



IN THE CORONERS COURT  
OF VICTORIA  
AT MELBOURNE

Court Reference: COR 2018 4528

**FINDING INTO DEATH WITHOUT INQUEST**

*Form 38 Rule 63(2)*

*Section 67 of the Coroners Act 2008*

Findings of: Ian James Guy, Coroner

Surname: Wilby

Given names: Jessica Morgana

Date of birth: 22 January 1973

Death occurred: 7 September 2018

Place of death: Port Melbourne, Victoria

Cause of death: Hanging

## INTRODUCTION

1. Jessica Morgana Wilby was born on 22 January 1973, to Elizabeth and Brian Wilby. Ms Wilby had a younger sister, Caroline. Sadly her father died but it is clear her mother and sister enjoyed a particularly close bond with Ms Wilby.
2. Ms Wilby lived with her partner, Mr Robert Sutton, with whom she had been in a happy relationship for about 14 years.
3. Ms Wilby joined the Coroners Court of Victoria (**the Court**) in 2013 and told friends she had found her dream job. She was certainly well credentialed for her role. She held a Bachelor of Arts (Psychology and Criminology); a Diploma in Educational Psychology, Masters in Forensic Psychology and a Bachelor of Laws. She had worked for the West Australian Police, Crime Commissions and the IBAC.
4. Ms Wilby was widely respected and liked by colleagues, staff and the legal fraternity. In her role as a Principal In House Solicitor, she conducted complex coronial investigations and appeared as counsel in a number of high profile inquests.
5. She has been variously described as being a perfectionist with a prodigious work ethic, friendly, bubbly, sociable and importantly, compassionate to the many grieving families who attend the Court. Her mother described her as a worrier and a light sleeper. She had no prior mental health issues.
6. In February 2018, Ms Wilby took on the role of Acting Senior Legal Counsel as well as continuing in her substantive role. This occurred at a time when the Court was suffering from very significant problems with its operations and culture. The most prominent description of the workplace culture existing at that time was “toxic”.
7. Within a very short period of time, Ms Wilby became highly stressed, withdrawn and began suffering from insomnia. By late April 2018, she had returned to her substantive role but her mental health continued to decline. She commenced sick leave at the end of May 2018 and did not return to full time work again.
8. Ms Wilby was desperate to get better and re-establish her career, one which she hoped one day would lead to her appointment as a coroner. She saw multiple general

practitioners, psychologists, and psychiatrists over a 5 month period and was prescribed numerous medications. The diagnosis was one of a work related major depressive disorder. Her attendance at health professionals increased as the potential return to work approached.

9. On 7 September 2018, Ms Wilby, aged 45 years took her life by hanging.
10. The primary issues that arose in this investigation are -
  - a. Her work duties and the workplace environment
  - b. The medical treatment provided
  - c. The changes made to the work environment to enhance employee wellbeing

#### **THE PURPOSE OF A CORONIAL INVESTIGATION**

11. Ms Wilby's death was a reportable death pursuant to s 4 (2) (a) of the Coroners Act 2008 (the Act), as her death was unnatural or unexpected.
12. Coroners independently investigate reportable deaths, to find, if possible: identity, medical cause of death and with some exceptions, the surrounding circumstances of the death. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities. The law is clear that coroners establish facts; they do not cast blame or determine criminal or civil liability.<sup>1</sup>
13. Under the Act, coroners also have the important function of helping to prevent deaths and promoting public health and safety and the administration of justice through making comments and recommendations in appropriate cases about any matter connected to the death under investigation.
14. The coronial investigation into Ms Wilby's death was assumed by me in my capacity as a reserve magistrate and coroner in Victoria. I also hold the judicial office of magistrate

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<sup>1</sup> 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.

of the Local Court of New South Wales. My appointment arose to avoid any potential conflict of interest given Ms Wilby's employment and close working relationship with the coroners and staff of the Court; a number of whom have made witness statements in this investigation. It has also meant that the legal and registry services of the Court could not be involved. I have been assisted in this matter by the Office of Public Prosecutions.<sup>2</sup>

15. Victoria Police assigned Detective Sergeant Tony Hupfeld as Coroner's Investigator for the investigation into Ms Wilby's death. An exhaustive investigation by Detective Sergeant Hupfeld produced a detailed brief of evidence that included witness statements from family, friends, colleagues, medical professionals and a very large number of exhibits. The brief spans some 5000 pages.
16. After considering all of the evidence, I am satisfied the statutory findings required under the Act can be made and that following consultation with Ms Wilby's family, 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.
17. The breadth of these findings and observations made should be seen against two important factors. First, I am conscious of an independent investigation by WorkSafe and the need under section 7 of the Act to avoid unnecessary duplication of inquiries and investigations that are more properly within the province of WorkSafe<sup>3</sup>. Secondly, I am aware of the need for caution in endeavouring to resolve the many conflicting accounts, claims and counter claims where witnesses have not been called and assessments are unable to be made as to credibility.

#### **IDENTITY OF THE DECEASED**

18. Ms Wilby was visually identified by her partner, Mr Robert Sutton on 7 September 2018.<sup>4</sup> Identity is not in issue in this case and does not require further investigation.

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<sup>2</sup> By both a Managing Principal Solicitor and a Crown Prosecutor

<sup>3</sup> Although the WorkSafe investigation is ongoing, I have determined to proceed to make findings given the time that has elapsed since Ms Wilby's death

<sup>4</sup> Robert Sutton p 168

## **MEDICAL CAUSE OF DEATH**

19. On 8 September 2018, Professor David Ranson, specialist forensic pathologist practising at the Victorian Institute of Forensic Medicine (VIFM), conducted an examination upon the body of Ms Wilby and provided a written report dated 9 September 2018. The examination revealed injuries consistent with hanging. Professor Ranson reported that Ms Wilby's cause of death was compression of the neck in circumstances of hanging.<sup>5</sup>
20. I accept Professor Ranson's opinion as to the cause of death.

