IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2025 001170

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Deputy State Coroner Paresa Antoniadis Spanos
Deceased:	LGT
Date of birth:	1970
Date of death:	2025
Cause of death:	1(a) Carbon monoxide poisoning
Place of death:	Victoria

INTRODUCTION

1. LGT was 54 years old when he was unexpectedly found deceased in his backyard. At the time, LGT lived in Victoria with his wife, QLT, and their children, JUT and NBT.

2. LGT and QLT were married in 2002 and built their family home in 2003, residing there with their children thereafter.

3. LGT was an Australian Army veteran. He was diagnosed with post-traumatic stress disorder after his 17 years of service, which he managed with counselling. LGT's health history also included hearing difficulties, osteoarthritis and type 2 diabetes mellitus. LGT managed his health by remaining active and going to the gym.

4. According to QLT, her husband drank alcohol regularly, normally having one to two drinks on most days.

THE CORONIAL INVESTIGATION

5. LGT'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.

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. The Victoria Police assigned an officer to be the Coronial Investigator for the investigation of LGT's death. The Coronial 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 LGT'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]

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

Identity of the deceased

10. In 2025, LGT, born 1970, was visually identified by his daughter, JUT, who signed a formal Statement of Identification to this effect.

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

Medical cause of death

12. Senior Forensic Pathologist, Dr Matthew Lynch, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an examination on 4 March 2025 and provided a written report of his findings dated 7 April 2025.

13. The post-mortem examination and CT scan revealed focal coronary artery calcification.

14. Routine toxicological analysis of post-mortem samples detected ethanol at 0.08 grams per 100 millilitres of blood, [2] and carboxyhaemoglobin at 62% saturation.[3]

15. Dr Lynch considered the likely origin of the carbon monoxide was fumes from the lawn mower. While the circumstances surrounding inhalation of the fumes is not known, Dr Lynch opined that one possibility is that LGT suffered a cardiac event within the confined space of the shed, and collapsed while the mower's motor was running, subsequently succumbing to carbon monoxide poisoning.

16. Dr Lynch provided an opinion that the medical cause of death was *"1(a) Carbon monoxide poisoning"*.

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[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.

[2] Ethanol (ethyl alcohol, alcohol) is a social drug and product of yeast fermentation of sugars. In Australia, it is illegal for full license holders to drive with a blood alcohol concentration of more than 0.05 g/100 ml.

[3] Carboxyhemoglobin is the complex formed within red blood cells when haemoglobin is exposed to carbon monoxide. Carboxyhemoglobin saturation > 50% is considered life-threatening.

17. I accept Dr Lynch's opinion.

Circumstances in which the death occurred

18. In the days preceding his death, LGT complained of chest pain to his family. However, as this usually occurred after LGT had been to the gym, neither he nor his family considered the complaints to be concerning.

19. On 1 March 2025, LGT and QLT attended an event at the Birallee Tavern in Wodonga. They arrived between 1.00pm and 1.30pm and left when the event ended, at around 4.00pm. While at the event, QLT noticed LGT had at least 10 alcoholic beverages.

20. When they got home, LGT stated that he was going out to mow the lawn. QLT warned him not to do so as it was a hot day, around 36 degrees outside. QLT then went to lay down as she was not feeling well.

21. While LGT was mowing the lawn, his daughter, JUT's boyfriend, ASC, arrived at the house. JUT asked her father why he was mowing the lawn. LGT told her that he had nothing else to do and that someone had to do it. JUT recalled that her father seemed fine at the time of this exchange. She and ASC then went inside to watch a movie.

22. About one and a half hours later, ASC left the house. When he left, he did not see LGT. Shortly after ASC left, another friend of JUT's arrived. They remained at the house for about one hour before leaving to get something to eat.

23. At around 7.00pm, QLT woke up and went looking for her husband. When she observed the lawn was partially mowed, she called out to him in the backyard but received no response. LGT's phone and keys were still in the house. QLT called JUT, who was already on her way home.

24. When JUT arrived home, she looked for her father in the backyard. As she approached the garden shed, she noticed the two doors were closed. One door is permanently closed, and the other was closed but not locked when she approached.

