IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2011 4727

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
Section 67 of the ***Coroners Act 2008***

Inquest into the Death of: JONATHAN PAUL TOZER

Hearing Dates: 1 March 2013

Police Coronial Support Unit Senior Constable Kelly Ramsey, Assisting the Coroner

Findings of: AUDREY JAMIESON, CORONER

Delivered On: 12 March 2013

Delivered At: Level 11, 222 Exhibition Street
Melbourne 3000

I, AUDREY JAMIESON, Coroner having investigated the death of **JONATHAN PAUL TOZER**

AND having held an inquest in relation to this death on 1 March 2013
at Melbourne
find that the identity of the deceased was **JONATHAN PAUL TOZER**
born on 27 August 1963
and the death occurred on 17 December 2011
at Royal Melbourne Hospital, Grattan Street, Parkville 3052
from:

1 (a) MULTIPLE INJURIES IN A PEDESTRIAN STRUCK BY A BUS
1 (b) INTELLECTUAL DISABILITY

in the following circumstances:

BACKGROUND CIRCUMSTANCES

1. Jonathan Paul Tozer was 48 years of age at the time of his death and lived at 27 Gardenia Street, Blackburn, a Nadrasca[1] residential care facility.

2. Nadrasca provides services, facilities and support programs for adults with disabilities. It is a Department of Human Services funded organisation, which also receives funding from the Federal government. Jonathan had resided at Nadrasca facilities for approximately 25 years but throughout his life, Jonathan's parents, Bill and Enid Tozer, remained actively involved with their son and participated in and supported the organisation.

3. Jonathan was diagnosed with intellectual disabilities at birth. He had limited speech but was able to take directions. Jonathan had a fascination with trains and cars. From an early age he had to be supervised otherwise he would run away. He frequently absconded only to be subsequently located at a place that usually involved a train or a railway station. On 28 January 2011, Jonathan absconded from his residence through the front door after it had been left unlocked for a few minutes. He was subsequently found at Southern Cross Railway Station.

[1] A.C.N. 125 235 047

SURROUNDING CIRCUMSTANCES

4. Jonathan had been attending Nadrasca where he had been involved in the Adult Training Support Service at 8 Witt Street, Mitcham for approximately 14 years. His attendance at the training service was 5 days per week from 9.00am to 3.00pm and he was conveyed each way by bus.

5. On Friday 16 December 2011, Jonathan was conveyed to the Witt Street service by bus, arriving at approximately 8.50am. He attended the regular morning meeting in the staff room before being taken by his key worker, Mr Imre Ivanka, to his "Tower", a viewing platform that Jonathan utilised to watch the passing traffic on Whitehorse Road. Mr Ivanka left Jonathan returning to perform administrative work in the Core Group Room where he could also see the "Tower".

6. A short time later, Mr Ivanka could not see Jonathan. Around the same time a neighbour, Ms Lucy Giglio, presented at the Nadrasca reception and advised staff that she had seen one of their client's outside on Witt Street. When staff went outside, Jonathan had gone. A search for his whereabouts began.

7. After leaving the Witt Street building Jonathan ran down a grass embankment and into the path of a bus travelling west in the left lane of Whitehorse Road, Mitcham. The bus driver stopped immediately and contacted '000'. Jonathan was attended to by passers, including an off duty nurse who was driving past the scene of the collision. First aid was administered until the arrival of ambulance paramedics. Jonathon was conveyed by ambulance to the Royal Melbourne Hospital where investigations showed severe injuries including traumatic subarachnoid haemorrhage, spinal injury with paraplegia, ruptured tricuspid valve of the heart and multiple rib fractures. He had an unstable cardiovascular system and required open heart surgery to repair the tricuspid valve but despite these endeavours Jonathan developed cardiogenic shock.

8. Following consultation with Jonathan's family a decision was made to implement palliative care only. Jonathan died on 17 December 2011. He became an organ donor.

INVESTIGATION

9. Dr Michael Burke, Forensic Pathologist at the Victorian Institute of Forensic Medicine performed an external examination on the body of Jonathan Tozer and reviewed a post mortem CT scan and the medical records. The external examination showed injuries in keeping with the clinical history and the CT scan showed blood within the ventricles of the brain. Dr Burke reported that in the absence of a full post examination a reasonable cause of death could be attributed to multiple injuries from being struck by a bus arising from Jonathan's intellectual disability.

10. The Police investigation concluded that the bus driver had approximately one second to try to take evasive action to try to avoid colliding with Jonathan and was hence unable to avoid hitting him.

11. In a statement obtained from Enid Tozer, I note that she and her husband had spoken with the bus driver to inform him that they did not hold him responsible for their son's death. Similarly, Mrs Tozer was clear about their ongoing support of Nadrasca stating that:

    "We can't speak highly enough of Nadrasca."

.INQUEST

12. An inquest was held in accordance with section 52(2)(b) *Coroners Act 2008* because immediately before death, Jonathan Tozer was a *person placed in custody or care* as is defined in section 3 of the Act.

13. The inquest was dealt with by way of a summary of the circumstances. No witnesses were called. No issues were identified by the investigation that required further exploration in the public hearing.

FINDINGS

I make no adverse finding against the bus driver in this matter.

I make no adverse finding against Nadrasca and or its employees and find that the care and supervision of Jonathan by Nadrasca was reasonable and appropriate and that Jonathan absconded from the Witt Street facility on 16 December 2011, despite their best endeavours to keep him safe.

I accept and adopt the cause of death as identified by Dr Michael Burke and I find that Jonathan Paul Tozer tragically died from multiple injuries when he was struck by a bus in circumstances which are a direct result of his behaviours associated with his intellectual disability.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that this Finding be published on the internet.

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

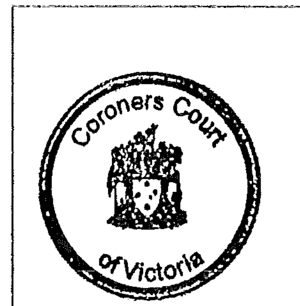
Mr William Tozer

Chief Executive Officer, Nadrasca

Ms Kellie Gumm, Trauma Program Manager, Royal Melbourne Hospital

Senior Constable Darren McCracken, Investigating member, Victoria Police

Signature:



AUDREY JAMIESON
CORONER
Date: 12 March 2013