IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2010 002064

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
*Section 67 of the **Coroners Act 2008***

I, JUDGE IAN L GRAY, State Coroner, having investigated the death of NICOLE JOY MILLAR without holding an inquest:

find that the identity of the deceased was NICOLE JOY MILLAR
born on 30 May 1968
and that the death occurred on 1 June 2010
at the Alfred Hospital, 55 Commercial Road, Melbourne Victoria 3004
from:

I (a) COMPLICATIONS OF CUTANEOUS BURNS.

Pursuant to section 67(1) of the **Coroners Act 2008** there is a public interest to be served in making findings with respect to **the following circumstances:**

INTRODUCTION AND PURPOSE

1. This investigation examined the circumstances and contributing factors relating to the death of Ms Nicole Joy Millar. Before I make my findings on these circumstances and factors, I wish to convey my sincere condolences to Ms Millar's family and friends. The unexpected and violent death of a person is a devastating event. Violence perpetrated by an intimate partner is particularly shocking, given this relationship is expected to be one of safety and protection.
2. In this finding I will explore whether any lessons can be learnt, which might prevent similar deaths in the future. This role is one of two parallel functions of the modern coronial system. The first involves the findings that I must make under the *Coroners Act 2008* (Vic), which requires, if possible, that I find the:
   - identity of the person who has died
   - cause of death (for our purposes this usually refers to the medical cause of the death); and
   - circumstances surrounding the death.

3. It is the investigation I am permitted to conduct surrounding the circumstances of a death that gives rise to my ability to consider broader issues of public health and safety. These considerations form the second parallel purpose of a coronial investigation into a death. This purpose has been enshrined in the Preamble of the *Coroners Act 2008* (Vic), which sets out that the role of the coroner should be to:

   - contribute to the reduction of the number of preventable deaths; and
   - promote public health and safety and the administration of justice.

RELEVANT HISTORICAL FACTS

4. Ms Millar was a 42-year-old woman who had three children from previous relationships. At the time of her death, she was living with her youngest son, aged 15, in her rented public housing. Also living at this address was Ms Millar's current partner, Mr David Hopkins, with whom she had commenced an intimate relationship in September 2008. Both individuals had histories of illicit drug use involving marijuana, heroin and amphetamines.

5. In February 2008, Ms Millar sought assistance from Anglicare Integrated Family Services for support in the areas of parenting and family violence perpetrated by a previous partner. Ms Millar was referred to a Family Drug and Alcohol Counsellor for additional support with her drug and alcohol use.

6. Ms Millar was supported by Anglicare Integrated Family Services between February 2008 and May 2009, during which time she mentioned her relationship with Mr Hopkins. Early indications were that their relationship was not violent. However, by March 2009, Ms Millar disclosed that Mr Hopkins had been violent, including one incident where he had pushed her out of a moving car. Soon after, the Anglicare worker ceased assisting Nicole as it was deemed that her willingness to improve her situation deteriorated.

7. Ms Millar's support from Anglicare's Drug and Alcohol Counsellor occurred between March 2008 and May 2010. During these contacts, she seldom discussed her relationship with Mr Hopkins and when she did, described it as 'on-off'. Ms Millar's last contact with the Counsellor was 26 May 2010, when she was informed that her file would be closed as no contact had been made since 3 March 2010. The Counsellor was unaware of violence occurring in the family setting; rather, the impression was that Ms Millar was doing well with her new employment and did not appear to be using drugs at the time.

8. Ms Millar had been employed on a casual basis as a driver for an organisation in Bayswater from February or March 2010. At around lunchtime on 25 May 2010, Mr Hopkins attended Ms Millar's work premises screaming abuse at her and later drove off. He returned at about

2.30pm, drove his car behind hers and accelerated into the back of Ms Millar's car. Upon exiting the car, he held her down and threatened *"Don't think you're gonna be safe tonight because I'll come round and kill you"*. Ms Millar's boss, Mr Forster-Davies, came to the aid of Ms Millar, and Mr Hopkins physically assaulted him before driving away.

9. According to Mr Foster-Davies, Ms Millar was petrified, physically shaking and unable to speak. She told him that if Mr Hopkins saw them talking, it would be worse for her, then drove away to resume her work duties. Later that day, Mr Forster-Davies called Ms Millar when he noticed that she was late returning to work. Ms Millar told him that Mr Hopkins had been chasing her and tried to run her off the road, and that she was too scared to drive. When advised to make a report to the police, Ms Millar stated she was too afraid.

