IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2019 0350

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Leveasque Peterson
Deceased:	JM
Date of birth:	11 August 1976
Date of death:	19 January 2019
Cause of death:	1(a) Mechanical asphyxia in setting of external compression of chest by ride on mower
Place of death:	Lilydale, Victoria

INTRODUCTION

1. On 19 January 2019, JM was 42 years of age when he died at his home in Lilydale following an accident while operating his ride-on lawnmower. He is survived by his partner and three children.

2. JM was a professional earthmoving contractor with experience operating excavators, bobcats and tandem tippers. He was known to be a cautious machine operator.

THE CORONIAL INVESTIGATION

JM'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. Victoria Police assigned Senior Constable Steven Reid (**SC Reid**) to be the Coroner's Investigator for the investigation of JM's death. SC Reid conducted inquiries on my behalf, including taking statements from witnesses – such as the forensic pathologist, a treating clinician and investigating officers – and submitted a coronial brief of evidence. Despite efforts, SC Reid was unable to obtain signed statements from JM's family who were understandably shocked and distressed by the event.

6. This finding draws on the totality of the coronial investigation into the death of JM, 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]

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

Circumstances in which the death occurred

7. On Saturday, 19 January 2019, JM was preparing his property for his stepson's birthday party by mowing the lawns on an orange Kubota F360 ride-on lawnmower. His partner was setting up at the front entrance of the house where a marque had been erected.

8. Sometime between 12:00pm and 1:00pm, JM was mowing along a steep section of land above a 1.6-metre-high retaining wall when the lawnmower rolled over, toppling over the retaining wall and landing on its side adjacent to a shed and pinning JM underneath and causing fatal injuries.

9. At about 1:00pm, his partner and stepdaughter went looking for JM. They discovered him pinned underneath the lawnmower, unresponsive and showing no signs of life. His partner ran back to the house and called emergency services. With the aid of a neighbour, they unsuccessfully attempted to lift the lawnmower to release JM.

10. Emergency services attended a short time later but there was nothing they could do for JM who was pronounced deceased by Ambulance Victoria paramedics at the scene. State Emergency Service volunteers extracted JM at 2:39pm using air jacks to raise the lawnmower.

Identity of the deceased

11. On 19 January 2019, JM, born 11 August 1976, was visually identified by his partner, DG.

12. Identity is not in dispute and required no further investigation.

Medical cause of death

13. Forensic Pathologist Dr Matthew Lynch from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 24 January 2019 and provided a written report of his findings dated 22 February 2019. In preparation of his report, Dr Lynch reviewed the Victoria

[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.

Police Report of Death, VIFM contact log, routine post-mortem computed tomography (**CT**) scan and scene photographs.

14. The post-mortem examination revealed linear abrasions to the chest and abdomen and lacerated mesentery with 10ml hemoperitoneum in keeping with the reported history.

15. The CT scan showed fractures of the left and right 7th to 9th ribs anteriorly and cerebral oedema.

16. Routine toxicological analysis of post-mortem samples did not detect any alcohol or common drugs or poisons.

17. Dr Lynch provided an opinion that the medical cause of death was mechanical asphyxia in setting of external compression of chest by ride on mower.

18. I accept and adopt Dr Lynch's opinion.

FURTHER INVESTIGATION

19. On 3 April 2019, Senior Constable David Giulieri (**SC Guilieri**) of the Victoria Police Collision Reconstruction and Mechanical Investigation Unit (**CRMIU**) conducted a mechanical investigation of the Kubota lawnmower.

20. SC Guilieri observed that the lawnmower showed few signs of damage. He noted that it was in serviceable condition. He observed that there were no scuff marks on the webbing of the seatbelt to indicate the seat belt was worn.

21. SC Guilieri noted that the lawnmower used a hand throttle attached to the left side of the steering column. On inspection, it was set to about 70%. SC Guilieri also observed that the two-speed gear box was in neutral position.

