



# MAGISTRATES COURT of TASMANIA

## CORONIAL DIVISION



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### Record of Investigation into Death (Without Inquest)

*Coroners Act 1995  
Coroners Rules 2006  
Rule 11*

I, Simon Cooper, Coroner, having investigated the death of Josef Vratislav Horcicka

**Find, pursuant to section 28(1) of the *Coroners Act 1995*, that**

- a) The identity of the deceased is Josef Vratislav Horcicka;
- b) Mr Horcicka died as a result of a fractured cervical spine due to an unwitnessed mechanical fall;
- c) In the absence of an autopsy I am unable to determine the precise cause of Mr Horcicka's death; and
- d) Mr Horcicka died on 26 September 2016 at Calvary St Luke's Hospital Launceston, Tasmania.

In making the above findings I have had regard to the evidence gained in the investigation into Mr Horcicka's death. The evidence includes medical records and reports and an affidavit from his only son, Vaclav.

#### **Introduction**

Mr Horcicka was born on 27 January 1927 in the town of Liny in what was then Czechoslovakia. He migrated to Australia in 1951 and met and married his wife Barbara in the 1960s. The couple lived together in the Launceston suburb of Norwood until Mrs Horcicka's death in 2014. Mr Horcicka was 89 years old at the time of his death. He had suffered Parkinson's disease for some time prior to his final period of hospitalisation.

On 16 August 2016 Mr Horcicka suffered an unwitnessed fall at his home. In that fall he suffered a fractured cervical spine. He was taken by Ambulance to the Launceston General Hospital (LGH). He died some weeks later due to the fractured spine. However, the fact of his death was not reported to the coroner for nearly 2 years. I observe that section 19 of the *Coroners Act 1995* provides that any person who has reasonable

grounds to believe that a death is reportable, is obliged to report that death to a coroner or police officer 'as soon as possible'. It is an offence to fail to comply with that obligation.

The definition of 'Reportable death' in section 3 of the *Coroners Act* 1995 includes:

*“(a) a death where –*

*(i) the body of a deceased person is in Tasmania; or*

*(ii) the death occurred in Tasmania; or*

*(iii) the cause of the death occurred in Tasmania; or*

*.....*

*'being a death –*

*(iv) that appears to have been unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury; or*

*(v) that occurs during a medical procedure, or after a medical procedure where the death may be causally related to that procedure, and a medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death.”*

Plainly, Mr Horcicka's death should have been reported much earlier than it was.

The obligation to report is an important one. Coroners have a statutory obligation to investigate deaths, including those in a medical setting, and make, where appropriate, recommendations to prevent similar deaths occurring in the future. Failing to report a death as soon as possible can compromise any investigation. For example, as was the case here, if there is a delay in reporting a death no autopsy can be carried out. Findings at autopsy are often crucial pieces of evidence.

### **The course of treatment**

Returning to the circumstances of Mr Horcicka's injury and death, his medical records indicate that he felt a severe pain between his shoulder blades when he fell. It is reported that he complained of tingling in his hands and feet.

Upon admission, a CT scan of the brain, cervical and thoracic spine was carried out because, as it turned out correctly, an emergency department doctor suspected Mr Horcicka had suffered a fracture of his cervical spine. The CT scan was carried out at the LGH in the evening of 16 August 2016. The images taken were sent electronically to

a radiological practice based in Sydney, New South Wales and reviewed by a radiologist, Dr Jules Comin. After review of the images, Dr Comin prepared a report which was sent back to the LGH. That report included the following:

*“There is no definite acute fracture of the cervical spine... but note is made of what appears to be prominent paraspinal haematoma around the C3-C5 level”.*

After the CT scan was carried out, and the report received, Mr Horcicka was seen by a junior orthopaedic registrar, Dr Namit Sharma. Dr Sharma read the CT scan report, the extract of which is reproduced immediately above.

An orthopaedic surgeon, Mr David Edis, saw Mr Horcicka the following day, 17 August 2016. Mr Edis decided as there was no abnormal neurology an MRI scan of Mr Horcicka's spine was unnecessary. When asked to comment on Mr Horcicka's death as part of this investigation Mr Edis could not recall reviewing Mr Horcicka and had no recollection of his assessment of any imaging. Mr Edis said that his reading of Mr Horcicka's medical notes suggested that he had discussed the case at the time with another orthopaedic surgeon, Mr Roger Butorac, and that Mr Horcicka was under Mr Butorac's care and not his.

Comment was sought from Mr Butorac. He agreed that Mr Horcicka was seen by Dr Sharma. Mr Butorac said that the medical records indicated he discussed Mr Horcicka's case with Dr Sharma, but did not review him personally. Like Mr Edis, Mr Butorac said he had no actual recollection of Mr Horcicka or his management.