CIRCUMSTANCES OF THE INCIDENT

10. On 1 June 2010, Ms Millar and Mr Hopkins drove Ms Millar's youngest child to school. Ms Millar then drove them to the Woolworths Supermarket in Bayswater. She parked the car for 4.5 minutes in the Woolworths car park, before driving to the nearby petrol station.

11. At 8.22am, Mr Hopkins exited the passenger's seat to refuel. He refuelled for 30 seconds, and then carried the petrol pump nozzle to the passenger side door and removed a knife from his belt. Mr Hopkins re-entered the front passenger door and pumped fuel over Ms Millar. He physically restrained her as she screamed for help and sounded the car horn. Mr Hopkins then stabbed Ms Millar in the neck whilst pumping more petrol over her. He ignited the fuel on Ms Millar with a cigarette lighter and the inside of the vehicle erupted into flames. Mr Hopkins immediately exited the vehicle and removed his burning jacket and shoes, and paced near the rear of the vehicle.

12. Ms Millar's whole body was on fire, but she eventually managed to exit the vehicle and stumble a short distance before falling to the ground, engulfed in flames. Mr Hopkins prevented any person coming to her assistance or aid, threatening to kill them if they assisted her. Mr Hopkins stabbed himself, but not with any life-threatening severity. Mr Hopkins walked up close to Ms Millar, ensuring that she could hear him and said, *"burn bitch burn,"* - *"I hope you die"* – *"burn let her burn"* – *"hurry up and burn"*. Ms Millar could be heard screaming for almost all of the time that she was on fire.

13. One witness drove his car towards Mr Hopkins to enable assistance to reach Ms Millar. Other witnesses extinguished the flames and carried her charred body away from the burning vehicle in an attempt to make her safe. Paramedics arrived and Ms Millar was transported by air ambulance to the Alfred Hospital. Her injuries were non-survivable, with full thickness burns to over 90 per cent of her body, and she died in hospital the same day.

14. Mr Hopkins fled 200 metres west of the petrol station where he was located by police on the rear steps of a church. The above events were captured on CCTV.

INVESTIGATIONS

Forensic Medical and Scientific Investigation

15. An autopsy of Ms Millar's body and post mortem CT scanning (PMCT) were performed by Senior Forensic Pathologist Dr Matthew Lynch, which revealed the cause of her death to be *complications of cutaneous burns*.[1] Dr Lynch stated that the post mortem examination revealed evidence of burns to greater than 95 per cent of the body surface area. There was also an incised injury to the neck, left wrist and left hand. Post mortem toxicological analysis of blood revealed the presence of diazepam, nordiazepam, ketamine, lignocaine, metoclopramide, midazolam, free morphine and thiopentone, consistent with therapeutic administration.

Criminal Investigation

16. Mr Hopkins pleaded guilty to the murder of Ms Millar. On 19 October 2010, he was sentenced to life imprisonment with a non-parole period of 30 years.

Specialist Family Violence Investigation

17. Senior Constable Nicholas Densley prepared a brief of evidence on the circumstances surrounding the death of Ms Millar. Following a review of this evidence, I requested the Coroners Prevention Unit (CPU)[2] to examine Ms Millar's death as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD).[3]

18. Ms Millar had contact with a community-based Child Protection Worker in March 2009. During this meeting, she denied any alcohol use and informed the worker that she and Mr Hopkins had ended their relationship. Later, a Department of Human Services (DHS) Child Protection Worker became involved with monitoring the welfare of Ms Millar's youngest son. The available information indicates that in the week preceding Ms Millar's death, the DHS had only limited involvement with her. No further information was available.

19. There was no evidence that Ms Millar or Mr Hopkins had contact with the justice system or health system in the 12 months prior to Ms Millar's death. The fatal incident appears to have

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[1] Report of Dr Matthew Lynch dated 15 September 2010.

[2] The Coroners Prevention Unit is a specialist service for Coroners established to strengthen their prevention role and provide them with professional assistance on issues pertaining to public health and safety.

[3] The VSRFVD provides assistance to Victorian Coroners to examine the circumstances in which family violence deaths occur. In addition, the VSRFVD collects and analyses information on family violence-related deaths. Together this information assists with the identification of systemic prevention-focussed recommendations aimed at reducing the incidence of family violence in the Victorian community.

occurred in the context of drug use by Mr Hopkins in a relationship characterised by a history of family violence. There was no history of mental illness for either Ms Millar or Mr Hopkins. His criminal history comprised property offences and one drug possession offence. Ms Millar was previously a victim of intimate partner violence in previous relationships.