## **BACKGROUND**

21. Before turning to the circumstances of Ms Wilby's secondment to higher duties, a brief outline of the organisational structure of the Court operating at the relevant time should be given. At the Coroners level was the State Coroner, Deputy State Coroner and 9 Coroners. They were supported variously by a Chief Executive Officer, an Executive Officer, Principal Registrar, Manager Coronial Prevention unit and Manager Legal Services /Senior Legal Counsel. A large number of staff in turn worked for those in Executive roles.
22. The Court is in turn under the effective management of Court Services Victoria (CSV) whose role is relevantly, to provide or arrange for the provision of administrative services and facilities necessary to support the performance of the judicial functions of the Victorian Courts.
23. Ms. Wilby commenced her employment with the Court as a Principal In House Solicitor (PIHS). Performance assessments for 2013/14 – 2015/16 indicate she was assessed as exceeding expectations.<sup>6</sup> As of February 2018, Ms Wilby had a total leave balance of over 40 days, indicating that she did not take all of her leave annually.
24. The role of PIHS saw Ms Wilby become responsible for some of the most challenging and complex matters within the Court, notably Police contact death cases and unsolved

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<sup>5</sup> Dr Ranson p 134

<sup>6</sup> CCOV Personnel file. No managers' comments appear in the 2017 or 2018 reviews due to a change in system

homicides. The position description for the role states that the PIHS provides *'assistance to Coroners with their investigations into reportable deaths, liaising with many internal and external parties including Victoria Police, the Victorian Institute of Forensic Medicine, families, lawyers and interested parties.'* The role required the incumbent to prepare memoranda of advice for coroners, preparing matters for inquest, appear as counsel assisting at inquests, and appear and instruct in the Court of Appeal on behalf of the Court.<sup>7</sup>

25. Ms Wilby's role in itself demanded very long work hours into the evening and on weekends. It is said she was incredibly committed to and absolutely loved the coronial jurisdiction.<sup>8</sup>
26. In February 2018, a vacancy occurred in the Court for the position of Senior Legal Counsel (SLC). This arose from the sudden departure at the end of 2017 of the lawyer who held the substantive position. Another lawyer acted in the role from 27 December 2017 until mid-February 2018.
27. The position description for the role SLC states that it is to lead Legal Services for all the coroners across Victoria; providing assistance in their investigations, liaising with internal and external parties, preparing advisings, preparing matters for inquest, appearing as counsel, appearing and instructing in appeals, supervise a team of solicitors, provide resources in an efficient and cost effective manner. It involved being part of the Court's Operational Executive team that assists the CEO in driving the strategic direction of the Court.<sup>9</sup>
28. Following an expression of interest, Ms Wilby was chosen for the role. It was seen by her as a further opportunity to advance her career and her aspiration to become a coroner. It was initially to be for a period of 2 to 3 weeks, commencing 19 February 2018 and due to end on 13 March 2018. She continued however to carry out her duties

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<sup>7</sup> Position description PIHS p 1060-3

<sup>8</sup> Coroner Hawkins p 203

<sup>9</sup> Position description p 1045

as a PIHS. The failure to effectively backfill roles was a relatively normal practice in Legal Services and the Court generally.<sup>10</sup>

29. The role of SLC entails both legal and management duties. There was a large case load of complex cases, preparing matters for inquest and or writing complex findings. The management side included managing approximately 15-20 legal services staff, including legal officers /solicitors and the in house legal team.<sup>11</sup> The managerial side included carrying out performance appraisals for staff, leave approval, budgeting and staff recruitment. It has been described as a job that you wouldn't wish on your own enemy.<sup>12</sup> The position was described as having an inherent tension: an expectation of looking out for the best interests of the legal team, whilst simultaneously ensuring that the coroners felt like they were adequately supported.<sup>13</sup>
30. Ms Wilby was in essence performing three roles; the legal role as PIHS, the legal role of SLC and as a manager. It was only after Ms Wilby returned to her original role in April 2018 that the management responsibilities of the SLC were removed and a new role within the Court created.
31. Although Ms Wilby was accustomed to and willingly worked long hours in her previous role, she began working from 8 am to 9 pm and sometimes to midnight.<sup>14</sup> Severe insomnia and rumination began.
32. Almost immediately after commencing the role, Mr Sutton could tell she was becoming stressed. Whilst performing the role: *"Jessica transformed from being a happy, outgoing, articulate, high achiever to withdrawn, anxious and stressed. She shunned any social engagement and the insomnia continued"*.<sup>15</sup>

### **Events of 15 March 2018**

33. The three week period of Ms Wilby acting in the new role and carrying her existing role was due to end, however on 15 March 2018, the then acting Executive Officer, Mr

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<sup>10</sup> Rebecca Johnson-Ryan p 224

<sup>11</sup> Clare Mullen p 228

<sup>12</sup> Rebecca Johnston-Ryan p 220

<sup>13</sup> Ibid p 224

<sup>14</sup> Medical notes p 2249

<sup>15</sup> Robert Sutton p 158

Greene emailed staff to advise that Ms Wilby would continue in SLC role. No end date was specified.<sup>16</sup>

34. That very day, Ms. Wilby was found by staff in a distressed state at work unable to speak and not responsive. She was shaking and incoherent.<sup>17</sup> She was later seen by Mr Greene. She was confused, and unable to communicate. He formed the opinion she was having a sort of breakdown. He took her by taxi to her home where he says, he met Mr Sutton.<sup>18</sup> She was encouraged to stay home for as long as she needed and provided with details of CSV Support Line. Mr Greene stated he notified senior Executives in the Court and at CSV.
35. Consistent with the many observations about her concerns of reputational damage to her career, Ms Wilby felt embarrassed and humiliated by the events of 15 March 2018. She returned to work the following day. She met with her colleagues Alex Cottrell<sup>19</sup> and Laima Panders after work on 16 March 2018.<sup>20</sup>
36. Given the extraordinarily large workload Ms Wilby was carrying at the time, and in a most difficult and stressful work environment that was evident to all, it is unclear why her highly distressed state on 15 March 2018 was not viewed as work related, particularly as in an email from Mr Greene to CSV the preceding day, it was said the role Ms Wilby was undertaking required “significant heavy lifting.”<sup>21</sup>
37. Mr Greene says he made enquiries with a member of the Legal Services Team who, it is said, indicated there were relationship stressors at home and Ms Wilby had been seeking counselling for them. How this incorrect information may have come into existence is not known. Mr Sutton categorically refutes this assertion.<sup>22</sup> The abundant medical reports demonstrate the only stressor in Ms Wilby’s life was her work.

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<sup>16</sup> Email p 2249. Mr Greene commenced his role as Acting Chief Executive Officer on 26 February 2018 until 31 July 2018.

