IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 1210

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)
Section 67 of the Coroners Act 2008

Findings of:	Ian James Guy, Coroner
Deceased:	Stephen Myall
Date of birth:	17 June 1958
Date of death:	14 or 15 March 2018
Cause of death:	1(a) Hanging
Place of death:	Quarry at Hobbs Road, Bullengarook, Victoria

INTRODUCTION

1. Stephen Myall was a 59-year-old man who lived in Bullengarook at the time of his death.

2. Mr Myall married his wife, Joanne Duncan, in 2005. The couple later adopted their son, Steve, who enjoyed an especially close relationship with Mr Myall.

3. Apart from some minor medical issues, Mr Myall was in good physical health at the time of his death. He had never reported any mental health related issues to his family, his employer, or his general practitioner.[1]

4. At the time of his death, Mr Myall held the judicial office of magistrate of the Magistrates' Court of Victoria. He was, by all accounts, a highly respected magistrate who displayed courtesy, compassion and an utter commitment to his role.

5. Mr Myall took his own life on 14 or 15 March 2018.

THE PURPOSE OF A CORONIAL INVESTIGATION

6. Mr Myall's death was reported to the Coroner as it appeared both unexpected and unnatural, and so fell within the definition of a reportable death in the *Coroners Act 2008*.

7. The role of a coroner is to independently investigate reportable deaths to establish, if possible, identity, medical cause of death and surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

8. The Coroner's Investigator prepared a coronial brief in this matter. The brief includes statements from witnesses, including family, the forensic pathologist, treating clinicians, and investigating officers.

9. The Court also obtained statements from the Chief Executive Officer and the Acting Chief Executive Officer of the Magistrates' Court of Victoria and a copy of a report prepared by David Caple and Associates Pty Ltd entitled *Investigation, Analysis, Risk Assessment and Report on the Work Occupational Health and Safety Operations of the Magistrates' Court of Victoria*.

[1] Coronial Brief, Statement of Dr Stephen Newton, page 1.

10. The coronial investigation into Mr Myall's death was transferred to me in November 2019 in my capacity as a reserve magistrate and coroner in Victoria. I also hold the judicial office of magistrate of the Local Court of New South Wales.

11. Following consultation with Mr Myall's family, I am satisfied the investigation does not require the conduct of an inquest. There is however a significant public interest in the publication of these findings on the Court's website.

12. I have based this finding on the evidence contained in the coronial brief and the further materials obtained by the Court. In the coronial jurisdiction facts must be established on the balance of probabilities.[2]

IDENTITY

13. On 16 March 2018, Joanne Duncan visually identified her husband, Stephen Myall, born 17 June 1958.

14. Identity is not in dispute and requires no further investigation.

BACKGROUND

15. In December 2005, Mr Myall was appointed as a magistrate after working as a solicitor with Legal Aid and private practice. He initially presided at the Melbourne Magistrates' Court before moving to Broadmeadows and Geelong and eventually being assigned to Sunshine and Werribee in 2014.[3]

16. Mr Myall was at first reluctant about moving to the Sunshine Magistrates' Court as he enjoyed working at Geelong, which was more closely aligned with his rural upbringing. Ms Duncan described him as *"very much a country person"*. Mr Myall initially likened Sunshine Magistrates' Court to a city court but later grew more comfortable working there.[4]

17. He was described as having an exceptional work ethic. Ms Duncan noted at the time of her husband's death, he had accrued 90 days of recreational leave and had more than 70 days of long service leave. He was scheduled to shortly take two weeks of leave. She said she would often nag him about not taking leave, but got the impression that he felt taking leave was an

[2] This is subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.
[3] Coronial Brief, Statement of Joanne Duncan, page 1.
[4] ibid, page 2.

inconvenience. Mr Myall last took leave during the Christmas shutdown period.[5] He was clearly passionate about his work, but it is clear work was his main stressor.

