water race alignment" referred to in PWS's submission.

ANNEXURE A

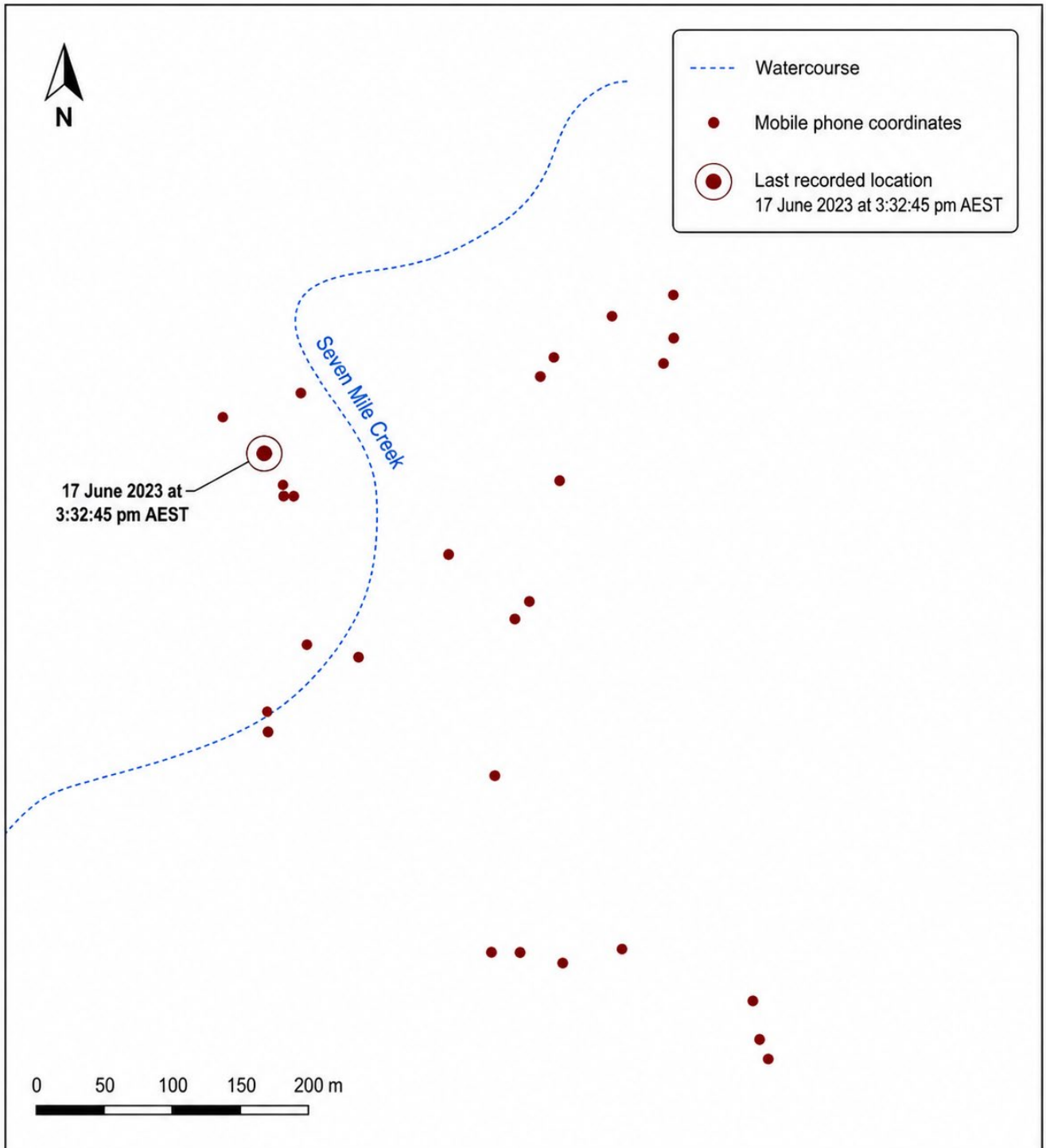
- Police Report of Death for the Coroner;
- Forensic Pathologist Report dated 20/02/2026;
- Forensic Anthropologist Report dated 20/02/2026;
- Forensic Odontologist Report dated 05/02/2026 and 20/02/2026;
- Forensic Biology Reports dated 17/04/2026 and 20/02/2026 ;
- Affidavit of Senior Sergeant James Scicluna;
- Affidavit of Constable Wayne Bradford;
- Affidavit of Inspector Danny Jackson;
- Affidavit of Sergeant Jessica Godfrey;
- Affidavit of Senior Constable Connor Pask;
- Affidavit of Detective Constable Daniel Dellar;
- Affidavit of Constable Donna-Lee Bower;
- Affidavit of Senior Constable Allira Bartush;
- Affidavit of First-Class Constable Theresa Chisholm;
- Affidavit of Constable Robert Oberrauter;
- Affidavit of Sergeant Katrina Chivers;
- Affidavit of Constable Benjamin Shepherd;
- Affidavits of First-Class Constable Dean Wotherspoon;
- Statement of Jean Lambion;
- Statement of Justine Ropet;
- Affidavit of Joshua Strudwick;
- Affidavit of Melissa Lancaster;
- Affidavit of Gabrielle Patterson;
- Affidavit of Mark McGuire;
- Affidavit of Shane Hedger;
- Affidavit of Kallam Frandsen;
- Affidavit of Candice Mason;
- Affidavit of Ingrid Ekman;
- Affidavit of David Roe;
- Affidavit of Jon Oliver;
- Affidavit of Anthony Hage;
- Affidavit of Jarrod Boys;
- Affidavit of Kenneth Gamble;
- Affidavit of Constable Lucy Brown;