<sup>17</sup> Advice received by Alex Cottrell (p 310), then acting principal registrar from Paul Stevens , Corporate Services Manager

<sup>18</sup> Mr Sutton states (supplementary statement October 2020) he was called and met Ms Wilby at their home and that he has never met Mr Greene

<sup>19</sup> Alex Cottrell p 315

<sup>20</sup> Laima Panders p 330

<sup>21</sup> Greene Email p 2247

<sup>22</sup> Supplementary statement of Robert Sutton October 2020



38. It is evident Mr Greene did contact Ms Goddard of CSV on 15 March 2018 and advised of Ms Wilby's distress.<sup>23</sup> Ms Goddard says she was later told by Mr Greene that Ms Wilby was having time off and the explanation for her stress was relationship issues. It is again unclear how this information came to be. She returned to work the following day and there were no relationship issues.
39. The evidence of Mr Greene that he never heard from Ms Wilby again after the events of 15 March 2018 before going on leave is incorrect.<sup>24</sup> Ms Wilby returned to work the following day and Mr Greene's leave commenced on 3 April. On 2 April 2018, he introduced Ms Wilby to his temporary replacement, Mr Medcroft.<sup>25</sup>
40. Despite the clearly alarming events of 15 March 2018, Ms Wilby's multiple roles and workload at the Court continued unchanged for another five weeks. On 26 March 2018, Ms Wilby consulted her first doctor complaining of significant insomnia and rumination for several weeks over what she needed to do at work in her new role.<sup>26</sup> It was to be the first of many medical appointments as set out later in these findings.
41. The investigation indicates some legal staff made offers to Ms Wilby to assist with her work load.<sup>27</sup> It is said the help was not accepted. The level of potential assistance that could have been given is far from certain. Ms Wilby's desire to maintain her reputation in the eyes of the Court and not be seen as having failed in that role may also have been a factor. It is however evident from a document found in her briefcase after her death that she felt she was not receiving the assistance she needed and that several of the other lawyers had responsibilities and workloads for other members of the Court.
42. Ms Wilby spoke with Coroner Olle in early April 2018. She told Coroner Olle she had approached Mr Greene in March 2018 before he went on leave indicating she wanted to be relieved of the SLC role and that Mr Greene indicated he would take action.<sup>28</sup> Mr Sutton also says he convinced her to tell Mr Greene she was not being properly

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<sup>23</sup> Alicia Goddard p 433. Ms Goddard commenced as Executive Officer, People and Culture CSV on 22.1 2018

<sup>24</sup> Timothy Greene p 256

<sup>25</sup> Bradley Medcroft p 259

<sup>26</sup> Dr Vukasin p 454

<sup>27</sup> Rebecca Johnston-Ryan p 226, Claire Mullen p 232

<sup>28</sup> Coroner Olle p187

supported in the role and wanted to return to her usual role but Ms Wilby was told he didn't have anyone else to perform it.<sup>29</sup>

43. Mr Greene states that he spoke with Ms Wilby about her thoughts on being released from this “*untenable situation*” and returning to her original position; that she assured him she was “all good” and wanted to continue; that she agreed to relinquish files from her substantive position and allocate to others.<sup>30</sup> If, contrary to the information Ms Wilby relayed both to Coroner Olle and to Mr Sutton, she had wanted to continue in that role, it is uncertain why Mr Greene said he attempted to find a replacement for her but was unable to do so before he went on pre-planned leave overseas.
44. In the absence of Mr Greene, Mr Medcroft commenced as Acting CEO on 3 April 2018 until the return of Mr Greene in early May 2018. He says he had been told by Mr Greene, that Ms Wilby is “*someone who gets over stressed*” and “*watch her carefully and move her back to her role if required.*”<sup>31</sup>
45. It became evident to many at the Court in at least April 2018 that Ms Wilby was deeply distressed. Her friend Coroner Hawkins said she became socially withdrawn, her bubbly and social personality was completely gone and she looked physically unwell.<sup>32</sup>
46. In early April 2018, Coroner Gebert spoke with Ms Wilby over her concerns for her welfare. They agreed she needed to move from the role and spoke with the then acting Executive Officer, Ms Barbis.<sup>33</sup> Coroner Olle was also deeply concerned about Ms Wilby following a discussion in early April 2018, in which she indicated that apart from her existing workload, she had been directed to complete Performance Development Plans (PDP's) for all legal staff, for which she had no prior training, as a matter of priority. Coroner Olle relayed his concerns for Ms Wilby's welfare to Mr Medcroft.<sup>34</sup>

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<sup>29</sup> Robert Sutton p 158

<sup>30</sup> Timothy Greene p 251

<sup>31</sup> Summary p. 18; conversation between CI Hupfeld and Mr Medcroft

<sup>32</sup> Coroner Hawkins p 205

<sup>33</sup> Coroner Gebert p 214. Sarah Gebert was in 2018 a Principal in House Solicitor and appointed a Coroner in 2019

<sup>34</sup> Coroner Olle p 188

47. Ms Wilby had also spoken to Mr Sutton about the requirement to complete the PDP's, telling him the half yearly plans had not been completed by her predecessor and she had not supervised any of the solicitors.<sup>35</sup>
48. Mr Medcroft says it was apparent to him Ms Wilby was overwhelmed and that she admitted it was impossible for her to do all the work. He said he raised the issue of re-allocation of her case load but she did not believe it was feasible given its complexity.<sup>36</sup>
49. Mr Medcroft moved quickly and appropriately to create the additional role of manager, legal services; that is removing the legal case load and dealing only with management responsibilities. From 11 April 2018, Mr Medcroft enquired with government and private law firms for someone to take on the new role. Outside recruitment was unsuccessful and the Manager, Coroners Prevention unit was requested to perform the role on a temporary basis.<sup>37</sup>
50. On 13 April 2018, Mr Medcroft sent an e-mail to the then State Coroner Judge Hinchey providing an update on efforts to find someone to take over the SLC role on a temporary basis-
- “I checked in with Jess again tonight and her preference is to hold the fort next week until we can get someone in place .She is understandably concerned re perception of her capability if she were to take leave at a critical moment, or otherwise contribute to leadership instability in the team. I have weighed this carefully against my concerns for her welfare and believe we should keep the status quo another week. I have been very clear with Jess that I am here to help and also that she can take leave if she wants to. I took the PDPs off her (this is a key stressor) and will read through them and consider the best approach over the weekend”.*<sup>38</sup>
51. On 23 April 2018, an email was sent by Mr Medcroft to all staff. It noted Ms Wilby had been acting in the role of SLC for nine weeks, being significantly longer than was anticipated; in that time she has continued carrying most of her substantive case load; she was extremely committed and hard working and had done a difficult task well.