25. JUT stated that LGT usually kept this shed locked as he kept petrol and tools inside. The garden shed measured 3 metres wide by 2.25 metres deep, with a pitched roof of 2 metres at its highest, and 1.8 metres at the sides. The shed had a double hinged door, with pavers for flooring. There was minimal ventilation within the shed.

26. As JUT entered the shed, she saw the lawn mower straight ahead and her father seated on a golf bag, against the back wall of the shed. He was upright, with his arms beside him. JUT stated that LGT's body was white, and he looked like he had fainted. JUT called out to her mother who ran to the shed. JUT, her friend, and QLT dragged LGT towards the doors of the shed, commenced cardiopulmonary resuscitation (**CPR**), and contacted emergency services at 7.48pm.

27. At 7.55pm, Ambulance Victoria paramedics arrived and took over CPR, but LGT was unable to be revived. LGT was declared deceased at 8.10pm.

28. Between 8.36pm and 9.04pm, Victoria Police Officers arrived. Leading Senior Constable Darren O'Neill (**LSC O'Neill**), Coroner's Investigator, inspected the lawn mower and found the fuel tank was empty with the throttle still in the full throttle position. LSC O'Neill found nothing to suggest that anyone else was involved in LGT's death or that he had otherwise died in suspicious circumstances.

29. On 23 April 2025, LSC O'Neill examined LGT's lawnmower. QLT stated that the mower was bought for LGT as a Christmas gift in 2023, had not been used much and had not been services as far as she knew. Nor was she aware of any issues with the mower.

30. LSC O'Neill advised that the mower presented in excellent condition, with no apparent faults or failures. The manual for the lawn mower also provides appropriate warning against running the engine indoors or in poorly ventilated areas, due to risk of carbon monoxide poisoning.

31. LSC O'Neill noted that whilst it cannot be determined if LGT entered the garden shed with the mower running, there is a strong likelihood this was the case. He further opined it is possible that once LGT entered the shed, he had a cardiac event and collapsed. With the mower running, it produced lethal levels of carbon monoxide until the fuel was depleted and the engine stopped.

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was LGT, born 1970;

    (b) the death occurred on 1 March 2025 in Victoria;

    (c) the cause of LGT's death was carbon monoxide poisoning; and

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

33. The available evidence supports a finding that LGT died from carbon monoxide poisoning, in circumstances of an accidental death that occurred within the confines of the garden shed with minimal ventilation while the lawn mower engine was running, and that he likely fell unconscious at some stage before finally succumbing to carbon monoxide fumes.

34. While it is possible that LGT suffered some manner of cardiac event while in the shed, there is insufficient evidence to support a formal coronial finding that such an event caused or contributed to his death.

COMMENTS

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

35. I asked the Coroners Prevention Unit (**CPU**)[4] to provide a report regarding deaths from accidental carbon monoxide poisoning.

36. The CPU identified 69 unintentional carbon monoxide poisoning deaths in Victoria between 2000 and 2025, of which, males accounted for 51. Among the 69 deaths:

(a) 27 occurred in a house fire (where the house fire was the carbon monoxide source);

(b) 22 occurred in a house, garage/shed, boat, tent, workplace, caravan or hotel/motel (with the carbon monoxide source being something other than the structure being on fire);

(c) 17 occurred in a vehicle that was not involved in a collision; and

(d) three occurred in a post-collision vehicle fire.

37. A number of recommendations have been made in relation to unintentional carbon monoxide poisoning deaths, particularly to ensure safety of homes, which contribute to a large portion of carbon monoxide poisoning deaths, whether through house fires, unsafe electrical or gas fittings, or poor ventilation.

[4] 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.

38. While carbon monoxide poisoning tends to occur more frequently in the home, there is a risk to human life in any situation where there is an internal combustible engine being used in a confined space, such as the lawn mower in LGT's case, which cannot be underestimated. Of note, none of the 10 unintentional carbon monoxide poisoning deaths since 2020, occurred in the home.

39. I convey my sincere condolences to the family and friends of LGT for their loss.

40. Pursuant to section 73(1A) of the Act, I order that a de-identified form of 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:

QLT, senior next of kin
Department of Veterans' Affairs
Leading Senior Constable Darren O'Neill, Victoria Police, Coronial Investigator

Signature:

Deputy State Coroner Paresa Antoniadis Spanos

Date: 15 May 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.