In any event, after undergoing the CT scan of his head and spine Mr Horcicka was fitted with a cervical collar. Had the CT scan report been correct that there was no definite acute fractures then the decision to fit Mr Horcicka with a cervical collar would have been reasonable. So would the decision to treat him conservatively with a combination of physiotherapy, rest and analgesia.

On 18 August 2016, Mr Horcicka was seen by a physician, Dr Hannan, who noted improvement with analgesia and suggested that Mr Horcicka be mobilised. Accordingly, Mr Horcicka was stood up and sat down by an occupational therapist, actions which caused him a significant increase in pain. This in turn led to an immediate and urgent review by the LGH medical team. Although it would appear that no standard neurological examination was performed, a repeat CT scan of Mr Horcicka's cervical spine was undertaken. The scan showed that he had a fracture/subluxation of the C5–C6 intervertebral and facet joints. An MRI scan was carried out which confirmed the findings which were that Mr Horcicka was a high level C5-C6 paraplegic/quadruplegic

(albeit with a degree of arm function). The circumstances in which Mr Horcicka sustained his original injury and the evidence of the treatment that he received leads to the conclusion that the fracture had been sustained when he fell at home on 16 August 2016. I am satisfied that the sitting down by the occupational therapist jarred Mr Horcicka's bones causing ligament disruption and separation and compression of his spinal cord.

Mr Horcicka was transferred the following day to the neurosurgical unit at the Royal Hobart Hospital. After admission to the RHH Mr Horcicka's radiology, including the original CT scan of the cervical spine, was further reviewed. That review showed a C5 inferior articular process fracture. Mr Horcicka was immobilised, fitted with a halo crown and medicated. Surgery was delayed because of the presence of antiplatelet agents. He was reviewed by the RHH's neurology team in respect of the need to manage his Parkinson's disease. A decision was made that no antipsychotic drugs be administered as these would likely have had the effect of worsening his Parkinson's disease. Mr Horcicka's condition deteriorated. On 20 August 2016 he was notably agitated. A decision was made to administer morphine and, despite the recommendation of the neurology team, olanzapine (an antipsychotic drug). There is no basis to criticise that decision in the circumstances.

On 22 August 2016 his condition was discussed with his son and a decision made to proceed with surgery. On 24 August 2016 at the RHH an anterior cervical vertebral fusion with plating was performed. Two days after this surgery Mr Horcicka was noted to be alert, obeying commands and speaking more clearly. However, he developed pneumonia which was treated with antibiotics.

After a period of recuperation at the RHH, Mr Horcicka was returned to the LGH on 31 August 2016. Over a period of some days Mr Horcicka experienced a slightly improved level of neurological function. However his improvement was not permanent. On 14 September 2016, after review by the hospital's palliative care team and discussion with both Mr Horcicka and his son, a decision was made to treat him palliatively in accordance with his wishes. In short, all treatment of Mr Horcicka ceased and he slowly deteriorated and eventually died on 26 September 2016.

### **Consideration of Treatment**

It is obvious on the evidence that the fact that Mr Horcicka had sustained a C5 inferior articular process fracture was missed when the first CT scan was performed upon his admission to the LGH.

That omission shaped the treatment that Mr Horcicka received. It is inconceivable that he would have been treated conservatively, including by a physiotherapist and an occupational therapist, involving mobilisation, had the presence of a C5 fracture been identified.

As part of the investigation in relation to Mr Horcicka's treatment and subsequent death, I sought advice from Dr Anthony J Bell (MB BS MD FRACP FCICM), medical advisor to the Coroner's Office. Dr Bell in his report to me made the point, a reasonable one in my view, that notwithstanding the fact that the fracture was not identified in the initial CT scan, given Mr Horcicka's age and clinical presentation, an MRI scan ought to have been carried out. This was particularly so given that a paraspinal haematoma was identified in the initial CT scan. I accept Dr Bell's view that an MRI scan was still required to define the extent of any ligamentous injury.

### **Comments and Recommendations**

The circumstances of Mr Horcicka's death are not such as to require me to make any recommendations pursuant to Section 28 of the *Coroners Act* 1995. However, given the circumstances of his death I consider it appropriate to make two comments necessary.

First, I **comment** that an MRI scan of the cervical spine is better at detecting ligamentous injury than a CT scan, a potentially critical consideration where an injury to the cervical spine is suspected of having been sustained, particularly in an elderly patient.

Second, I **comment** that the ability of coroners to effectively perform their functions under the *Coroners Act* 1995 is dependent upon the timely reporting of reportable deaths. The fact that Mr Horcicka's death was not reported until nearly 2 years after Mr Horcicka's death is not acceptable.

I convey my sincere condolences to the family and loved ones of Mr Horcicka.

**Dated** 25 July 2019 at Hobart in the State of Tasmania.

**Simon Cooper**  
**Coroner**