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<sup>35</sup> Robert Sutton p 158

<sup>36</sup> Bradley Medcroft p 260

<sup>37</sup> Michael Boyle p 319

<sup>38</sup> Medcroft Email p 2264

52. On 23 April 2018, Ms Wilby returned to her substantive position of PIHS. She described to her doctor that on return, there was a “*big backlog to catch up on*” and that separation from the acting role as SLC remained incomplete.<sup>39</sup>
53. Her mental health however continued to decline with constant thoughts of failure and reputational damage. On one occasion in late April, Ms Wilby was so distraught that she could not physically speak. She tried to open her mouth but no words came.<sup>40</sup> Coroner Hawkins states she was extremely worried and spoke with others about her concern for her friend’s well-being.
54. On 31 May 2018, Coroner Gebert met with Ms Wilby and advised her staying at the Court was not helping her, that she believed her friend had suffered a sort of trauma during the acting role that needed to be dealt with.<sup>41</sup> She convinced her to speak with the counsellor at the Court, Kathy Gilbert who observed circular thinking and great distress.<sup>42</sup> On 31 May 2018, Ms Wilby left work stating she would never be back.<sup>43</sup>

#### **Events on taking Sick leave**

55. Ms Wilby commenced sick leave on 31 May 2018. Medical certificates were submitted that were non-descript such as unwell and unfit for usual occupation. In June 2018, Ms Wilby indicated to Michael Boyle, then Acting Manager Legal, a desire to ease herself back into work by working from home. In July 2018, her doctor provided to the court some guidelines for a gradual increase in the days working from home and subsequently the number of days working from home. The guidelines anticipated a return to full time work at the Court in October 2018.<sup>44</sup>
56. Apart from enquiries from her friends at the Court as to her welfare, Mr Sutton stated that Ms Wilby received virtually no contact or support from the Court after going on sick leave.<sup>45</sup> Even allowing for her clear reluctance to disclose the nature of her illness,

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<sup>39</sup> Medical records – Psychology Melbourne p 4181

<sup>40</sup> Coroner Hawkins p 205-6

<sup>41</sup> Coroner Gebert p 215

<sup>42</sup> Notes of Gilbert p 2290

<sup>43</sup> Coroner Gebert p 215

<sup>44</sup> Ms Wilby worked 3 days in July and 6 days in August from home

<sup>45</sup> Robert Sutton p 161

Mr Sutton's observation is an eminently fair one. Of equal concern is the state of knowledge of and lack of action taken by CSV.

57. Mr David Ware was the Chief Executive Officer in CSV between 30 January 2017 and 28 September 2018. Although aware of and dealing with an extraordinary number of issues concerning senior personnel from the Court and the ongoing problem of the Court culture, he said: "*no one ever raised issues or concerns with me relating to Jessica.*"<sup>46</sup>
58. Ms Alicia Goddard commenced with CSV in January 2018 as Executive Director, People and Culture. She stated that when she became aware that people were acting in Ms Wilby's role and that she was on extended leave, she did not view this as unusual given the information she received about Ms Wilby's asserted relationship issues. In a meeting on 20 June 2018 with a number of senior employees with the Court she became aware that Ms Wilby had been away from work for a significant period of time, but she said there was no suggestion her absence was due to workplace issues.<sup>47</sup> At the risk of repetition, it is unclear how this incorrect information concerning relationship issues stated by Ms Goddard arose.
59. Ms Goddard says the issue of Ms Wilby's return to work had been raised with her, and that the reason for her absence was a heavy bronchial infection, general exhaustion and relationship issues. She stated: "*I did not understand her absence from work to be associated with workplace issues but rather a physical illness.*"<sup>48</sup> She said she gave advice to the Court concerning a return to work on that basis. It is of particular concern that as of September 2018, being two months after the advice given in June 2018 about a return to work, Ms Goddard says she was unaware that Ms Wilby had not returned to work.<sup>49</sup>
60. It can be reasonably inferred from Ms Goddard's statement that had CSV been aware at any time in those three months, that Ms Wilby's absence was related to workplace issues, a different return to work approach would have occurred. It might also be hoped

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<sup>46</sup> David Ware para 115

<sup>47</sup> Alicia Goddard, CSV, p 447

<sup>48</sup> Ibid p 447

<sup>49</sup> Ibid p 452

that significant and meaningful action within the Court would have been taken by CSV and importantly, re-assurance provided to Ms Wilby.

61. In any event, whilst at home, Ms Wilby's condition continued to deteriorate with obsessive thoughts about what had happened at the Court and its impact upon her career. It was during her time on sick leave that she disclosed to her partner a serious failed suicide attempt at home. Despite being told to tell her doctors, she failed to do so.
62. On 23 July 2018, Ms Wilby was found by her family in a severe catatonic like state and taken to the Austin Hospital. There was a diagnosis of serotonin syndrome caused by the interaction of several of the drugs she was taking. She was discharged some three days later.
63. Medication changes continued but without success and with it, regret from Ms Wilby that she should have given the other medication more time to work.
64. Mr Sutton said Ms Wilby became increasingly concerned her sickness may have an adverse effect on her future career prospects. No amount of reassurance could convince her otherwise. She refused to submit a WorkCover claim and continued to use her sick leave and paid her own doctor's bills.<sup>50</sup>
65. As the date for her planned return to work approached, the number of medical appointments increased. Ms Wilby had four appointments within two days a matter of days before she was initially due to return to work on 2 July 2018, and her suicide occurred three days before she was due to return to work at the Court in September 2018.
66. In a medical appointment on 4 September 2018, three days before her death, Ms Wilby identified a perpetuating stressor as her pending decision to pursue a WorkCover claim and running out of sick leave. Her doctor noted she seemed to understand it would be difficult for her to return to work in her mental state but at the same time she hoped she could do so in order to preserve her job and reputation.<sup>51</sup>

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<sup>50</sup> Robert Sutton p 159

<sup>51</sup> Dr Kumar p 497

67. In the days leading up to her death there were lengthy discussions and messages with her family concerning her limited options. Ms Wilby came to the view she was not fit to return to work and was planning to either ask for twelve months leave without pay or to lodge a WorkCover claim. Either option brought with it more anguish as she believed it would adversely affect her career prospects with the Court. As she said to her mother: *“I’ve fucked everything up (her reputation). Everyone will know I have mental health issues /anxiety”*.<sup>52</sup>

68. On 7 September 2018, Mr Sutton arrived home about 7 pm to find Ms Wilby deceased. A suicide note was found nearby.

### **Insights from Ms Wilby about the new role and work environment**

69. A work briefcase belonging to Ms Wilby was located after her death. It contained a number of documents written by her including draft messages and summaries of her thoughts. They provide a valuable insight into how Ms Wilby viewed the new role at work and the work place environment.

