IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2020 5818

**FINDING INTO DEATH WITHOUT INQUEST**

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

| | |
|---|---|
| Findings of: | Caitlin English, Deputy State Coroner |
| Deceased: | Michelle Lorraine Duque |
| Date of birth: | 29 December 1967 |
| Date of death: | 24 October 2020 |
| Cause of death: | 1(a) Multiple injuries in a motor vehicle incident |
| Place of death: | Western Highway, Gordon, Victoria |

## INTRODUCTION

1. On 24 October 2020, Michelle Lorraine Duque was 52 years old when she suffered fatal injuries in a motor vehicle collision. At the time of her death, Ms Duque lived at Drouin with her partner.

## THE CORONIAL INVESTIGATION

2. Ms Duque'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.

3. 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.

4. 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.

5. The Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Duque's death. The Coroner's Investigator conducted inquiries on my behalf, including taking statements from witnesses – such as family, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence.

6. This finding draws on the totality of the coronial investigation into Ms Duque's death, including evidence contained in the coronial brief. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity. In the coronial jurisdiction, facts must be established on the balance of probabilities.[1]

[1] 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.

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

### Identity of the deceased

7. On 24 October 2020, Michelle Lorraine Duque, born 29 December 1967, was visually identified by her partner, Peter Hanham.

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

### Medical cause of death

9. Senior Forensic Pathologist, Dr Michael Burke, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an inspection on 26 October 2020 and provided a written report of his findings dated 27 October 2020.

10. Toxicological analysis of post-mortem samples identified the presence of ondansetron, which is used to treat nausea and vomiting.

11. Dr Burke provided an opinion that the medical cause of death was *"1(a) Multiple injuries in a motor vehicle incident"*.

12. I accept Dr Burke's opinion.

### Circumstances in which the death occurred

13. Ms Duque moved to Australia from the United Kingdom in 2019 and lived with her partner, Peter Hanham.

14. In the days preceding her death, Ms Duque and her partner had driven around western Victoria, viewing the Silo Art Trail. On 24 October 2020, they began making their way home.

15. That afternoon, the couple drove along the Western Freeway at Gordon toward Melbourne (eastbound). Ms Duque was driving her 2008 Mini Cooper Coupe and her partner was seated in the front passenger seat.

16. The Western Freeway at this location is a four-lane bitumen road travelling in an east to west direction. There were two lanes of traffic in each direction. Opposing carriageways were separated by a grassed nature strip.

17. At the location of the collision, adjacent eastbound lanes were separated by a broken white line. The road was bordered by white painted fog lines and a bitumen shoulder on each side.

The section of road was straight with a slight incline and was lined with protective barriers on both sides. The speed limit was 110 kilometres per hour. Due to Grand Final Day and COVID-19 travel restrictions, the road was abnormally quiet on this day.

18. The weather that day was overcast and there had been patches of drizzle. For the most part, road conditions were dry and there was a calm breeze.

19. As the couple approached the Chapmans Road overpass, Ms Duque spotted an echidna on the roadway. She expressed concern it would be killed if it remained on the roadway and stopped her car in the left-hand running lane of the freeway, activating her hazard lights at the same time.

20. Mr Hanham exited the car and approached the echidna, which tucked its head in. He decided to wait in the emergency lane for it to move.

21. In the meantime, three other vehicles were making their way toward the Mini Cooper that was at a standstill on the freeway. Each of these vehicles were traveling eastbound in the left lane.

22. The first vehicle was a sedan, which has not been identified.

23. The second vehicle was a 2007 Honda Accord Sedan with a sole female occupant.

24. The third vehicle was not subsequently involved in the incident, but the driver stopped post-incident to assist. He witnessed the collision.

25. At approximately 3.00pm, Ms Duque drove her car from the left lane to the right lane of the Western Freeway as the first two eastbound vehicles quickly approached her location. The unidentified sedan subsequently moved into the left emergency lane, driving between Mr Hanham standing at the safety barriers, and Ms Duque's car. It did not collide with anyone or anything and continued driving without stopping.

26. At the same time, Ms Duque continued to move to the right lane. However, by this time the Honda Sedan was also moving to the right lane in a planned overtake. It was only at this time that the driver saw Ms Duque's car. The Honda driver attempted to brake but struck the rear right corner of Ms Duque's Mini Cooper.

27. Ms Duque's car sustained substantial damage to the right rear corner through to the driver's door and trapped Ms Duque in the vehicle. The impact shunted the Mini Cooper to the left emergency lane, spinning it anti-clockwise. It subsequently struck the left side steel safety

barrier, deflecting back over the right, where it stopped on the outer edge of the right-hand lane.

28. Ambulance paramedics attended shortly thereafter, finding Ms Duque conscious and alert but experiencing breathing difficulties. Further emergency services attended, extricating Ms Duque from the vehicle.

29. At approximately 4.00pm, Ms Duque was placed in an ambulance at which time her condition deteriorated, and she went into cardiac arrest. Despite treatment, Ms Duque passed away at 5.06pm.

30. The driver of the Honda sedan sustained minor bruising from seatbelt and airbag deployment. She was taken to hospital for precautionary checks at which time a blood sample was taken, which later returned a negative result for both drugs and alcohol.

31. Victoria Police have not been able to identify the speed of the Honda Sedan at the time of the collision, but it appeared it had not exceeded the speed limit.

32. Senior Constable Guinther Borgelt, Coroner's Investigator, noted that there were two factors that may have contributed to the collision. These were:

    (a) Ms Duque had only spent 19 months in Australia and may not have been familiar with road safety awareness relating to wildlife on Australian roads. Combining this with her love of animals, she decided to stop her vehicle in the running lane of an operational freeway in an apparent attempt to protect the echidna. This placed herself in danger of a collision; and

    (b) at the time of the collision, there was minimal traffic on the Western Freeway, which may have given Ms Duque a false sense of security in deciding to stop her vehicle in a running lane of a freeway. It was also likely that this false sense of security played a role in her decision to move her vehicle between the lanes.

33. It also appeared that the Honda driver's view of Ms Duque's car had been obscured by the unidentified family sedan and/or the shade of the overpass until just moments before the collision. The sudden movement of Ms Duque from the left lane to the right lane did not provide enough time for the Honda driver to avoid the collision.

34. I accept Senior Constable Borgelt's conclusions.

35. While Ms Duque's actions in attempting to save wildlife were admirable, safety of road users is paramount. Drivers should only stop their vehicles when it is safe to do so. VicRoads advises drivers that if an animal cannot be avoided on the road, it is safer to hit it in order to avoid injury or death to yourself or others.[2]

**FINDINGS AND CONCLUSION**

36. Pursuant to section 67(1) of the Act I make the following findings:

(a) the identity of the deceased was Michelle Lorraine Duque, born 29 December 1967;

(b) the death occurred on 24 October 2020 at Western Highway, Gordon, Victoria, from multiple injuries in a motor vehicle incident; and

(c) the death occurred in the circumstances described above.

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

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

Peter Hanham, senior next of kin
Senior Constable Guinther Borgelt, Victoria Police, Coroner's Investigator

Signature:

Caitlin English, Deputy State Coroner

Date: 27 October 2021

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 investigation. 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.

[2] VicRoads, Animals, https://www.vicroads.vic.gov.au/safety-and-road-rules/road-rules/a-to-z-of-road-rules/animals (accessed 5 October 2021).