18. Mr Myall would often work late and stay back after sitting hours to debrief the day's events with a colleague. He would generally leave work between 6.30pm to 7.00pm, then swim for an hour each evening at Gisborne pool. It was, said his wife, his way to relieve the stress of the job. He did not however go to the swimming pool in the week leading up to his death.[6]

19. Apart from court sittings, Mr Myall was involved with varied committees and projects. His focus was on improving the criminal justice system, especially for the disadvantaged members of society.[7]

20. Described as sensitive, caring, and thoughtful, those traits brought with it a tendency to agonise about decisions to be made in court.[8] A colleague noted the court time of Mr Myall was often longer as he took particular trouble to ensure unrepresented persons were not disadvantaged from a lack of legal knowledge. His decisions were described as considered but took time to formulate, which added to his workload.[9]

21. The topic of ever-increasing court workloads featured in discussions with Mr Myall's wife and some of his colleagues. From time to time, Mr Myall spoke of being *"smashed"* at work to his wife. This term referred to the number of cases, sometimes up to 90, he had presided over that day. There were discussions with some colleagues how exhausted they were from the day's work and the burden of actually dispensing justice in busy lists. There was an observation that at times he seemed overwhelmed by the work they did and although there was nothing to suggest he could not deal with it, there was a sense by a colleague the pressure of the workload was wearing upon him.[10]

22. About a month prior to his death, Mr Myall had a telephone conversation with a friend. Apart from discussing ever increasing workloads, the focus of the call was very much on social justice issues, legislative sentencing restrictions, large Family Violence lists, policing and access to justice for defendants who were appearing by video-link.[11]

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[5] Coronial Brief, Statement of Joanne Duncan, page 7 to 8.
[6] ibid, page 3.
[7] Coronial Brief, Statement of Jennifer Grubissa, page 2.
[8] Coronial Brief, Statement of Robert Kumar, page 1.
[9] Statement of Reginald Marron, page 1.
[10] Coronial Brief, Statement of Jennifer Grubissa, page 3.
[11] Coronial Brief, Statement of Miranda Bain, page 2.

23. His friend and colleague Magistrate Robert Kumar stated the topic of the amount of work Mr Myall had was not raised in their numerous telephone discussions and he did not appear to be overborne by it. The discussions often turned to the effect of the judicial system on accused persons, Government decisions impacting on the judicial system, or the application of the law itself.[12]

24. On 2 March 2018, Mr Myall attended a wellbeing workshop for magistrates, conducted by the Judicial College of Victoria (**JCV**).[13] The workshop focussed on occupational stresses and provided magistrates with preventative and supportive measures to deal with these issues.[14] Mr Myall later told his wife he was grateful the JCV had organised a workshop focussing on magistrates' welfare.[15]

25. On 8 March 2018, there was significant criticism in the media of a decision by Mr Myall to adjourn charges of assault police against a youth offender to the end of the year so he could complete his Year 12 exams. Ms Duncan observed that Mr Myall felt pressure from the media in every case he heard and the prospect of an appeal from his decisions always weighed heavily on her husband's mind.[16]

26. On or about 12 March 2018, Ms Duncan noticed her husband appeared *"a bit flat"* and she asked him if he was okay. He replied that he was *"feeling a bit achy"*. She noted he appeared stressed and *"a bit brittle"* and had been a bit snappy during the week, which was unusual.[17]

27. Mr Myall's colleagues did not observe any change in his demeanour leading up to, nor on the day of, his death.[18] [19]

28. On 13 March 2018, the day before his last day at work, he telephoned Magistrate Kumar. Mr Myall said he was troubled by the media criticism of his decision concerning the adjournment of the charges against the youth, raised his concerns about young offenders being sent to Barwon gaol, and prisoners not being brought to Court in person. Magistrate Kumar sought to reassure him about his decision concerning the youth and that he should

[12] Coronial Brief, Statement of Robert Kumar, pages 1 to 2.
[13] Coronial Brief, Statement of Peter Lauristen, page 2.
[14] Coronial Brief, pages 17 to 19.
[15] Coronial Brief, Statement of Joanne Duncan, page 4.
[16] ibid, page 3.
[17] ibid, page 7.
[18] Coronial Brief, Statement of Mary Robertson, page 1.
[19] Coronial Brief, Statement of Jennifer Grubissa, page 2.

not worry about the other matters. There was no inkling there was anything wrong with Mr Myall.[20]

CIRCUMSTANCES IN WHICH THE DEATH OCCURRED

29. On 14 March 2018, Mr Myall worked at the Sunshine Magistrates' Court and left at approximately 4.40pm. This was unusual, as Mr Myall often worked until a much later time.[21]