70. It is evident Ms Wilby had reviewed the proposed job description for the new and separate management role planned by Mr Medcroft. In a briefcase document, she had -

- Identified a structural issue with the conflict in the Senior Legal Counsel role being responsible for managing Legal Services staff as well as providing senior legal advice and managing complex cases.
- Indicated she strongly believed that the position needed to be divided to ensure the essential work of the Court is done.
- Stated the current workload has been too great for her, as it had for her predecessor which she saw as being a structural issue of a position whose responsibilities are impossible for a single person to complete - which is untenable and she believed this was obvious to the Court.

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<sup>52</sup> Caroline Wilby p 177

- Said there had been an acknowledgement that she had been “set up to fail.”<sup>53</sup>
71. One document lists her thoughts such as: *staffing priorities, short term contracts, temps not trained, findings below standard, coroners unhappy, caseload and manager and email overload.*
72. The many management responsibilities were of major concern to her. She was stressed over and struggled with the uncertainty she saw concerning budgets, funding and recruitments. A document in the briefcase noted: *“the issue that I have when I started in this position I asked for an up to date organisational chart and there didn’t seem to be one. No one seemed sure what was business as usual.”*
73. In another document, Ms Wilby stated :
- “I have been told that I will be acting in the role for about 3 months and the intent is to recruit an external legal manager. I presume I will then return to my position... If I am to act in this position and deal with my usual in-house work I need support...”*<sup>54</sup>
74. An undated document in the briefcase noted a number of matters including –
- *Support for Coroners stretched;*
  - *Bandaidd approach to issues immediately evident since December, too much for one person;*
  - *Challenges increased as substantive position not backfilled and had to do both jobs–not feasible when legal team needs a lot of assistance ; and*
  - *Support sporadic due to absences, admin. tasking- level 5 judges resources.*
75. Below those observations is found a heading “*Layers*”, being things she was required to do -
- *Day to day m’ment;*
  - *Development of team-jnr and immediate requirements;*
  - *Executive m’ment / leadership group;*
  - *Advice across Court-seniority stretched; and*

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<sup>53</sup> Exhibit JW4 p 2688

<sup>54</sup> Exhibit MBS5 p 2678



- *Support: second + train + bring up to speed.*<sup>55</sup>

76. Perhaps the following document summarises her thoughts :

*“I agreed to take on this role because I really wanted to do it and who (sic) my potential to assist in th[e] current situation and knew I could do a good job of it. I knew I was walking into a dysfunctional team with a host of issues but saw it as a challenge and opportunity and something I could improve with the necessary support*

*I feel this had been challenging for: --*

- *My substantive position was not backfilled so I effectively have had to try and do both jobs which is not feasible and this is at a time when the legal team needs a lot of dedicated time*
- *Any usual support to this role has been sporadic and there has been no other support provided.*

*In the above circumstances I feel that this position is untenable.”*<sup>56</sup>

77. The documents in the briefcase reveal with clarity, Ms Wilby’s ability to identify the inherent problems with the role of SLC. How this was not seen by others and addressed much sooner is not known.

### **Information Ms Wilby provided to medical professionals about the Court**

78. Further insights into how Ms Wilby felt about her new role and the work place environment can also be found in the numerous medical reports.

79. A consistent narrative was given to each of the many professionals as to the reason for her stress and its cause. General Practitioners Dr Vukasin and Dr Sharma were told of insomnia arising from an increased workload and acting in a more senior role.<sup>57</sup>

80. To Ruth Perkins (psychologist), Ms Wilby said of the Court: *“it’s a toxic environment at work and has been for a while.”*<sup>58</sup>

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<sup>55</sup> Exhibit JW 5 p 2690

<sup>56</sup> Exhibit JW3 p 2686

<sup>57</sup> Statement of Dr Vukasin p 454

81. To Catherine Hogan (psychologist), she describes stress of work and a toxic environment.<sup>59</sup>

82. Ms Wilby attended Dr Mrdja-Getlinger (Psychiatrist) for the first time on 8 June 2018 and reported that she was:

*“...very stressed by her new position, needing to work quite hard in order to meet all the deadlines...For the first time she felt disappointed with herself and started to regret the decision of stepping into the new role. She worried about her reputation at work after she was demoted back to her position, when her struggle became obvious.”*<sup>60</sup>

*“ Jessica described the change was difficult and significant as she found herself needing to manage a relatively big team of 24 people on short notice at the volatile and disharmonious times, whilst the culture and leadership style also changed with arrival of the new CEO.”*

*“Her relationship with the new CEO was not good since the newly introduced working culture was very tough and she stated on a few occasions she was yelled at.”*<sup>61</sup>

83. On 28 June 2018, Ms Wilby attended upon Dr Trevor Rule (Psychologist) - whom she saw once, cancelling appointments scheduled thereafter. She reported:

*“...that there had been substantial changes in her workplace since January, including changes in several senior management and other key staff position, which Ms Wilby said were the cause of significant uncertainty and had been stressful for herself and other staff..” and “..some staff had been particularly uncooperative.”*<sup>62</sup>

84. Clinical notes of Dr Rule record Ms Wilby indicating it was impossible to do two jobs :

*“She began working from 9 am to 9/10 pm and after about 3 weeks she began not sleeping. When she returned to her own job, she still had to cover parts*

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<sup>58</sup> Statement of Dr Perkins p 469

<sup>59</sup> Catherine Hogan p 467

<sup>60</sup> Statement of Dr Mrjda-Getlinger p 473

<sup>61</sup> Report of Dr Mrjda-Getlinger p 4078

<sup>62</sup> Ibid p 478

*of the other job on an ongoing basis. There was a huge backlog, she couldn't delegate, her work began to slip and she was not working in accordance with her values".*<sup>63</sup>

85. Importantly, Dr Rule describes the following:

*"Ms Wilby described feeling compelled to continue with the additional role to which she had been temporarily promoted, although she was finding the role quite stressful. She described a significant backlog of manager tasks and a lack of clarity in organisational structure as contributing to this stress. The reported consequence of this stressful period included; lengthy work hours, sleeplessness and noticeable weight loss. A further cause of distress for Ms Wilby was learning that the recruitment process for the role of Legal Manager had been started and it appeared to Ms Wilby that she would not be considered for the role. Reportedly in May 2018 Ms Wilby requested that she return to the role she was in prior to February and this request was granted."*<sup>64</sup>

