IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

COR 2023 000994

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 63(2)

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

Findings of:	Coroner Paul Lawrie
Deceased:	Robin James Woller
Date of birth:	8 October 1946
Date of death:	20 February 2023
Cause of death:	1(a) CHEST AND PELVIC INJURIES SUSTAINED IN A RIDE ON LAWN MOWER INCIDENT
Place of death:	270 Oneils Lane, Anakie, Victoria, 3213
Keywords:	Ride-on mower, lawn tractor, towing, trailer, loss of control, roll over, traumatic asphyxia

INTRODUCTION

1. On 20 February 2023, Robin James Woller was 76 years old when he was found deceased in a paddock on the family's rural property in Anakie, Victoria. Mr Woller had been using a ride-on mower and a trailer laden with cut wood – both had rolled over.

2. Mr Woller was retired and lived on the property with his wife, Patricia Woller, and their son, Timothy Woller.

THE CORONIAL JURISDICTION

3. Mr Woller'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.

4. 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.

5. 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.

6. Sergeant Glen Jones acted as the Coroner's Investigator for the investigation of Mr Woller's death. Sergeant Jones conducted inquiries on my behalf and compiled a coronial brief of evidence.

7. This finding draws on the totality of the coronial investigation into the death of Robin James Woller 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]

[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

BACKGROUND

8. In 1985, Mr and Mrs Woller and their three children moved from New Zealand to Australia. Mr Woller worked as a crane operator and rigger before he retired in 2014.

9. After his retirement, Mr Woller and his wife purchased a farm in Anakie. Mr Woller was very active around the farm and would frequently assist neighbours. He habitually used his ride-on mower to get around between the properties. He was experienced driving a wide range of machinery, including ride-on mowers and skid steer loaders[2]. He was also very familiar with the terrain around the farm.[3]

10. Mr Woller had a medical history of hypercholesterolaemia, cardiomyopathy, osteoarthritis, Type 2 diabetes mellitus, and coronary artery disease for which he was prescribed several medications, including a beta-blocker, bisprolol[4] and Diamicron (gliclazide[5]).

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

Circumstances in which the death occurred

11. The ride-on mower used by Mr Woller had been out of service (requiring replacement parts) between December 2022 and January 2023. Consequently, the grass around the property was longer than usual.

12. After lunch on 20 February 2023, Mr Woller went out to work in a paddock where he had been cutting and clearing a large fallen tree branch. He was using a John Deere L100 ride-on mower hitched to a small trailer for hauling the cut wood. He was last seen by Mrs Woller at approximately 1.00pm.

13. At approximately 4.00pm, Mrs Woller went outside to look for her husband as he had not returned to the house as expected. She found the ride-on mower and its small trailer both tipped on their side at the bottom of the paddock. She could see Mr Woller's legs on top of the upturned mower but could not see the rest of him. Mrs Woller went back to the house and telephoned their neighbour, Tim Woods, for help.

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evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

2 "Bobcats"

3 Statement of Timothy Waller – CB013

4 Bisoprolol is a synthetic beta-blocker indicated for hypertension.

5 Gliclazide (brand name Diamicron) – an anti-diabetic medication, used to treat Type 2 diabetes mellitus.

14. Mr Woods made his way directly to the paddock and found Mr Woller lying on his back pushed up against the wheel of an unhitched 6' x 4' trailer with the ride-on mower's trailer partially on top of him. There were seven to eight logs of wood on and around his chest. The cowling at the front of the ride-on mower was damaged on its right side. The engine was not running.

15. Mrs Woller called 000 Emergency, and Mr Woods commenced cardiopulmonary resuscitation (CPR) according to instructions. Other neighbours, Robert and Sue Eyton also came to assist. Ambulance Victoria paramedics attended but it was soon clear that any further resuscitation efforts would be to no effect and Mr Woller was declared deceased at 4.40pm.

16. Victoria Police investigators attended and examined the scene as part of a wider investigation. They observed tyre marks on the grass, suggesting the ride-on mower and its trailer had travelled down and across the slope of the paddock from west to east.

17. Timothy Woller restacked the ride-on mower's trailer with the wood that had fallen out. He described it as a "big load" that he estimated weighed more than 200 kg. With the ride-on mower and its trailer on the slope, he was able to lift the left rear wheel of the mower and, once at a height of approximately one metre "the weight of the trailer took over" and flipped the mower over.

18. Even though this experiment appears to have been conducted without anyone sitting on the ride-on mower, it is consistent with a likely mechanism for the critical events. That is, the heavy weight of the loaded trailer, in combination with the slope that was being traversed, may have precipitated a loss of control or roll over of the ride-on mower.

19. I note that the trailer coupling was of the simple ball and socket type which would have allowed only limited differential roll[6] between the ride-on mower and its trailer. A trailer that was rolling over, once it reached the roll limits of the coupling, would impart significant torque to the mower and a tendency for it to roll as well.

20. I note that a heavily laden trailer also has the potential to impart a sideways force on the rear wheels of the ride-on mower (inducing yaw) if the draw bar of the trailer is at a significant

[6] That is, rotation around the longitudinal axis of the ride-on mower and trailer.

angle to the longitudinal axis of the mower. This effect is amplified if the draw bar is pointing downhill, and by the speed of the vehicles. The two adverse forces from the trailer (that is, the forces inducing roll and yaw) may also occur in combination. Lastly, these problems are exacerbated when the vehicles are in motion over uneven ground and the forces involved are dynamic rather than static.