30. That evening, Ms Duncan attended an event and stayed at her sister's house in Melbourne. At 8.45pm, their son Steve called Ms Duncan to let her know Mr Myall had not returned home. Steve had also been trying to telephone his father, but his calls were not answered. Ms Duncan thought he may have gone to the supermarket or to the swimming pool. When Steve noted Mr Myall's swimming bag was gone Ms Duncan concluded her husband had gone swimming and was not worried he had not yet returned home.[22]

31. Steve text messaged his mother at 9.30pm, reporting to her that Mr Myall had still not arrived home. Ms Duncan immediately tried to telephone her husband, but he did not answer. She asked Steve to search at the pool and around Bullengarook. Becoming concerned, Ms Duncan kept telephoning her husband until midnight, but her calls remained unanswered. She also thought he may have gone to his mother's house but decided against ringing given the late hour.[23]

32. The next morning, Ms Duncan tried telephoning her husband at 6.00am. When there was no answer, she called his mother who advised he had not been there. Ms Duncan then telephoned Gisborne police. She did not make an official missing person report but was informed there had been no accidents involving the make and model of her husband's vehicle.[24]

33. A further search by Steve on the way to work was unsuccessful. Amid growing concerns, he left work early and met his mother in Melbourne. Checks with the swimming pool operators confirmed Mr Myall had not been there the previous night.

[20] Coronial Brief, Statement of Robert Kumar, page 2.
[21] Coronial Brief, Statement of Joanne Duncan, page 7.
[22] Coronial Brief, Statement of Joanne Duncan, page 4.
[23] ibid, pages 4 to 5.
[24] ibid, page 4.

34. Ms Duncan also made enquiries with the Werribee Magistrates' Court and was told he had not arrived at work that day.[25]

35. A family friend used an App to locate Mr Myall's mobile phone on a track off Hobbs Road in Bullengarook. Ms Duncan drove to Bullengarook with Steve and her sister and telephoned Gisborne police on the way.[26]

36. At approximately 10.35am on 14 March 2018, Leading Senior Constable Georgina Thompson and Senior Constable John Wilson found Mr Myall's vehicle in a disused quarry off Hobbs Road, Bullengarook. A short distance away, they found Mr Myall deceased. A handwritten suicide note was later found in his vehicle.[27]

CAUSE OF DEATH

37. On 16 March 2018, Dr Gregory Young, a Forensic Pathologist practising at the Victorian Institute of Forensic Medicine, conducted an inspection and provided a written report, dated 20 March 2018. Dr Young concluded that a reasonable cause of death was '*Hanging*'.

38. Dr Young explained that hanging is a form of asphyxia due to compression of the neck structures by a ligature tightened by the weight of the body. Death may be due to reflex cardiac arrest, occlusion of the blood vessels of the neck, or airway obstruction. In cases of hanging, unconsciousness can occur very rapidly, and death follows shortly after. Fractures of neck structures may also occur, including the hyoid bone, thyroid cartilage, and cervical spine.

39. Dr Young noted no unexpected signs of trauma were seen during inspection.

40. Toxicological analysis of post mortem specimens taken was negative for common drugs, alcohol and poisons.

41. I accept Dr Young's opinion as to cause of death.

COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT

42. What emerges from the investigation is evidence of a person totally committed to his role as a judicial officer and one who remained throughout his legal career passionate about social

[25] ibid, page 5.
[26] ibid, page 5.
[27] Coronial Brief, page 2.

justice issues and its impact upon the justice system and in particular upon the disadvantaged.

43. He was clearly troubled by issues such as legislative changes impacting on sentencing options and subsequent incarceration rates, funding issues and the subsequent ability of lawyers to represent accused, and the rights of defendants to appear at Court.

44. He expressed at times, exhaustion and frustration at the ever-increasing workload of magistrates and the ability in those circumstances to do justice to those who appeared before him.

45. His long work hours appear a reflection of an increasing workload, involvement in out of court committees, a desire to ensure unrepresented persons were not disadvantaged in court, the extra time needed to formulate reasons, and very significant worry over decisions he made.