86. When there was an initial planned return to work on 2 July 2018, Dr Rule noted:

*"The prospect of returning to work, and the consequences of having to take time away from work due to the impact of the demands of the workplace, were also troubling Ms. Wilby. It was noted that Ms. Wilby described herself as being very self-critical and setting high standards for herself. She seemed particularly concerned that the events of the past months would have had a negative impact on her career path".*<sup>65</sup>

87. On 14 August 2018, Ms Wilby met with Professor Malcolm Hopwood at Albert Road Clinic, who diagnosed her as suffering from a Major Depressive Episode, noting the probability of mild Generalised Anxiety Disorder with perfectionistic personality traits. He considered that the stress within her role at the Court had acted as a significant precipitation.<sup>66</sup>

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<sup>63</sup> Notes of Dr Rule p 4175

<sup>64</sup> Ibid p 479

<sup>65</sup> Ibid p 479

<sup>66</sup> Dr Hopwood p 493

88. On 4 September 2018, Ms Wilby reported to Dr Shakira Kumar (Psychiatrist), that her difficulties:

*“...started in February 2018 in the context of workplace restructure, increased workplace responsibilities and demands, and staffing issues (including new management who Ms Wilby felt targeted by). Ms Wilby described a significant increase in stress and deterioration in sleep resulting in chronic insomnia.”<sup>67</sup>*

89. It can be seen from the above brief outline of the medical reports that a constant theme emerged. Ms Wilby felt unsupported at the Court, that the demands placed upon her in the new role were plainly too great and in a work environment that she and many others have described as “toxic”.
90. Ms Wilby also confided with her family. Each formed the view she was unsupported at work; that a large volume of work had been given to her without providing her with any assistance and that there were unrealistic expectations placed upon her.<sup>68</sup>

### **The workplace environment**

91. It can be seen Ms Wilby was deeply concerned about the work place environment. A sense of the turmoil that existed at the Court can be gleaned from the fact that those on long term sick leave, excluding Ms Wilby, included the former Chief Executive Officer, the former Principal Registrar, the former Senior Legal Counsel and an Acting Principal Registrar. There appear to have been 4 Acting CEO’s within months from late 2017 to February 2018. Numerous legal staff had also left the Court in the preceding 2 years.
92. Evidence that the operation and culture of the Court was, at the time dysfunctional, comes not just from statements of individuals gathered in the investigation, nor just from Ms Wilby. It is to be observed that from 2017 to 2018 there have been no less than 4 reports and or reviews commissioned into the workings of the Court.

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<sup>67</sup> Dr Kumar p 498

<sup>68</sup> For example Mr Sutton p 158, Elizabeth Wilby p 170,p171, Caroline Wilby p 175, p 176

93. It is evident that difficulties within the Court were not limited to the time Ms Wilby took on the new role, but can be traced back to at least 2015. The composition of the Executive of the Court has obviously changed over that period.
94. In 2015, external management consultants were engaged to produce a Staff Cultural and Engagement Survey. The results could fairly be described as alarming with statements of dissatisfaction of the work place culture, unaddressed inappropriate behaviour by some and very low morale.
95. The extent to which the Court responded to the 2015 review is not known, as is the knowledge of and response if any, by CSV.
96. In November 2017, a number of senior personnel were introduced by the Court as part of an “operational review team”.<sup>69</sup>
97. Separate to the review team, Colin Galston, a Principal Risk Officer with CSV began reviewing compliance by the Court with legislative requirements to address Risk Management in the workplace. On 8 August 2017, a workshop was held with a number of the Executives of the Court. They expressed “review fatigue” and that his work would not result in any changes as previous reviews had been ignored.<sup>70</sup>
98. In October 2017, Mr Galston commenced a series of workshops with staff from the Court. He was again met with a number of them complaining of “review fatigue” and expressing a lack of faith that anything would change. It became clear over the subsequent weeks “...*there were considerable problems, unhappiness and frustration...*” at the Court. Mr Galston also formed the view that the Court was not running well or effectively and staff were extremely unhappy.<sup>71</sup>
99. Among the many concerns expressed by Court staff to Mr Galston were:
- Mistrust across the Court;
  - Vicarious trauma;
  - Lack of clear roles and responsibilities;

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<sup>69</sup> Dianne Barbis as Executive Officer from November 2017 and Timothy Greene as Chief Executive Officer from February 2018

<sup>70</sup> Colin Galston p 394

<sup>71</sup> Colin Galston p 401

- A toxic culture;
- Work being restructured and reallocated without consultation;
- Staff being brought in on short term contracts and high staff turnover;
- Lack of accountability; and
- Staff unhappy and frustrated; issues about behaviours of some colleagues.

100. The completion of the Risk Register stalled with the departure of a number of senior staff and increased tensions within the Court.<sup>72</sup> It is evident that Mr Galston was deeply troubled about the information he received and for the welfare of Court staff and did all he could to bring those concerns to the attention of CSV.

101. Ultimately, CSV engaged Dr Fullerton of Rushall Consulting Group to carry out Executive development work with the Court. During February 2018, he met with a number of staff and judicial officers. Regrettably, that review ended after Dr Fullerton tendered his resignation from the project. He observed in his e-mail dated 28 February 2018 to the Court that it was the first time he had taken this course with a client and that he had not taken the decision lightly.<sup>73</sup>

102. Thereafter, yet a further extensive external review was commissioned by CSV in 2018. The Human Synergistics Report produced in April 2018 focused on work place culture and safe work environment. In relation to the legal team, the following findings were made:

- The current culture is low;
- Member role clarity is below average;
- Member role conflict is above average
- Quality of service is below average; and
- Employee satisfaction is below average.<sup>74</sup>

103. These results ultimately prompted the engagement by CSV of Mr Vince Scopelliti, from Wise Workplace Consulting to undertake a review of the Court. Commencing in

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<sup>72</sup> Colin Galston p 415

<sup>73</sup> Dr Fullerton email p 3635

<sup>74</sup> Report p 3634-3875

August 2018, Mr Scopelliti reported on his findings to the Court’s executive and staff in early December 2018 (after Ms Wilby’s death).

