IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2024 006507

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Therese McCarthy
Deceased:	Mr B[1]
Date of birth:	1944
Date of death:	7 November 2024
Cause of death:	1a: Consequences of mechanical restraint following ride on mower incident
Place of death:	Glenmaggie, Victoria
Keywords:	Ride on mower – roll-over protective structures – safety measures

[1] This finding has been deidentified.

INTRODUCTION

1. On 7 November 2024, Mr B was found deceased on his property, following an accident on a ride on mower. Mr B was 80 years old and at the time of his death, lived alone in Glenmaggie, Victoria.

2. Mr B is survived by his three children, and six grandchildren. Mr B is fondly remembered as a proud and determined man with a good sense of humour.

3. Mr B had a long and successful history as a businessman and farmer. He began his business in a garage in Deer Park. Throughout his career, he grew the business into a national operation employing approximately 180 people. After retiring, Mr B focused his energy on farming, running beef cattle, and maintaining his property at Glenmaggie.

THE CORONIAL INVESTIGATION

4. Mr B'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.

5. 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.

6. 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.

7. Victoria Police assigned Leading Senior Constable Christopher Skiba to be the Coronial Investigator for the investigation of Mr B's death. The Coronial Investigator conducted inquiries on behalf of the Court, including taking statements from witnesses – such as family, neighbours, the forensic pathologist, treating clinicians and investigating officers – and submitted a coronial brief of evidence. A report was also provided by the Victoria Police Collision Reconstruction and Mechanical Investigation Unit following a mechanical inspection of Mr B's mower.

8. In July 2025, I assumed carriage of the investigation into Mr B's death from then Coroner John Olle for the purpose of finalising the case and making findings.

9. This finding draws on the totality of the coronial investigation into the death of Mr B 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.[2]

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

Circumstances in which the death occurred

10. Having purchased the Glenmaggie farm in 1998, Mr B lived there alone since his wife passed away from lung cancer in 2008. He maintained regular contact with his adult children, and was close with his neighbours, Dave and Fiona.

11. Fiona and Mr B had a gardening club and would bake together, and Dave would help Mr B maintain his mower. In his statement, Dave recalled that Mr B was very familiar with the mower and always maintained it in "*good working order*", mowing the slopes on his property.

12. Mr B's son, Jeffrey, noted that he spent much of his time at Glenmaggie and "*was constantly tinkering and maintaining the property*". He was in good health for his age, and his family understood that he did not have any ongoing health issues and did not believe he was taking any medications.

13. Dave mentioned that he and Fiona would try to keep an eye on Mr B as they knew he was living alone at Glenmaggie. They also persuaded him to purchase a Spot Tracker. This device enabled Mr B to press a button and share his location using satellite signal.

14. In the months prior to his death, Dave recollected that Mr B seemed to be "*slowing down*" and appeared more tired than usual. Jeffrey noted that frequent travel between Melbourne and Glenmaggie was becoming difficult for his father.

15. Jeffrey recalled that he had recently decided the farm was too difficult for him to manage. He purchased a smaller property in Gisborne, closer to family, and was preparing for the

[2] 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.

Glenmaggie property to be sold. Whilst this was a difficult decision for Mr B, given the pride he took in the property, his approach was pragmatic.

16. On 4 November 2024, Mr B spent the day in Gisborne with Jeffrey. Jeffrey encouraged Mr B to stay for a barbeque, but he was determined to return to home to prepare the property for a real estate agent to take photos for the sale of the property. He phoned Jeffrey at 7.27pm to tell him he had arrived home safely.

17. At 11.21am the following day, Mr B sent himself a Facebook post. In their statements, Dave and Jeffrey note that the only place on the property with phone reception was in the house, which suggests Mr B was in the house when he sent this message.

18. At 6.26pm on 5 November 2024, Mr B's granddaughter sent him a message. At 6.53pm, a group message was also sent between Jeffrey, a friend of Jeffrey's and Mr B. Mr B did not respond to either message.

19. On the morning of 7 November 2024, Jeffrey phoned Mr B, but he did not answer. Jeffrey was not concerned as he suspected his father simply did not have phone reception at the time.

20. However, when Jeffrey had not heard back from his father by the following evening, he became worried. Jeffrey recalls that he thought that there may have been a power outage or that Mr B's phone battery was flat. At 7.27pm, he sent a text message to his father to ask if he was alright.

21. Growing concerned, Jeffrey then contacted family members and Mr B's neighbours. Dave and Jeffrey spoke on the phone, and Dave confirmed he had not spoken to Mr B for a few days.

22. Just after 8.00pm, at Jeffrey's request, Dave went to check on Mr B. He found the shed door open and the radio on. The back door of the house was locked. Dave noticed Mr B's Landcruiser parked at his cabin beside the river and drove down.

23. Upon arriving at the cabin, Dave found Mr B's Landcruiser parked outside the yard with the mower trailer attached and the ramps extended. Dave drove closer and observed the mower wheel down the embankment. He descended two to three metres and found the mower upside down with Mr B trapped underneath. He thought it clear that Mr B was deceased at this time and a short time later, emergency services confirmed it.

24. Police formed the opinion that Mr B may have driven the mower to the edge of the embankment to cut the grass on the edge. He may then have inadvertently positioned a wheel too far onto the soft and sandy edge, causing the mower to unbalance and tip, trapping Mr B underneath. His phone was found out of his reach on the grass, though I am aware that he was found in an area without phone reception. Mr B's Spot Tracker was suspended from a belt loop but was unfortunately wedged behind his back and out of reach. Attending police did not identify any evidence of suspicious circumstances or third-party involvement.