46. He felt pressure from the media in the cases he heard and was troubled by recent criticism.

47. It is not possible to identify the extent to which one or more of those stressors played in his final decision. As his wife observed, "*The main reason for Stephen's stress was his work, which he also loved*".[28]

Judicial wellbeing at the Magistrates' Court of Victoria

48. Given the predominant stressor in Mr Myall's life was his work, and his death was the second suicide of a (current or former) judicial officer appointed to the Magistrates' Court of Victoria, my investigation necessarily reviewed how the Court addressed judicial wellbeing at the time of Mr Myall's death and the changes thereafter.

49. In 2015, an inaugural two-day program on judicial wellbeing and judicial stress was presented by the JCV.

50. In 2016, the JCV provided a dedicated wellbeing website available for magistrates and registrars containing fact sheets, self-assessment tools, podcasts, and applications.

51. Since 2016, judicial officers have had access to a team of senior psychologists from an external organisation that provides support through a dedicated counselling program as part of the Judicial Officers Assistance Program. The Program provides free and confidential

[28] Coronial Brief, Statement of Joanne Duncan, page 8.

telephone counselling to all judicial officers.[29] It should be observed that Mr Myall did not seek assistance from the program.

52. In October 2017, the then Chief Magistrate Peter Lauritsen established a Judicial Wellbeing Committee (**JWC**), comprising magistrates, the JCV, and external advisors with the aim of providing advice on matters affecting judicial wellbeing in the Magistrates' Court of Victoria. This led to the Magistrates' Court implementing a number of changes to support judicial wellbeing, which have included:[30]

    (a) magistrates and judicial registrars now receive a 'chamber day' each month (and additional days for reading and preparation when needed) to be used for writing decisions and research;

    (b) four wellbeing days (six days for new appointees) are scheduled each year for debriefing and support with no court duties to be undertaken on that day; and

    (c) provision of Professional Wellbeing Supervision, which allows judicial officers to self-refer for face-to-face sessions with external senior psychologists.

53. Following a recommendation from the JWC, external occupational health and safety experts, David Caple and Associates Pty Ltd, were engaged to review the operations of the Magistrates' Court. In March 2019, a final report was presented entitled *Investigation, Analysis, Risk Assessment and Report on the Work Occupational Health and Safety of Operations of the Magistrates' Court of Victoria* (**the Caple report)**.

54. The Caple report drew upon the views of magistrates, judicial registrars, and substantial data of the Court's operations. The report, totalling over 60 pages, is extensive and made a number of recommendations, many of which have already been implemented or are under consideration.

55. A statement dated 16 March 2020 was received from Elissa Scott, Acting Chief Executive Officer of the Magistrates' Court of Victoria, responding to the recommendations in the Caple report and setting out the changes made within the Court affecting judicial wellbeing (**the response**). The following outline provides a summary of the main issues.

56. The Caple report noted the ever-increasing size of daily Court lists and workloads within the sitting times. It noted that since 2016, there had been a year on year 25 per cent increase in

[29] Statement of Elissa Scott, page 2.
[30] ibid, pages 2, 3.

criminal cases finalised. The Caple report advocated placing limits on the number of cases listed on any given day. It noted the increasing workloads brought delays in hearings and stress to judicial officers in not being able to determine matters as promptly as desired.

57. In June 2018, then Chief Magistrate Lauritsen issued a practice direction to ensure strict adherence to court sitting time between 10.00am and 4.00pm with an hour for lunch. The current Chief Magistrate, Judge Lisa Hannan, is conducting a review of all practice directions, including a review of the starting and finishing times to explore different approaches to address workloads. A new position of Strategic Advisor (Listings and Allocations) has been created to focus on listings and allocation of judicial resources.[31]

58. On the broader topic in the Caple report of the prevention of psychological illnesses from work duties, the response noted the JWC is no longer operating and the Chief Magistrate has assumed responsibility for its functions in consultation with other magistrates and Board of Management. The response noted the Court is committed to maintaining the ongoing relationship with the JCV with a focus on stress, mental health, and wellbeing programs.[32]

59. The response indicated ongoing education of magistrates through the JCV of available wellbeing initiatives, dealing with vicarious trauma, and peer support. It noted the extension of the Judicial Officers Assistance Program for family members of judicial officers,[33] the availability of online mental health programs, and current consideration to training and leadership programs for judicial leaders. In addition, judicial officers receive full medical assessments every two years.[34]

60. The Caple report recommended a review of existing entitlements and allowances. The response noted the finalisation of plans for magistrates assigned to after-hours courts for additional accrued leave and after hours work by volunteers receiving leave in lieu.[35] I note that magistrates now also have the option to purchase additional leave beyond the current four-week entitlement, which has been taken up by approximately 40 per cent of magistrates.