104. Mr Scopelliti identified a large number of issues including:

- A lack of communication by management contributing to a culture of distrust, gossip and negativity;
- Behavioural issues by some including bullying, harassment and verbal abuse;
- A failure to create a safe workplace; and
- A lack of proactive management of vicarious trauma and a lack of someone to talk to.<sup>75</sup>

105. Apart from the reviews referred to above, there was an acknowledgment in a Health and Wellbeing Plan created by the Court following the death of Ms Wilby :

*“Additional challenges such as organisational culture, persistent change particularly in the leadership of the Court and uncertainty around key positions has elevated levels of workplace stress, potentially leading to compromised levels of health and wellbeing.”<sup>76</sup>*

106. The purpose of these observations of the work environment is not to act as a review of the management practices of the Court. Nor is it suggested that all staff felt aggrieved or that a single individual or a particular cohort of the Executive were responsible. It is simply to underscore the disturbing workplace culture that existed at the time Ms Wilby assumed higher duties, how she perceived the level of support, how the issue of the culture within the Court figured so prominently in her dealings with her doctors and may well explain why she was dreading returning to the Court.

## **The medical care of Ms Wilby**

107. The second significant issue to arise in the investigation was the medical care provided.

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<sup>75</sup> Summary p 78

<sup>76</sup> Health and wellbeing Plan 2018-2019 p 3918

108. When Ms Wilby became depressed, it is evident that, as she said to her sister, she was looking for “*a magic wand*” to resolve her issues.<sup>77</sup> An indication of her stress and distress is to be gleaned from the fact that over a five month period she had 39 medical appointments with seven GP’s, three psychiatrists and four psychologists and was searching for an immediate solution to her problems including seeing multiple practitioners on the same day.<sup>78</sup> It is highly likely she was not disclosing her attendances to other professionals.
109. Ms Wilby complained about medications not working after only very short periods of taking them. Mr Sutton has noted that a careful record was kept of the medications and their use by Ms Wilby.<sup>79</sup> The problem however with the multiple and frequent medication changes was according to Dr Cidoni, the difficulty for a stabilisation of the medical levels and for an assessment of the response to the various agents.<sup>80</sup>
110. Ms Wilby seemed most reluctant to take up the advice of several professionals to being admitted to hospital. Although, as Dr Cidoni notes, she was making enquiries about extending her insurance to cover hospitalization, so that reluctance may not have been absolute.
111. What is plain is that Ms Wilby was deeply concerned about the impact that any treatment, particularly a hospital admission, might have on her future career ambitions of becoming a Coroner. This appears to have been an overarching concern seen to govern many of her choices and perhaps also her desire to return to work sooner than advised and her efforts to find ‘a magic wand’.
112. Psychiatrist Dr Anthony Cidoni was engaged in this investigation to review the extensive medical material and concluded there were 3 diagnoses -
- i. Major depressive disorder, single episode in the context of difficulties at work;
  - ii. General anxiety disorder; and

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<sup>77</sup> Text message 5/7/18 p 2350

<sup>78</sup> Report of Dr Cidoni p 504

<sup>79</sup> Supplementary statement of Robert Sutton October 2020

<sup>80</sup> Ibid p 523



- iii. Obsessive-compulsive personality traits in terms of perfectionism and tendency to ruminate over problems.
113. Dr Cidoni stated the personality traits were unlikely to be a disorder as such due to the lack of history of previous functional impairment. He noted however the personality traits drove the depression and anxiety and made it much more difficult for her to cope with the workplace situation.<sup>81</sup>
114. There was also little monitoring of compliance with her medication; Dr Cidoni noting that she did not have any prescribed antidepressants in her system.<sup>82</sup> There were a total of seven prescribers of antidepressants, hypnotics and antipsychotics, making it difficult in liaison and continuity of care. It is clear polypharmacy contributed to the serotonin syndrome and her subsequent admission to Hospital in July 2018 and it is certainly possible both the effects of the medications and withdrawal of these exacerbated her anxiety and insomnia.<sup>83</sup>
115. Mr Sutton has expressed concern about advice given by a health professional to Ms Wilby as to the use of one of the medications.<sup>84</sup> I am satisfied however, based upon Dr Cidoni's comprehensive review of all the medical material that I should accept his opinion that the treatment of a combination of psychological therapies and antidepressants was consistent with the clinical guidelines for the management of major depression.<sup>85</sup>
116. Dr Cidoni also observed the large number of health professionals seen by Ms Wilby meant that she spent much of the clinical time repeating her story rather than delving into the deeper issues.<sup>86</sup>
117. Regrettably, there was no disclosure to the hospital or to the many treating professionals of her recent suicide attempt at her home. I am satisfied such a disclosure would have markedly increased her level of risk, have led to a change in her management plan and the potential for inpatient admission for a comprehensive

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<sup>81</sup> Dr Cidoni p 517

<sup>82</sup> Ibid p 522, p172

<sup>83</sup> Ibid p 520

<sup>84</sup> Supplementary statement of Robert Sutton October 2020

<sup>85</sup> Dr Cidoni p 526

<sup>86</sup> Ibid p

review and assessment.

118. The reason for her non-disclosure is to found in a message to her sister on 1 September 2018 that read :

*“I would contemplate the hospital if there could be some benefit-and it’s pointless now considering my state in which I’ll try anything but I think if I get admitted I can kiss the judicial appointment I was aiming for goodbye”.*<sup>87</sup>

119. Dr Cidoni turned to the issue of obsessional thoughts and her feeling she would not get better, noting she :

*“Understandably, wanted a quick fix and her tendency to perfectionism undoubtedly resulted in a rapid assessment of the utility of the intervention. It also appeared that she did not feel reassured that the episode would pass, that she would return to normal and that she needed to give medications and psychological interventions more time.”*<sup>88</sup>

120. Significantly, Dr Cidoni identified there was a failure to specifically target the obsessional thoughts regarding self-perception that she had failed, would not get better or be able to return to work and had suffered reputational damage.<sup>89</sup> He said she was obsessed with a toxic workplace. In Dr Cidoni’s opinion, the belief that she would not get better and she believed had become worse as a result of the medication: *“is a critical underpinning of the desire to suicide”.*<sup>90</sup>

121. These thoughts, he said, reflected a distorted thinking and catastrophizing. Dr Cidoni considers they were a very significant driver of her distress and there appears to have been little specific intervention around these thoughts.<sup>91</sup>

122. Finally, Dr Cidoni opined whether Ms Wilby’s role in the Court dealing with cases of mental illness and suicide weighed on her stress about returning to work. He said her previous experience of cases of suicide may have contributed to her thinking she

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<sup>87</sup> P 2320

<sup>88</sup> Dr Cidoni p 518

<sup>89</sup> Ibid p 522

<sup>90</sup> Ibid p 524

<sup>91</sup> Ibid p 524

would not get better and that it appears likely she had a fear of suicide as a possible outcome of her situation. This important observation is relevant given the issue of lack of attention to vicarious trauma was raised in some of the reviews of the Court.

