

IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2013 1488

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)

Section 67 of the Coroners Act 2008

I, IAIN TRELOAR WEST, Deputy State Coroner having investigated the death of Succurine MASCARENHAS

without holding an inquest:

find that the identity of the deceased was Succurine MASCARENHAS

born on 8 November 1959

and the death occurred on 7 April 2013

at Melba Highway, Dixons Creek 3775, Victoria

from:

1 (a) MULTIPLE INJURIES SUSTAINED IN A MOTOR VEHICLE INCIDENT
(DRIVER)

Pursuant to section 67(2) of the **Coroners Act 2008**, I make findings with respect to **the following circumstances:**

1. Succurine Mascarenhas was a 54-year-old woman who resided in Dandenong with her husband, Mr Menino Mascarenhas. They have one son.
2. On 7 April 2013, Mrs Mascarenhas was driving her Mitsubishi van on the Melba Highway near Dixons Creek. Melba Highway is a single carriageway road heading generally north-south and with a speed limit of 100km/h. There is provision for one lane in either direction, separated by painted solid double lines. The road surface at the collision location is a sealed bitumen spray and is in very poor condition. On this evening, the road was wet but it was not raining. Visibility was good.
3. On the same stretch of road, Mr Troy Stanley was driving a Kenworth prime mover, which was also towing a four-axle dog trailer. Ms Courtney Fraser was also driving south along the Melba Highway in her Nissan Navarra with her friend, Ms Emma Booth in the passenger seat. Her vehicle was towing a horse float, which had her two prized horses inside.
4. At approximately 8.20pm, Mr Stanley was in 17th gear, and whilst rounding the right bend of the road, the back of his truck slid around to the left, and he lost control. Witness Mr Graham Polkinghorne (who was following the truck north on Melba Highway) stated *'suddenly the trailer of the truck kicked out to the right. It crossed over the centre line of the*

road. The trailer kept sliding out to the right. It appeared to take up the whole road in a couple of seconds.' Mrs Anne Polkinghorne who was with her husband also stated *'I noticed the rear of the truck move across the road a little to the left, within a split second the truck was side on to us across the road. The truck was on the wrong side of the road...the truck was still going forward.'* Mr Polkinghorne stated that previously the truck was driving in a completely normal manner. Ms Fraser stated *'I then saw the truck coming in the opposite direction. Suddenly the trailer behind the truck came onto my side of the road...The next thing I see the yellow truck side on coming at me.'*

5. Mr Stanley's truck rotated clockwise and slid passenger side on, and the area near the passenger side steering wheel collided with the front of Ms Fraser's Nissan. He continued past her vehicle and the rear passenger side of the tipper collided with the front of Mrs Mascarenhas's Mitsubishi. As a result of the collision, Ms Fraser and Ms Booth sustained serious but not life threatening injuries. Mrs Mascarenhas's legs were trapped under the front dash and steering components. She suffered major abdominal trauma and significant upper body and head trauma and was deceased at the scene. She was transferred to the William Angliss Hospital in Upper Ferntree Gully where she was certified deceased by Dr Jonan Woo.
6. Detective Senior Constable (DSC) Robert Hay from the Major Collision Investigation Unit provided a report on the incident. He noted that Mr Stanley was travelling within the speed limit of 100km/h, as the maximum possible speed around the bend was 99.6km/h in wet conditions. As a result of the poor conditions and low road friction, the rear of his truck had begun to rotate clockwise causing a jack knife to occur and once commenced, this process was irreversible. The truck became sideways across the road and was struck by the Nissan Navarra causing it to continue to rotate further clockwise and tilt over, striking the horse float. The rear of the tipper struck Mrs Mascarenhas's vehicle. DSC Hay opined that the collision was caused because the truck and dog trailer were travelling too fast (faster than advisory, but under the posted speed limit), the wet road, the truck and trailer being unladen and the low friction value of the road, which was lower than the acceptable standards for Vic Roads. The weather conditions at the time were inclement which would have lowered the road friction but not to such a low level. Mr Stanley was not under the influence of any drugs or alcohol and had not exceeded any driving hours.
7. Mechanical Investigator and Sergeant of Police, Leigh Booth, inspected the vehicles involved in the collision. In relation to the Kenworth truck and trailer, Sergeant Booth stated that the trailer had ineffective brake assembly on the offside of the front axle of the trailer and weeping shock absorbers. This would render the trailer as being unroadworthy prior to and at the time of impact. The truck however was in roadworthy condition and had no mechanical fault, which would have caused or contributed to the collision. There was no mechanical fault with the trailer, which would have caused the collision. The ineffective brake assembly on the offside of the front axle may have caused a degree of brake 'pull,' which may have resulted in some degree of trailer instability, however Sergeant Booth could not quantify this aspect further. He expected that the driver would be aware of any adverse braking characteristics.
8. Forensic Pathologist Dr Yeliena Baber from the Victorian Institute of Forensic Medicine conducted an external examination of Mrs Mascarenhas and provided a report of her findings. She identified massive abdominal injuries with exposure of internal organs. The post-mortem CT scan showed complete pelvic disruption, fractured right femur and tibia, and multiple other fractures. Toxicological analysis was negative for any ethanol (alcohol) or any other common drugs or poisons.

9. I find that the cause of death of Succurine Mascarenhas was multiple injuries, which she sustained as a driver in a motor vehicle incident.

COMMENTS

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

The speed zone in the series of bends where this collision occurred was a 100km/h speed zone. The speed limit was changed soon after to be 80km/h and it is recommended that this lowered speed zone remain.

RECOMMENDATIONS

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

The Victoria Police Major Collision Investigation Unit commented that the road surface at this location is poor and has low friction value. I recommend that Vic Roads review the road and consider resurfacing it, in an attempt to prevent incidents of a similar nature in the future.

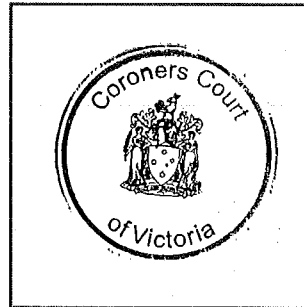
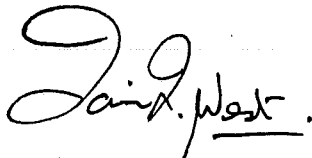
I direct that a copy of this finding be provided to the following:

Mr Menino Mascarenhas

Leading Senior Constable Paul Doevelaar, Yarra Ranges Highway Patrol

Vic Roads

Signature:



IAIN WEST
DEPUTY STATE CORONER
Date: **3 July 2014**