20. Ms Millar's covertness about violence occurring between her and Mr Hopkins potentially contributed to her death. Her adult children did not recognise the violence occurring in her relationship. Only her co-workers witnessed the true extent of the violence. Her employer, Mr Forster-Davies responded to the violence by ceasing her employment, thereby isolating her. As Ms Millar had a 15-year-old child, a potential reason for her unwillingness to disclose the violence might have related to involvement by the DHS and the risk of his removal from her care, as well as concerns about her son's wellbeing.

21. One of the strongest predictors of future victimisation is prior victimisation. Despite this, research shows that women experiencing family violence are more likely to deal with issues themselves or talk to friends rather than seek support due to barriers such as fear, isolation, lack of support and shame.

22. Interventions aimed at preventing future victimisation were potentially missed with Ms Millar. Given her history and her disclosure of violence to the Anglicare Practitioner, regular contact for the purposes of monitoring her ongoing safety could have been encouraged. I cannot state that this would have prevented her death, but there nevertheless remains the potential for a different outcome.

23. When Mr Hopkins attended Ms Millar's workplace and was violent towards her, she rejected the suggestion of reporting the incident to the police by her co-workers. Had this incident been reported to police, Mr Hopkins might have come under their surveillance. However, at the time of the incident, Mr Hopkins was not known to police. Mr Hopkins' assault of Ms Millar's boss was also not reported to police.

Findings pursuant to section 67 of the *Coroners Act 2008*

24. I find that:

    a. the identity of the deceased was Nicole Joy Millar; and

    b. Ms Millar died from complications of cutaneous burns, on 1 June 2010, at the Alfred Hospital, 55 Commercial Road, Melbourne Victoria 3004, in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the **Coroners Act 2008**, I make the following comment(s) connected with the death:

25. Members of a victim's social network can play a significant role in addressing violence and abuse. Oftentimes, friends, family members and work colleagues are the first to know or suspect that violence is occurring. Their actions, both big and small, can make a meaningful difference toward helping victims increase their safety and address a problematic relationship. In order for this to occur, it is necessary for the community to have a sound understanding about the range of behaviours that comprise family violence, and the options available to assist those at risk.[4] In addition, it is important that messages emphasising that family violence is a crime and not condoned in the community continue to be expressed.[5]

26. In a large number of family violence homicides reviewed as part of the Victorian Systemic Review of Family Violence Deaths (VSRFVD), there was evidence that family members, friends, neighbours and/or co-workers were aware or suspected that violence was occurring in the relationship. It has also been identified that these 'third parties' do not feel equipped to assist or are concerned that becoming involved may make the situation more dangerous for the victim or themselves.

27. To address this, various violence prevention initiatives have been implemented, ranging from increased community awareness to legislative provisions such as the Northern Territory's mandatory reporting of domestic violence laws. In Victoria, responses to this issue have also included a community education component, such as the Commonwealth Government's 1800 RESPECT telephone counselling initiative. These initiatives have featured strategies to develop a shared understanding of family violence, promote community resources and services and encourage attitudinal and behavioural change.

28. However, the circumstances surrounding Ms Millar's death and many others indicate that families, friends, colleagues and neighbours need an effective mechanism to bring suspected family violence to the attention of an authority empowered and equipped to respond in a timely manner. Noting that Crime Stoppers is a recognised brand and has accountability mechanisms, I consider that it has the potential to fill the gap between public awareness campaigns and emergency services with respect to family violence.

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[4] Walsh, C., McIntyre, S-J., Brodie, L., Bugeja, L. & Hauge, S. 2012, Victorian Systemic Review of Family Violence Deaths – First Report, Coroners Court of Victoria, Melbourne, Victoria, 48.

[5] Ibid.

RECOMMENDATIONS

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation(s) connected with the death:

29. Crime Stoppers has developed the Say Something campaign, which urges young people who witness acts of violence to be brave and look out for their friends by reporting incidents of violence confidentially. A website and iPhone app are available to help empower young people to report crime easily and online without identifying themselves. I therefore recommend that Victoria Police, together with Crime Stoppers, conduct a trial extending the Say Something campaign to family violence.

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

Mr Joel Read, Senior Next of Kin
Acting Chief Commissioner Tim Cartwright, Victoria Police
Ms Samantha Hunter, CEO, Crime Stoppers
Sgt Nicholas Densley, Victoria Police, Coroner's Investigator
Dr Lyndal Bugeja, Manager, Coroners Prevention Unit.

Signature:

JUDGE IAN L GRAY
STATE CORONER
Date: 12/1/15

Coroners Court of Victoria