123. I accept Dr Cidoni’s opinion that Ms Wilby treatment was appropriate and in line with standard practices, subject to the limitations that were placed on the ability of the medical professionals to adequately treat her, given the number of professionals she saw and the sporadic and inconsistent nature of many of those visits. I am satisfied there were no missed opportunities in her medical care and that no meaningful recommendations can be made.

### **COMMENTS PURSUANT TO SECTION 67(3) OF THE ACT**

124. Given the compelling connection between Ms Wilby’s mental illness and her work, it is important to consider the changes made within the Court to enhance and improve the wellbeing of staff.
125. In September 2018, following the death of Ms Wilby, members of the Executive of the Court, CSV and the Judicial College of Victoria formed a Wellbeing Steering Committee with the aim of developing and implementing an ongoing Health and Wellbeing Plan.<sup>92</sup> Using as a base, the deficiencies in the workplace culture identified in the Wise review, the 2018 – 2019 Plan aimed to achieve a healthy and productive workplace culture through protection and prevention, better work systems, promotion and awareness and support.<sup>93</sup> The plan was extended to 2020 with an anticipated external review of the effectiveness of the plan.
126. To address vicarious trauma, in addition to the existing Employee Assistance Scheme, staff are provided with access to four sessions each year with an external psychologist.
127. A functional review of the structure of the Court was commissioned in 2019 by external advisors. Among the recommendations was a restructure of the Legal Services section to enhance supervision and strengthen line management.

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<sup>92</sup> This has now been amalgamated into the Health, Safety and Wellbeing Committee

<sup>93</sup> Health and Wellbeing Plan p 3945

128. Significant structural changes have occurred within the Court with the creation of the role of Director, People and Wellbeing; a Health and Wellbeing Advisor; a Risk Management Committee<sup>94</sup> and a Health, Safety and Wellbeing Committee.<sup>95</sup>
129. The Chief Executive Officer, Ms Gale has outlined a number of programs presented to staff; among them: -
- Programs directed on mental health and vicarious trauma;
  - A proposed peer support program is envisaged in 2021;
  - A supervisors and manager training program that emphasises the obligations under the Occupational Health and Safety Act, and
  - A refreshed induction program that deals with addressing complaints, code of conduct and workplace respect.
130. Operational Risk Registers and a health and wellbeing intranet page have been created that has links to programs, support services and resources.<sup>96</sup> A number of informal health and wellbeing initiatives have been introduced to enhance morale. A new strategic plan and values statement is being finalised that aims to guide conduct, behaviour and culture.
131. The structural changes within the Court and the introduction of varied programs that have as their focus the health and wellbeing of staff have been considerable. I do not consider that any meaningful recommendations to enhance staff wellbeing within the Court can be made.
132. It is reassuring to note the Chief Executive Officer's statement that under the leadership of the new State Coroner Judge Cain, ensuring staff have a safe, fair and predictable workplace has been a core accountability and focus of the Court. It was also noted that there is a growing culture of trust, confidence and optimism at the Court.<sup>97</sup>

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<sup>94</sup> The Risk Management Committee role includes recording and managing of health and safety risks

<sup>95</sup> The Wellbeing committee merged to this new committee; comprising court staff, an external psychologist and representative of judicial college of Victoria

<sup>96</sup> Caroline Gale; statement 13 October 2020 p 5

<sup>97</sup> Carolyn Gale; statements 20 December 2019 and 13 October 2020

## CONCLUSION

133. What was a dream job for Ms Wilby turned within a matter of weeks to an unimaginable nightmare. With no prior mental health issues and with the responsibilities of a new work role, Ms Wilby changed from a high achieving, vibrant, vivacious individual to one suffering from an acute mental illness. Desperate to get better she began a merry go round of multiple doctors and medications. It is undoubtedly the case this exacerbated her condition and reduced her prospects of recovery.
134. It would however be simplistic and wrong to view her death as a case of a lawyer who merely struggled with a difficult management role and who should have stayed with a single doctor. It would also be wrong to view her perfectionist trait or concern for her reputation in the Court as a failing on her part. It should be remembered Ms Wilby suffered a work related major depressive disorder. The work place and its culture at the time, was deeply flawed.
135. The role of Senior Legal Counsel was patently beyond the capacity of one person yet she also carried her existing role of Principal In House Solicitor. The event of 15 March 2018 where Ms Wilby had a breakdown at the Court was plainly work related, yet after returning to work the next day she continued with her responsibilities unchanged for another five weeks. Whilst on sick leave for three months, with the exception of her work friends, the lack of support from the Court and from CSV was stark. The pressure she felt she was under at work and her distress about the workplace environment is compelling. As Dr Cidoni observed: *“The very severe and enduring nature of Ms Wilby’s anxiety about the workplace and returning to work is noted.”*<sup>98</sup>
136. The Coroners Court holds a unique position in the justice system. It seeks to find the truth, to effect change where needed and to bring closure to grieving families. There are an extraordinary number of dedicated people in this jurisdiction who work towards these ideals. One of them was Ms Wilby. Her identity was, as her sister Caroline observed, tied to her role and she was proud of what she did.<sup>99</sup> On any view, Ms Wilby was entitled to and deserved far better.

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<sup>98</sup> Dr Cidoni p 189

<sup>99</sup> Caroline Wilby p 178

137. It is hoped that the family may take some small comfort in knowing that significant changes have been made to the structure and work environment of the Court that will enhance and improve the wellbeing of staff.

138. Having investigated the death without holding an inquest, I find pursuant to s 67(1) of the *Coroners Act* that Jessica Morgana Wilby, born 22 January 1973, died on 7 September 2018 at her home in Port Melbourne from hanging, in the circumstances described above.

139. I convey my sincere condolences to Ms Wilby's family for their loss.

140. Pursuant to s 73(1) of the Act, I direct this finding be published on the internet.

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

Robert Sutton, senior next of kin  
Elizabeth Wilby  
Caroline Wilby  
His Honour Judge Cain, State Coroner  
Chief Executive Officer, Court Services Victoria  
Detective Sergeant Hupfeld, Coroner's Investigator

Signature:



**IAN JAMES GUY**

**CORONER**

6 November 2020