61. The Caple report raised the potential for spreading some existing types of work to judicial registrars. The response indicated the allocation of work between magistrates and judicial registrars is under consideration and judicial officers in leadership roles are provided

[31] Statement of Elissa Scott, page 16.
[32] ibid, page 8.
[33] Statement of Elissa Scott, page 2.
[34] ibid, pages 5 to 11.
[35] ibid, page 13.

additional time out of court. In addition, the Strategic Advisor is examining better support options for magistrates in the country courts including consideration of splitting of existing after-hours roster and the use of duty magistrates from a headquarters Court to take over cases by the use of video-link.[36]

62. The Caple report made further recommendations concerning magistrate safety. The response noted the recent installation of secure docks in a large number of courts, provision of defibrillators, a review whether regional court finishing times need to factor the return journey time for magistrates driving back to a headquarter court, the collation of sick leave statistics, quarterly regional coordinator meetings chaired by the Chief Magistrate discussing health and wellbeing responsibilities, and a commitment to the International Framework for Court Excellence that includes health and wellbeing initiatives.[37]

63. The issue of a review of induction programs for new magistrates was first raised by the former Chief Magistrate when the JWC was established. The Caple report noted a review by the Court was already under way and observed new appointees will have a variety of professional backgrounds and as a result there was a need to tailor the induction and mentoring support appropriately. It noted the program should ensure the occupational health and safety risks associated with the work are recognised with practical guidance about support programs and people available for peer support.

64. The response noted a revised induction program for new magistrates was being finalised subject to consultation with judicial officers and in the interim the program individually designed on the learning needs of the appointee was being overseen by the Chief Magistrate.

65. Finally, the response also noted a number of programs on wellbeing delivered by the JCV in August 2017, March 2018, March 2019, and June and November 2019. A list of wellbeing initiatives prepared by the JCV is also distributed to all judicial officers.

66. In my view, the changes made and those to be made to improve judicial wellbeing by the Magistrates' Court of Victoria in consultation with the JCV following the death of Mr Myall are both timely and significant. I do not consider any meaningful recommendations under the Act can be made.

[36] ibid, page 14.
[37] ibid, pages 17 to 19.

FINDINGS AND CONCLUSION

67. The death of Mr Myall deeply shocked his family, friends and colleagues. It shocked the Victorian and indeed broader legal community. The topic of judicial wellbeing, although known in the past, received comparatively little attention. Following the death of Mr Myall, the topic became a national discussion. Academic research papers, conferences, seminars, and numerous committees within the Courts at all levels turned their attention to judicial wellbeing. I think it fair to say there is a far greater appreciation of the importance of judicial wellbeing and of the critical need to reflect it in the way the Courts operate now and in the future.

68. By way of final comment, the Magistrates' Court of Victoria has stated it is *"committed to embedding a positive organisational culture that promotes the health and wellbeing of its judicial officers and staff".*[38] They are sound and appropriate sentiments that must be matched with positive and continued action to implement various measures to strengthen the health and wellbeing of judicial officers and staff.

69. Having investigated the death, without holding an inquest, I find pursuant to section 67(1) of the *Coroners Act 2008* that Stephen Myall, born 17 June 1958, died on 14 or 15 March 2018 at a quarry at Hobbs Road, Bullengarook, Victoria, from hanging in the circumstances described above.

70. I convey my sincere condolences to Mr Myall's family for their loss.

71. Pursuant to section 73(1) of the Act, I direct this finding be published on the Internet.

[38] Statement of Elissa Scott, page 20.

72. I direct that a copy of this finding be provided to the following:

Joanne Duncan, senior next of kin

Helen Myall

Her Honour Judge Lisa Hannan, Magistrates' Court of Victoria

Sergeant Scott Wakefield, Victoria Police, Coroner's Investigator.

Signature:

IAN JAMES GUY

CORONER

Date: 4 August 2020