22. He observed that the rear right-hand tyre was deflated but was unable to determine if it was deflated prior to or post the incident. If the tyre was deflated prior to the incident, SC Guilieri opined that it may have made the vehicle unstable.

23. On 22 January 2019, Detective Sergeant Robert Hay (**DS Hay**) of CRMIU was requested to review and reconstruct the incident. DS Hay reviewed a copy of the Traffic Incident Report, scene photographs, 3D scans of the scene and lawnmower and a Kubota manual found online.

24. DS Hay calculated that the slope JM was mowing at the time of the roll-over had a downward angle of 20 degrees. The wheel tracks, in his opinion, were consistent with the lawnmower being driven up and down the slope, in accordance with the safety manual.

25. DS Hay observed an impact mark on the top of the retaining wall appearing to suggest an impact between the wall and lawnmower blade. He was however unable to provide an opinion on whether this contributed to the incident.

26. DS Hay noted that the Kubota operator's manual suggested that if the lawnmower was fitted with a rollover protection system (**ROPS**), the seatbelt should be worn and, if there was no ROPS, the seatbelt should not be worn. He noted that JM's lawnmower was equipped with a ROPS and a seatbelt. However, at the time of the rollover, JM was not wearing the seatbelt.

27. It was the opinion of DS Hay that had he been wearing the seatbelt, he would not have become trapped under the lawnmower and may have survived, albeit with unknown injuries.

REVIEW BY THE CORONERS PREVENTION UNIT

28. The Court referred this matter to the Coroners Prevention Unit[2] (**CPU**) to review the circumstances of JM's death and seek opportunities, if any, arising for the prevention of deaths in similar circumstances.

29. CPU noted that the recommended maximum slope commonly stated by manufacturers in the operator's manuals is 15 degrees. While there was no safe working angle assigned to the Kubota lawnmower in the operator's manual CPU located online, the manual did specify that the lawnmower should be driven up and down a slope rather than across it.

30. CPU reviewed an alert published in December 2013 by Product Safety Australia on its website. The alert stated in part "*The main hazard to lawnmower riders is where they may fall and the lawnmower could run over them or fall on them*".

31. CPU considered that while there is merit in specifying a maximum safe angle, many people may not be able to evaluate the slope angle by sight. I agree with that proposition.

[2] The Coroners Prevention Unit (CPU) was established in 2008 to strengthen the prevention role of the coroner. The unit assists the Coroner with research in matters related to public health and safety and in relation to the formulation of prevention recommendations. The CPU also reviews medical care and treatment in cases referred by the coroner. The CPU is comprised of health professionals with training in a range of areas including medicine, nursing, public health and mental health.

32. CPU also noted that the Kubota operator manual stated that lawnmower riders should not travel downhill with the gearbox in a neutral position. In this instance however, the evidence does not indicate what direction JM was travelling. Given the lawnmower was found in neutral position, it is possible JM was traveling downhill which may have contributed to the roll over.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was JM, born 11 August 1976;

    (b) the death occurred on 19 January 2019 at Lilydale, Victoria, 3140;

    (c) the cause of death was from mechanical asphyxia in setting of external compression of chest by ride on mower;

    (d) the death occurred in the circumstances described above; and,

    (e) having considered all of the circumstances, I am satisfied that JM's death was the result of an accident in settings where he failed to wear the equipped seatbelt, was riding on angle greater than 15 degrees and travelled downhill with the gearbox in neutral position.

RECOMMENDATIONS

34. Pursuant to section 72(2) of the Act, I make the following recommendations:

    (a) That Product Safety Australia issue an updated product safety alert of ride-on lawnmowers. The alert could consider reiterating advice to riders to wear a seatbelt if there is a rollover protection system, not to mow on steep angles nor travel downhill with the gearbox in neutral.

35. I convey my sincere condolences to JM's family for their loss.

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

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

DG, Senior Next of Kin

Senior Constable Steven Reid, Coroner's Investigator

Product Safety Australia

Signature:

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LEVEASQUE PETERSON

CORONER

Date: 29 June 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.