- Survivability report of Dr Paul Scott;
- Final investigation affidavit/report of Constable Dean Wotherspoon;
- Report of Julian Gill, Parks and Wildlife Service;
- Maps and brochures held by Céline Aline Cremer;
- Diary of Céline Aline Cremer;
- Email Correspondence of Dr Paul Scott dated 26/06/2023; and
- Email Correspondence of Ariane Mathiew dated 21/04/2026.

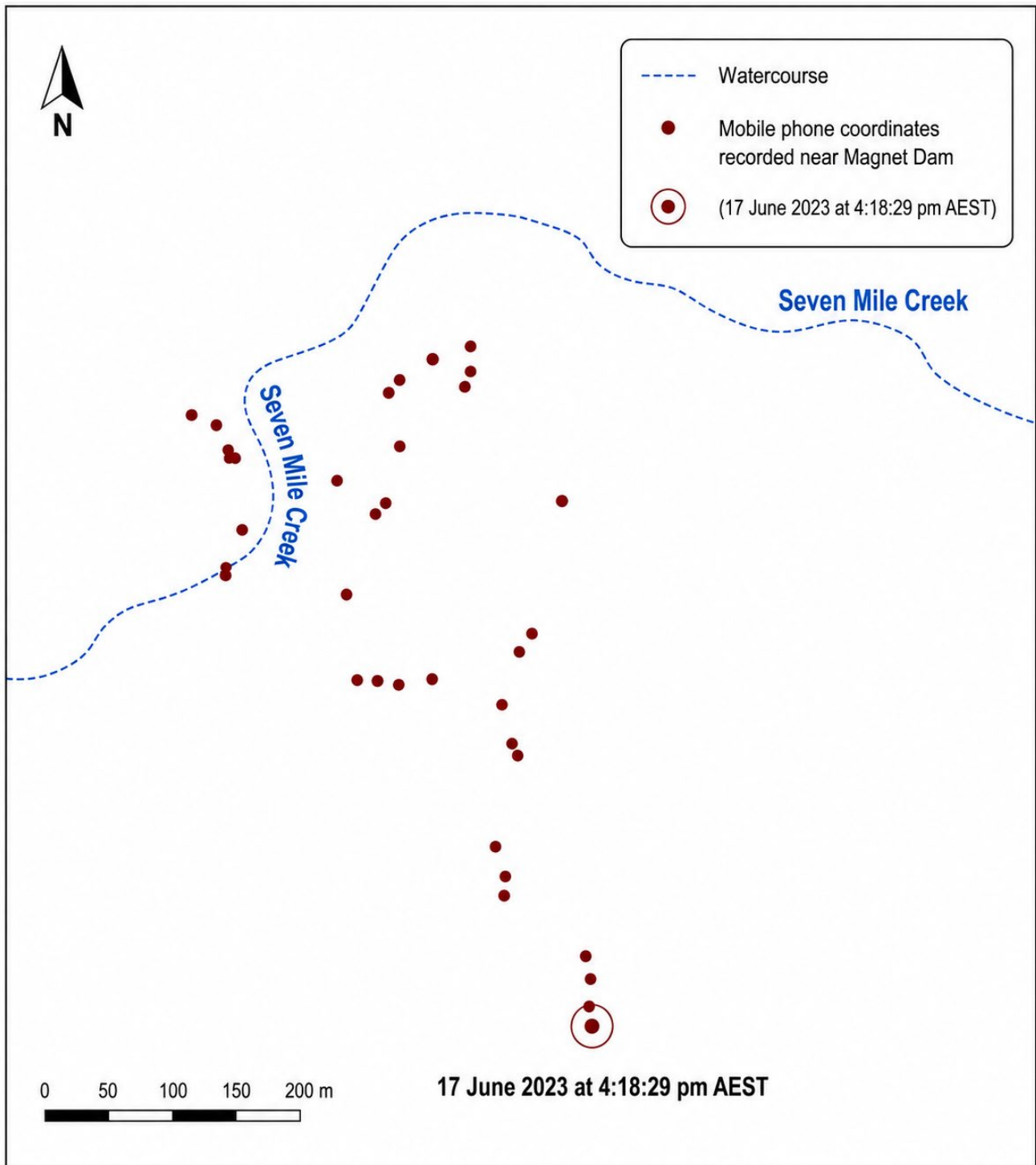
ANNEXURE B



Mobile phone co-ordinates 17 June 2023



***Mobile phone co-ordinates commencing near Magnet Dam at 3.32pm
17 June 2023***



Mobile phone co-ordinates, ending at 4.18pm, 17 June 2023

ANNEXURE C

Coroners Act 1995

s24. Jurisdiction of coroner to hold inquest into a death

- (1) Subject to section 25 , a coroner who has jurisdiction to investigate a death must hold an inquest if the body is in Tasmania or it appears to the coroner that the death, or the cause of death, occurred in Tasmania or that the deceased ordinarily resided in Tasmania at the time of death and –
 - (a) the coroner suspects homicide; or
 - (b) the deceased was immediately before death a person held in care or a person held in custody; or
 - (c) the identity of the deceased is not known; or
 - (d) the deceased died whilst escaping or attempting to escape from prison, a detention centre, a secure mental health unit, police custody or the custody of a person who had custody under an order of a court for the purposes of taking that person to or from a court; or
 - (e) the death occurred in the process of a police officer, correctional officer, mental health officer or prescribed person, within the meaning of section 31 of the Criminal Justice (Mental Impairment) Act 1999 , attempting to detain a person; or
 - (i) the deceased died at, or as a result of an accident or injury that occurred at, his or her place of work and the coroner is not satisfied that the death was due to natural causes; or
 - (f) the death occurred in such a place or in such circumstances that require an inquest under any other Act; or
 - (g) the Attorney-General directs; or
 - (h) the Chief Magistrate directs.
- (2) A coroner may hold an inquest into a death which the coroner has jurisdiction to investigate if the coroner considers it desirable to do so.

ANNEXURE D

Coroners Act 1995

reportable death means –

(a) a death where –

- (i) the body of a deceased person is in Tasmania; or