Identity of the deceased

21. On 20 February 2023, Robin James Woller, born 8 October 1946, was visually identified by his son, Timothy Woller.

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

Medical cause of death

23. Forensic Pathologist, Dr Joanne Ho of the Victorian Institute of Forensic Medicine conducted an autopsy on 23 February 2023 and provided a written report of her findings dated 5 July 2023.

24. The autopsy and post-mortem CT scan revealed multiple rib fractures comprising right posterior 4^{th} to 11^{th} rib fractures with displacement, right anterior 3^{rd} to 6^{th} rib fractures and anterolateral left 4^{th} to 8^{th} rib fractures.

25. Dr Ho commented that although CPR may account for some of these rib fractures, there were more than would be expected from the process of CPR. Moreover, the posterior rib fractures were not commonly seen arising from CPR.

26. The findings also suggested a "flail chest" involving the right 4th to 6th ribs. A flail chest is defined as two or more contiguous rib fractures with two or more breaks and typically occurs in the setting of blunt force trauma. Rib fractures and a flail chest can lead to respiratory compromise.

27. The autopsy also showed significant right pelvic rib fractures (ischium), which extended into the acetabulum. Ilium fractures are high-energy pelvic fractures and often occur in the setting of major trauma, such as a vehicle collision.

28. The circumstances in which Mr Woller was found, and the autopsy findings including bruising (over the lower chest and upper abdomen), skin slippage and red/yellow parchment-type

change (to the left deltoid, lateral left abdomen, left elbow, left hand and left thigh and over the left knee) raised the possibility of an element of traumatic asphyxia.

29. Dr Ho commented that the diagnosis of asphyxia is problematic, as it is based on non-specific autopsy findings and external evidence of trauma. Traumatic asphyxia is a subtype of mechanical asphyxia that occurs when a person's respiratory movements are restricted by a mechanical fixation of the chest, typically when the chest and abdomen are compressed against an unyielding object. This can lead to respiratory compromise with obstruction of oxygen transfer and ultimately lead to death.

30. Dr Ho observed that the possibility of a precipitating medical episode remained. Mr Woller had a history of C'lass I cardiomyopathy (also documented dilated cardiomyopathy), atrial fibrillation and left ventricular failure. At autopsy, Mr Woller's heart was not found to be enlarged and there was no significant coronary artery atherosclerosis. There are however some causes of sudden unexpected death, including cardiac arrythmias, where no anatomical findings are revealed on post-mortem examination. Other causes include seizure disorders and metabolic and biochemical derangements, which are difficult to diagnose at autopsy due to post-mortem artefact.

31. Toxicological analysis of post-mortem samples was unremarkable.

32. Dr Ho provided an opinion that the medical cause of death was CHEST AND PELVIC INJURIES SUSTAINED IN A RIDE ON LAWN MOWER INCIDENT.

33. I accept Dr Ho's opinion.

FINDINGS AND CONCLUSION

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

    a) the identity of the deceased was Robin James Woller, born 8 October 1946;

    b) the death occurred on 20 February 2023 at 270 Oneils Lane, Anakie, Victoria, 3213, from CHEST AND PELVIC INJURIES SUSTAINED IN A RIDE ON LAWN MOWER INCIDENT; and

    c) the death occurred in the circumstances described above.

35. Although it remains possible that Mr Woller suffered an acute medical event which precipitated the crash of the ride-on mower and trailer, there is no direct evidence that this is what occurred. Accordingly, I find this explanation is possible, but not probable.

36. The most likely cause of the crash is a loss of control and roll over of the ride-on mower, precipitated by its path across a slope and the adverse forces imparted by the heavily laden trailer.

COMMENTS

37. The dangers associated with tractors, quad bikes and similar vehicles are well known. One of the principal dangers with these vehicles are rollovers, often arising from use on sloping or uneven ground, obstacles, and improper loading. It is perhaps less obvious that ride-on mowers, with their smaller size and lower speeds, should be considered in the same way.

38. The John Deere L100 has a published weight of 209 kg. Like many ride-on mowers, it has a short wheelbase and a narrow track width necessary for its specific purpose – but these characteristics mean there are inherent limits to the vehicle's stability which must be borne in mind in ordinary operation. The situation is complicated by the addition of a trailer. As the weight of a towed load increases in proportion to the weight of the ride-on mower (plus the operator), the risk of loss of control is increased. Once it exceeds the weight of the ride-on mower, there may be a high likelihood of loss of control, including rollover.

39. It is sobering that a loss of control of this type could occur even though Mr Woller was experienced with the ride-on mower and familiar with the terrain over which he was operating.

40. In the last five years, 13 people have been killed in Victoria in incidents involving ride-on mowers. Six of those cases involved the mower rolling over or tipping.[7] I have directed that this finding be distributed to WorkSafe Victoria, the Victorian Farmers Federation, and the National Farmers' Federation with the aim of informing the safety information that each organisation delivers, particularly in respect of the risks associated with towing.

[7] Ough COR 2023 6902; Sayer COR 2022 7409; Balwin COR 2022 1394; Want COR 2021 4978; Mele COR 2020 6851; and Maloney COR 2019 0350

I extend my sincere condolences to Mr Woller's family and friends for their loss.

I thank the Coroner's Investigator and those assisting for their work in this investigation.

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.

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

Patricia Woller, Senior Next of Kin

Victorian Farmers Federation

National Farmers' Federation

WorkSafe Victoria

Sergeant Glen Jones, Coroner's Investigator

Signature:

CORONER PAUL LAWRIE

Date : 29 October 2024

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.