IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2021 004978

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner David Ryan
Deceased:	Neville Reginald Want
Date of birth:	6 September 1937
Date of death:	19 September 2021
Cause of death:	1(a) Traumatic asphyxia in the setting of a ride-on lawnmower incident (driver)
Place of death:	26 Amberly Drive, Nicholson, Victoria, 3882
Keywords:	Ride-on mower, slope, gardening maintenance safety

INTRODUCTION

1. On 19 September 2021, Neville Reginald Want was 84 years old when he died in a ride-on lawnmower accident at home. At the time of his death, Mr Want lived alone on a property at 26 Amberly Drive, Nicholson. He is survived by his children Roderick Want and Leanne Oake.

BACKGROUND

2. Mr Want had a history of heart problems and had a pacemaker installed after suffering a number of heart attacks. He also took various medications for his heart and blood pressure. At the time of his death, he was reported to be in good health.[1]

3. Mr Want lived on a small farm property surrounded by grass. He owned and operated a Husqvarna ride-on front mower which weighed around 238 kilograms. His neighbour and friend, Allan Riddell stated that "*Neville took pride in his yard and would mow his grass often to keep it looking good*".[2]

4. Mr Want wore a wristband which could activate an alarm via the internet. It had been configured to notify Mr Riddell in the event that the alarm was activated. However, on 15 September 2021, Mr Want had advised his daughter that his internet service was not working.[3]

THE CORONIAL INVESTIGATION

5. Mr Want'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.

6. 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.

[1] Statement of Leanne Oake dated 12 December 2021.
[2] Statement of Allan Riddell dated 21 December 2021.
[3] Statement of Allan Riddell dated 21 December 2021; Statement of Leanne Oake dated 12 December 2021.

7. 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.

8. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Mr Want'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.

9. This finding draws on the totality of the coronial investigation into the death of Mr Want including evidence contained in the coronial brief. While 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.[4]

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

Circumstances in which the death occurred

10. At about 10.15am on 19 September 2019, Mr Riddell heard Mr Want start his mower. Mr Riddell went outside to have his morning tea at around 10.40am and saw Mr Want from his property riding his mower. Mr Riddell then went inside.[5]

11. At about 12.20am, Mr Riddell went outside again and observed that Mr Want's mower had tipped over against an internal fence line on his property. Mr Riddell rushed over and located Mr Want underneath the mower and unresponsive. He stated that it appeared to him that Mr Want was deceased. The mower was in a location that consisted of a "*significant slope*" in the lawn running from behind a shed down to the fence line.[6]

12. Mr Riddell was unable to lift the mower and so telephoned his neighbour, David Blue who attended to assist with another neighbour, Mike Clifton. Together, the three of them were able to pull the mower off Mr Want. He was lying on his back against the fence line with "*his hands crossed over his stomach*" and his left leg "*bent at the knee*". They were unable to detect

[4] 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.

[5] Statement of Allan Riddell dated 21 December 2021.

[6] Statement of Allan Riddell dated 21 December 2021; Statement of Daniel Utting dated 18 November 2021.

a pulse and then contacted emergency services at around 12.35pm. Victoria Police and Ambulance Victoria subsequently attended and Mr Want was pronounced deceased at 1.02pm.[7]

13. I am satisfied that Mr Want was riding his mower across the slope in the lawn between the rear of his shed and the fence line when it tipped over sideways and trapped his body beneath it. The Coroner's Investigator made inquiries which disclosed that Husqvana ride-on front mowers are not to be operated on a slope of greater than 10 degrees. From his review of the scene, he estimated that the slope of the ground where Mr Want was located was approximately 20-30 degrees. There is no evidence that Mr Want had a medical episode which may have contributed to his death. There is also no evidence that the alarm on his wristband was activated at the time of the incident.

Identity of the deceased

14. On 19 September 2021, Neville Reginald Want, born 6 September 1937, was visually identified by his neighbour, Allan Riddell.

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

Medical cause of death

16. Forensic Pathologist Dr Gregory Young from the Victorian Institute of Forensic Medicine conducted an examination on 21 September 2021 and provided a written report of his findings dated 22 September 2021.

17. Dr Young reviewed the results of a computed tomography (**CT**) scan which revealed lateral fractures of the 7th to 9th ribs.

18. Toxicological analysis of post-mortem samples identified the presence of amiodarone[8] (and its metabolite desethylamiodarone), bisoprolol,[9] and frusemide.[10]

19. Dr Young provided an opinion that the medical cause of death was 1 (a) Traumatic asphyxia[11] in the setting of a ride-on lawnmower incident (driver).

---

[7] Statement of Allan Riddell dated 21 December 2021; Statement of Daniel Utting dated 18 November 2021.
[8] Amiodarone is used for severe tachyarrhythmias unresponsive to other therapies.
[9] Bisoprolol is a synthetic beta-blocker indicated for hypertension.
[10] Frusemide is a loop diuretic used to treat oedema and mild to moderate hypertension.
[11] Traumatic asphyxia is a form of mechanical asphyxia where there is mechanical fixation of the chest that restricts respiratory movements, thus preventing effective breathing. This may occur in a situation such as being pinned under

20. I accept Dr Young's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Neville Reginald Want, born 6 September 1937;

    b) the death occurred on 19 September 2021 at 26 Amberly Drive, Nicholson, Victoria, from traumatic asphyxia in the setting of a ride-on lawnmower incident; and

    c) the death occurred in the circumstances described above.

COMMENTS

Pursuant to section 67(3) of the Act, I make the following comments connected with the death.

22. Ride-on lawnmowers pose serious risks from tipping over. Product Safety Australia[12] publishes a safety alert on its website which warns consumers of the hazards associated with the operation of ride-on lawnmowers.[13] It states that the "*main hazard to lawnmower riders is where they may fall off and the mower could run over them or fall on them*" and that "*there have been hundreds of ride-on lawnmower injuries in Australia, and at least eight people in Australia have died from ride-on lawnmower-related incidents*".

23. One of the hazards identified in the alert is that a mower can tip and cause a person to fall off it if the rider "*drives across a slope or uneven surface*". It cautions consumers to always "*mow up and down slopes – NEVER mow across*" and not to "*mow on steep angles*".

I convey my sincere condolences to Mr Want'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.

---

an overturned vehicle. Whilst non-specific, features may include conjunctival petechiae, bruises and abrasions from the weight of the vehicle, and injuries to the chest wall including rib fractures.

[12] The Product Safety Australia website provides advice for consumers who buy and use products and for industry which manufactures imports and sells consumer products to help minimise injury illness and death related to unsafe products. The site is administered by the Australian Competition and Consumer Commission for all State and Territory consumer product safety regulators.

[13] Product Safety Australia (2013) 'Riding safely with ride-on lawnmowers' www.productsafety.gov.au/news/riding-safely-with-ride-on-lawnmowers

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

Leanne Oake, Senior Next of Kin

Senior Constable Adrian Haynes, Coroner's Investigator

Australian Competition and Consumer Commission

Signature:

Coroner David Ryan

Date : 16 January 2023

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.