- (ii) the death occurred in Tasmania; or
- (iii) the cause of the death occurred in Tasmania; or
- (iiia) the death occurred while the person was travelling from or to Tasmania –
being a death –
- (iv) that appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury; or
- (v) that occurs during a medical procedure, or after a medical procedure where the death may be causally related to that procedure, and a medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death; or
- (vi)
- (vii) the cause of which is unknown; or
- (viii) of a child under the age of one year which was sudden and unexpected; or
- (ix) of a person who immediately before death was a person held in care or a person held in custody; or
- (x) of a person whose identity is unknown; or
- (xi) that occurs at, or as a result of an accident or injury that occurs at, the deceased person's place of work, and does not appear to be due to natural causes; or

- (b) the death of a person who ordinarily resided in Tasmania at the time of death that occurred at a place outside Tasmania where the cause of death is not certified by a person who, under a law in force in the place, is a medical practitioner; or
- (c) the death of a person that occurred whilst that person was escaping or attempting to escape from prison, a detention centre, a secure mental health unit, police custody or the custody of a person who had custody under an order of a court for the purposes of taking that person to or from a court; or
- (d) the death of a person that occurred whilst a police officer, correctional officer, mental health officer or a prescribed person within the meaning of section 31 of the Criminal Justice (Mental Impairment) Act 1999 was attempting to detain that person;

ANNEXURE E

Coroners Act 1995

s28. Findings, &c., of coroner investigating a death

- (1) A coroner investigating a death must find, if possible –
 - (a) the identity of the deceased; and
 - (b) how death occurred; and
 - (c) the cause of death; and
 - (d) when and where death occurred; and
 - (e) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1999* .
 - (f)
- (2) A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.
- (3) A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.
- (4) A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.
- (5) If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care.