25. In his statement, Jeffrey observed that when Mr B's phone was brought back up to the house by emergency service workers, the messages sent to Mr B by his granddaughter on the evening of 5 October 2024 only displayed as 'delivered'. It therefore seems likely that Mr B did not return to his house after the evening of 5 November.

Identity of the deceased

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

Medical cause of death

27. Senior Forensic Pathologist Dr Michael Burke from the Victorian Institute of Forensic Medicine (**VIFM**) conducted an examination of Mr B on 11 November 2024 and provided a written report of his findings on 13 November 2024.

28. The post-mortem examination did not reveal any fractures or haemorrhages which Dr Burke considered to be the direct cause of death. The scene photographs and external examination also did not suggest that the mower was positioned in a way that would have impacted Mr B's breathing.

29. However, Dr Burke noted that Mr B was in a head down position for a considerable period, which is known to increase pressure within the skull. Further, the position of the machine is likely to have compromised circulation to his legs and decreased the return of deoxygenated blood to the heart. Although Mr B appeared very fit for his age, Dr Burke opined that he would have had limited physiological reserves and likely died secondary to these physiological challenges.

30. Toxicological analysis of post/ante-mortem samples identified the presence of a very small amount of ethanol. Dr Burke commented that the production of ethanol in the body is a natural part of the decomposition process. No other common drugs or poisons were identified.

31. Dr Burke provided an opinion that the medical cause of death was '*1(a) Consequences of mechanical restraint following ride on mower incident*'.

32. I accept Dr Burke's opinion.

EXAMINATION BY THE COLLISION RECONSTRUCTION AND MECHANICAL INVESTIGATION UNIT

33. On 8 and 9 November 2024, Senior Constable David Gordon Giuleri attended Maffra Service Centre, where Mr Bs 2001 Walker, zero turn, ride on mower was stored. The model of the vehicle was MTGHS. Senior Constable Giuleri examined the vehicle, which included testing the functionality of the vehicle's drive and steering mechanisms.

34. A slight bend was found to the forward speed control lever, preventing the vehicle from engaging the fast position. However, the lever was able to be bent to allow the vehicle to have full travel. It was also noted that the right-side drive tyre had low air pressure. However, it appeared satisfactory in the scene photographs and held pressure for the duration of the examination once reinflated.

35. The examination did not reveal that any faults, failures or conditions in the vehicle that could have caused or contributed to the incident.

CONCLUSION

36. The safe operation of ride-on mowers is an issue well-known to the Coroners Court of Victoria, with several matters having examined the use of roll-over protective structures (**ROPS**) and recommendations having been made in relation to the implementation of safety communication campaigns, updating relevant product safety alerts, and the fitting of inbuilt gradient gauges or alarms. [3] Accordingly, I recognise the ongoing importance of educating ride-on mower operators to understand the risks associated with different terrains; the importance of fitting their vehicle with a ROPS device; and of behaving with appropriate caution throughout operation.

[3] See for example, Finding into death without inquest of JM dated 29 June 2021, and Finding into death without inquest of Dominic Salvatore Mele dated 18 July 2022.

37. While the precise events leading up to the incident remain unclear, the operation of ride-on mowers on slopes or near embankments is known to increase the risk of roll-over.[4] ROPS devices are designed to minimise the risk of mowers tipping and mitigate resulting harm to the operator. Mr B's 2001 Walker mower was not fitted with a ROPS device or seatbelt at the time of its purchase; however, Walker introduced an add-on ROPS kit in 2009 which could be retrofitted to older models.

38. The operating manual applicable to Mr B's mower indicates a maximum recommended side slope operating angle of 20 degrees,[5] which was subsequently revised to 15 degrees for newer models,[6] with an explicit warning not to "*mow or dump grass within 5 feet of an embankment*".[7] Notwithstanding the absence of data before me which indicates the angle at which Mr B was mowing that day, I am satisfied that a ROPS device could have potentially reduced the likelihood of Mr B becoming trapped underneath the mower. At the very least, I consider that such a device could have afforded him sufficient clearance to reach and activate his Spot tracker. Of course, it is unclear whether Mr B would have retrofitted a ROPS device and by all accounts, he was confident on the mower, knew his farm and its slopes well, and held no concerns about his safety.

39. It remains possible that Mr B suffered an acute medical event which preceded the ride-on mower falling down the embankment, however, there is no direct evidence of this, and therefore I cannot make such a finding.

FINDINGS

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

a) the identity of the deceased was Mr B, born 1944;

b) the death occurred on 7 November 2024 at Glenmaggie, Victoria, from consequences of mechanical restraint following ride on mower incident; and

c) the death occurred in the circumstances described above.

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[4] As reflected in: Australian Competition and Consumer Commission (ACCC) 'Ride-on Lawn Mowers Guide'; and WorkSafe Victoria 'Preventing Ride-on Lawn Mower Rollover: Guidance on Managing the Risks of Using Ride-on Lawn Mowers'.

[5] Walker Manufacturing, *Walker Rider Lawnmowers: Owner's Manual* (Manual, 6 January 2002) 17-18.

[6] See for example: Walker Manufacturing, 'Operator's Manual: Safety, Assembly, Operating, and Maintenance Instructions' (Manual, 2025) 13, 38.

[7] Ibid 12, 39.

I convey my sincere condolences to Mr B's family for their loss.

Pursuant to section 73(1A) of the Act, I order that this finding be published on the Coroners Court of Victoria website in accordance with the rules.

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

Senior Next of Kin

Leading Senior Constable Christopher Skiba, Coronial Investigator

Signature:

Coroner Therese McCarthy

Date: 22 January 2026

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.