



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 Dr Peter Golus

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

- a) The identity of the deceased is Dr Peter Golus;
- b) Dr Golus died following a pyeloscopic stone extraction from his left kidney;
- c) The cause of Dr Golus' death was escherichia coli urosepsis; and
- d) Dr Golus died on 4 November 2017 at the Launceston General Hospital, Launceston, Tasmania.

**Introduction**

1. In making the above findings I have had regard to the evidence gained in the investigation into Dr Golus' death. The evidence includes:
  - a Police Report of Death for the Coroner;
  - an opinion of the forensic pathologist who conducted the autopsy;
  - medical records from both Calvary Health Care Tasmania and the Tasmania Health Service;
  - a report from Dr Jensen, urologist;
  - statement – Elizabeth Wells, Registered Nurse; meteorological evidence;
  - statement – Leoni Marie de la Motte, Registered Nurse; and
  - statement – Zachary Golus.
2. Aged 65 years at the time of his death in November 2017 Dr Golus was, according to his son Zachary, in good health. Although having suffered from prostate cancer in 2011 and from a hernia in 2016 (both of which were treated successfully) his medical records also support the suggestion that he was otherwise fit and healthy. He neither drank alcohol nor smoked and exercised regularly. Prior to his death he was in private practice as a psychologist.

### **Circumstances of Death**

3. On 3 November 2017 Dr Golus was admitted to St. Vincent's Hospital, Launceston for kidney stone surgery. The surgery was conducted by urologist Dr Robert Jensen and was apparently successful. The stone was disintegrated using a laser. Dr Jensen described the extraction as "uneventful". At the time of surgery he did not notice any obvious infection in Dr Golus' urinary tract.
4. Following surgery Dr Golus was returned to the ward at 5:50 pm. At that time he was observed to have stable vital signs. Medical notes indicate he was alert and oriented and declined offers of pain relief at 6.00pm describing his pain as 3/10.
5. However at 7.00pm his temperature was noted as rising, a fact documented accordingly on the observation chart. A phone call was made to Dr Jensen who gave orders for blood cultures and a catheter specimen of urine to be taken.
6. Dr Golus was reviewed by Dr Jensen at 8.30pm. Notes of that review were recorded by a registered nurse.
7. At 10.00pm, routine post anaesthetic observations continued. Apart from an elevated temperature, all Dr Golus' vital signs were recorded as remaining within acceptable parameters. He was noted to be both alert and oriented.
8. Medical notes record Dr Golus vomiting at 11.00pm. As a result he was given Ondansetron 8mg, an anti-nausea drug.
9. By 1.30am on 4 November 2017 the observation chart records Dr Golus complaining of pain in his abdomen after he had been assisted to use the bathroom.
10. As the early hours of the morning wore on, Dr Golus' condition deteriorated. Dr Jensen was contacted by nursing staff again at about 2.00am because observations had been taken and manual blood pressure was recorded as 84/60. Dr Jensen ordered saline to be given. 10mg of morphine is recorded as having been administered at 2.25am on account of Dr Golus' lower abdominal pain.
11. The next record of observations were at 2.50am. Dr Golus' blood pressure was by then dangerously low (60/40), his heart rate was 85 bpm, his temperature 36 degrees and he is recorded as having 16 breaths per minute. He was cold. By then it is quite apparent Dr Golus was dangerously ill.

