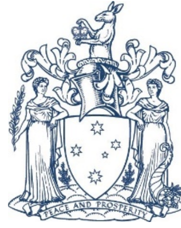

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2018 006287

FINDING INTO DEATH FOLLOWING INQUEST

Form 37 Rule 63(1)

Section 67 of the ***Coroners Act 2008***

Inquest into the Death of Nicola Jane Stephens

Delivered On:	12 September 2023
Delivered At:	Melbourne Coroners Court
Hearing Dates:	12 September 2023
Findings of:	Judge John Cain, State Coroner
Representation:	Lindsay Spence Counsel Assisting the Coroner Principal In-House Solicitor Coroners Court of Victoria
Keywords	Unsolved homicide, no persons charged, inflicted by a person or persons unknown

I, Judge John Cain, State Coroner, having investigated the death of Nicola Jane Stephens, and having held an inquest in relation to this death on 12 September 2023 at Melbourne Coroners Court find that the identity of the deceased was Nicola Jane Stephens born in England on 20 December 1971 and the death occurred on 15 December 2018 at the 'Park Towers', 332 Park Street, South Melbourne from a single stab injury to the abdomen inflicted by a person or persons unknown.

INTRODUCTION

1. On 15 December 2018, Nicola Jane Stephens ('Nicola', also known as Nicole Stephens) was 46 years old when she passed away from a single stab wound to the abdomen inflicted at the 'Park Towers', 332 Park Street, South Melbourne. Nicola resided within apartment 242 (Level 24) with her partner, John Willis. Also living in the apartment at the time was Rhys Brown and Daniel Hinds (who had been sleeping on the couch within Willis' apartment). Nicola's ex-partner Joseph Kiss resided within the same tower apartment block on Level 5.
2. Nicola was born in England on 20 December 1971 to Pauline and Eric Stephens, younger sister to Sherrie. In 1983 the Stephens family emigrated to Australia and Nicola later attended Brentwood High School, Glen Waverley. She gained a love affair with horses at an early age which remained with her throughout her life.
3. After leaving school she gained employment working in the office of a garden care and tree lopping business and then later became a receptionist for a company that her father was managing. She then served for a period of time within the Australian Army prior to leaving and gaining employment teaching children to ride horses.
4. Regrettably Nicola's life spiralled downhill after moving back to Melbourne and she developed a serious alcohol dependency that remained with her for the rest of her life, except for a stint with Alcoholics Anonymous and the Melbourne Alcohol Recovery Centre. She gradually lost touch with her family who had not seen her for approximately two years at the time of her passing although she would contact her mother every few weeks and talk with her on the phone.

THE CORONIAL INVESTIGATION

5. Nicola's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* (the Act). Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

6. 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.

7. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

8. Victoria Police assigned Detective Leading Senior Constable Adam Burnett and Detective Sergeant Anthony Hupfeld, Homicide Squad to be the Coroner's Investigator for the investigation of Nicola's death. The Coroner's Investigator compiled a brief of evidence that was filed with the Coroners Court in June 2021.

9. Pursuant to s52(2)(a) *Coroners Act 2008* an inquest into Nicola's death was mandatory as I suspected the death was the result of homicide. Further the exception in s52(3)(b) was not available as no person had been charged with an indictable offence in respect of the death being investigated by the coroner. An Inquest was held on 12 September 2023 however pursuant to s64 I declined to call evidence from any witnesses.

MATTERS IN RELATION TO WHICH A FINDING MUST, IF POSSIBLE, BE MADE

Circumstances in which the death occurred

10. On Saturday 15 December 2018, at 5.02pm a triple zero call was received from Daniel Hinds (who was using the mobile phone of John Willis). Ambulance Victoria initially prioritised the job as a 'code 1' life threatening emergency requiring an urgent response however, based on the responses provided by Daniel Hinds, an AV Duty Manager downgraded the job to a 'code 3' non urgent dispatch. Responding Paramedics therefore restocked their vehicle with medical supplies prior to departing St Vincent's Hospital at 5.10pm, arriving at the 'Park Towers', 332 Park Street at 5.54pm due to significant traffic delays.

11. Upon attending outside Apartment 242, AV Paramedics located Nicola Stephens deceased, lying in the corridor. They immediately requested assistance of Victoria Police who, upon their attendance, established a crime scene that was forensically examined.

12. Victoria Police arrested four persons that evening, being John Willis, Daniel Hinds, Rhys Brown and Joseph Kiss, all who were interviewed in respect of the matter.

13. Homicide Squad Detectives have filed with the Coroners Court an extensive brief of evidence compiled from the investigation undertaken. To date no person has been charged with any offence in relation to the death of Nicola Stephens.

14. Section 67(1) *Coroners Act 2008* requires me, in discharging my statutory functions, to find, *if possible*, the circumstances in which the death occurred. On the basis of the brief of evidence as it currently stands, I am unable to do so, other than to find that Nicola Stephens died from a single stab injury to the abdomen inflicted by a person or persons unknown. Nicola's death remains an unsolved homicide and I do not propose to discuss the evidence as it stands, so as not to prejudice any future criminal proceedings, were further information to come to light at a later date that would facilitate charges being laid in respect of Nicola's homicide.

Identity of the deceased

15. On 19 December 2018, Nicola Jane Stephens (also known as Nicole Stephens), born 20 December 1971, was identified via fingerprint comparison. Identity is not in dispute and requires no further investigation.

Medical cause of death

16. Forensic Pathologist Dr Michael Burke, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 16 December 2018 and provided a written report of his findings dated 8 February 2019.

17. The autopsy examination revealed a stab injury to the abdomen whilst no typical defensive type injuries were seen to the deceased.

18. Toxicological analysis of post-mortem samples identified the presence of ethanol, methylamphetamine, amphetamine, olanzapine, doxepin and the metabolites of cannabis.

19. Dr Burke provided an opinion that the cause of death was 1 (a) SINGLE STAB INJURY TO THE ABDOMEN.

FINDINGS AND CONCLUSION

20. Pursuant to section 67(1) of the *Coroners Act 2008* I make the following findings:

    a) the identity of the deceased was Nicola Jane Stephens, born 20 December 1971;

    b) the death occurred on 15 December 2018 at 'Park Towers', 332 Park Street, South Melbourne, Victoria, from a single stab injury to the abdomen; and

    c) on the available evidence I am unable to find the circumstances in which Nicola's death occurred, other than to find that she died from a single stab injury to the abdomen inflicted by a person or persons unknown.

21. I convey my sincere condolences to Nicola's family for their loss.

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

    a) Ricki Wilcox, Nicola's son and Senior Next of Kin

    b) Pauline and Eric Stephens, Nicola's parents

    c) Shane Patton APM, Chief Commissioner, Victoria Police

    d) Detective Sergeant Tony Hupfeld, Homicide Squad, Coroner's Investigator

Signature:

Judge John Cain
State Coroner
Date: 12 September 2023

NOTE: Under section 83 of the ***Coroners Act 2008*** ('the Act'), a person with sufficient interest in an investigation may appeal to the Trial Division of the Supreme Court against the findings of a coroner in respect of a death after an inquest. An appeal must be made within 6 months after the day on which the determination is made, unless the Supreme Court grants leave to appeal out of time under section 86 of the Act.