12. Registered Nurse (RN) De La Motte was responsible for nursing Dr Golus. She immediately rang the afterhours nursing coordinator RN Wells upon recording this blood pressure. RN Wells went straight to see Dr Golus with RN De La Motte. Both nurses report that at that time Dr Golus was alert, oriented and conversing appropriately with staff. Neither noted any alteration in his cognitive state.
13. RN Wells rang Dr Jensen. Dr Jensen says the telephone call occurred at 2.45am. RN Wells said it occurred at 2.10am. Dr Golus' medical records suggest that Dr Jensen is closer to the mark. In any event I consider little, if anything, turns on the discrepancy as to time and it is clear enough that there was only one conversation between nursing staff and Dr Jensen concerning Dr Golus at about this time. RN Wells says in the conversation she told Dr Jensen that Dr Golus' blood pressure was 60 /40. Dr Jensen says he was told it was 84/60 (I note the observation chart records Dr Golus' manual blood pressure at 2.50am as 60/40 – suggesting RN Wells account of the conversation is more likely than not to have been accurate). Dr Jensen sought confirmation that Dr Golus had been given his ordered IV antibiotics. RN Wells confirmed that this was so. Dr Jensen ordered the administration of a bolus of 500 mills of normal saline, followed immediately by 1 L of normal saline over 6 hours and to notify him if there are any further concerns.
14. Nursing staff were instructed to take observations of Dr Golus every 5 minutes by Dr Jensen - something better carried out, in hindsight, in the hospital's High Dependency Ward. However as there was only one nurse on duty in the HD Ward caring for 3 patients, nursing staff made a decision to leave Dr Golus where he was. This of course meant that the directed observations were unable to be carried out on that ward either as staff/patient ratios were comparable to, or less favourable than, those in the high dependency unit.
15. In her statement, RN Wells says that at 2.45am she was advised by RN De La Motte that Dr Golus' blood pressure had improved. I am satisfied that this cannot be correct. The only observation recorded at about this time is the one referred to in paragraph 10 above. I note that RN Wells is unable to recall the exact blood pressure reading she says she was given by RN De La Motte. I also note that RN De La Motte says nothing in her statement about such a conversation. There is no record, anywhere, of any significant improvement in Dr Golus' blood pressure.
16. The next objectively verifiable event occurred at 5.45am when his medical records record that Dr Golus woke in pain and was given Endone. His blood pressure was still dangerously low at 77/50 - a fact which suggests if there was an observation taken at 2.45am and there

had been any improvement it could not have been significant. In addition, Dr Golus' heart rate had increased and he was reporting his pain as being 8 /10. Dr Golus telephoned his son who attended St Vincent's immediately and reported that by the time he arrived his father was unable to speak or see properly.

17. At 6.45am, upon review of his overnight history, a decision was made by the St Vincent's Hospital morning shift coordinator for Dr Golus to be moved, belatedly in my view, to the hospital's high dependency unit.
18. His medical notes indicate that at 8.20am, Dr Golus was unresponsive and an emergency code call was made. CPR was commenced at 8.25am. At 9.15am he was transferred to the Launceston General Hospital (LGH) by ambulance where CPR continued. Staff at the LGH were unable to revive Dr Golus and he died at about 10.15am.

#### **Forensic Pathology and Expert Medical Evidence**

19. The fact of Dr Golus' death was reported pursuant to the provisions of the *Coroners Act* 1995. After formal identification, his body was transported by mortuary ambulance to the Royal Hobart Hospital (RHH). At the mortuary of the RHH, an autopsy was carried out upon his body by experienced forensic pathologist Dr Donald MacGillivray Ritchey. Dr Ritchey found the cause of Dr Golus' death was escherichia coli urosepsis, a severe infection in the urinary tract. I accept Dr Ritchey's opinion.
20. Dr Ritchey noted the sudden severe abdominal pain reported by Zachary was likely the result of a spasm of the left ureter 'colic' which is both notoriously painful and likely to have been exacerbated by sepsis. Similarly, the symptoms reported by Zachary of his father's difficulty with speech and eyesight are likely to have resulted from decreased blood flow to the brain due to his very low blood pressure.
21. As part of the investigation into Dr Golus' death, his treatment was comprehensively reviewed by the medical advisor to the Coronial Division Dr AJ Bell MB BS MD FRACP FCICM. Dr Bell provided a report in which he said that it was clear by 2.00am on 4 November 2017, Dr Golus had developed shock which was likely to have been septic shock. He expressed the opinion, with which I agree, that at that time Dr Golus should have been transferred to the LGH. Dr Bell also noted that the medical records make it clear that Dr Golus' vital signs were recorded at 2.50am and then not again for 3 ½ hours. I note, as pointed out above, this was despite an express direction (and patent need) for much more frequent observations.

**Comments and Recommendations**

22. The circumstances of Dr Golus' death are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act 1995*.
23. I convey my sincere condolences to the family and loved ones of Dr Golus, in particular, his son Zachary.

Dated 21 August 2019 at Hobart in the State of Tasmania.

**Simon Cooper**  
**Coroner**