IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2018 005312

FINDING INTO DEATH WITHOUT INQUEST

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

Findings of:	Coroner Darren J. Bracken
Deceased:	Sharni Dee Connolly
Date of birth:	16 January 1981
Date of death:	22 October 2018
Cause of death:	1(a) MULTIPLE DRUG TOXICITY
Place of death:	Royal Melbourne Hospital, 300 Grattan Street, PARKVILLE, Victoria, 3052

INTRODUCTION

1. Sharni Dee Connolly was 37 years old when she was pronounced dead at the Royal Melbourne Hospital 22 October 2018 from multiple drug toxicity. At the time of her death, Ms Connolly lived with her husband, Tim Connolly and sons, Harper (aged 10) and Leo (aged 6) at 7 Forrest Hill Close, Traralgon.

2. Ms Connolly was a registered nurse who previously worked in the emergency department at Latrobe Regional Hospital. She became a naturopath and had her own business, Gippsland Wellness, in Traralgon.

3. In 2017 she sustained an injury to her right hamstring in a fall while on holiday. According to her GP, Dr Dak Yor Akol of Hillcrest Family Medicine in Traralgon:

   "*She underwent multiple corrective surgeries* [to treat this injury] *with variable results and complications. As a result, she required opioid analgesics".*

4. She was prescribed tapentadol and pregabalin for pain.

5. Ms Connolly's medical history also included post-natal depression, anxiety and depression and multiple sclerosis.

6. Mr Connolly provided a statement to the coroner's investigator (**CI)** in which he described his wife as appearing increasingly dazed and confused as time went on and that she became unable to undertake normal household tasks. In the two months prior to her death, Mr Connolly continued to ask Ms Connolly what she was taking which resulted in her becoming defensive; she would tell him she needed the medication for her pain. Mr Connolly explained that: "*Due to her background I trusted she knew what she was doing".*

THE CORONIAL INVESTIGATION

7. Ms Connolly'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.

8. 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.

9. 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.

10. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation of Ms Connolly's death. The Coroner's 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.

11. This finding draws on the totality of the coronial investigation into the death of Ms Connolly 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

12. On 22 October 2018, Tim Connolly identified the deceased as his wife Sharni Connolly born 16 January 1981.

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

Medical cause of death

14. Forensic Pathologist, Dr Yeliena Baber, from the Victorian Institute of Forensic Medicine (**VIFM**), conducted an autopsy on 29 October 2018 and provided a written report of her findings dated 12 February 2019.

[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.

15. Toxicological analysis of antemortem samples identified the presence of tapentadol[2](~0.1mg/L), tramadol[3](~0.3mg/L), diazepam[4](0.08mg/L), clonazepam[5](0.01mg/L pregabalin[6](~5.8mg/L), valproic acid[7]~17mg/L), trimethoprim[8](~3mg/L) and temazepam[9](0.1mg/L).

16. Dr Baber commented that the use of multiple central nervous system depressant drugs (which I note included pregabalin) can have a cumulative effect and increase respiratory depression and sedation.

17. Dr Baber provided an opinion that the medical cause of death was *1 (a) Multiple drug toxicity*.

18. I accept Dr Baber's opinion.

Circumstances in which the death occurred

19. At approximately 8.00am on 20 October 2018, Mr Connolly found his wife lying on the kitchen floor with her children trying to rouse her. Mr Connolly assisted her to return to bed. He noted that "*While I was walking her to the bed Sharni was talking but none of it was making any sense".*

20. Mr Connolly left Ms Connolly in bed and went to attend to the children. Approximately two hours later, Harper got into bed with his mother. At approximately 1.30pm, Ms Connolly's sister arrived at Ms Connolly's home to take Harper and Leo out. The deceased's sister went into Ms Connolly's room to see her and to collect Harper. Harper told the deceased's sister he preferred to stay at home. The deceased's sister said that:

> *"I walked around to Sharni's side of the bed and I thought that I should move her and I noticed that he*[sic] *breathing was quite heavy but is* [sic] *usual for her to be like that. I couldn't see her because the room was dark".*

21. The deceased's sister left the house taking Leo with her.

22. Just prior to 2.00pm, Harper came out and told his father that there was "*something wrong with mum".* Mr Connolly went to the bedroom where he discovered that Ms Connolly had

[2] An opioid analgesic.
[3] An opioid analgesic.
[4] A benzodiazepine used to treat anxiety.
[5] A benzodiazepine used to treat panic attacks and anxiety.
[6] Medication used to treat neuropathic pain.
[7] Medication used as an anticonvulsant, bipolar disorder and neurogenic pain.
[8] Antibiotic used in the treatment of urinary tract infections.
[9] A sedative, hypnotic drug of the benzodiazepine class.

stopped breathing. He called emergency services and administered CPR under the instructions of the call taker until the arrival of crews from the Country Fire Authority and Ambulance Victoria. Resuscitation continued until there was return of spontaneous circulation.

23. Ms Connolly was transferred to the Emergency Department of Latrobe Regional Hospital arriving at 3.33pm. Dr Haider Al-Ubaidi, emergency physician, provided a statement to the CI noting that various tests and imaging (including CT brain) revealed multisystem failure and cerebral oedema indicating a lengthy period of hypoxic brain injury.

24. At 8.35pm Ms Connolly was transferred by helicopter to the Royal Melbourne Hospital (**RMH).**

25. On 22 October 2018, following discussion with Ms Connolly's family about the possibility of brain death, a nuclear medicine scan was performed. The scan revealed no evidence of cerebral perfusion and was otherwise consistent with brain death and Ms Connolly was formally certified as brain dead at 4.45pm. Her family generously agreed to organ donation.

FURTHER INVESTIGATIONS

26. Given the quantity and variety of the medications found in Ms Connolly's blood samples, I referred the matter to the Coroner's Prevention Unit[10] **(CPU)** and requested that it review the prescribing practices of the doctors involved in the medical management of the deceased.

27. The CPU reviewed Pharmaceutical Benefits Scheme (**PBS)** and Medicare records together with Ms Connolly's medical records from Hillcrest Family Medical Clinic, Flourish Medical Group, Latrobe Regional Hospital and the RMH.

28. The CPU advised me that, in addition to Dr Akol, Dr Tolulope Onibokum of Flourish Medical Group in Traralgon also prescribed medications detected in Ms Connolly's antemortem samples.

29. Having reviewed the prescribing to Ms Connolly in the period proximal to her death, the CPU advised me in relation to each of the medications as follows:

Tapentadol

[10] 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.

30. Between 2 July and 1 October 2018, Dr Akol provided Ms Connolly with 15 prescriptions (including repeats) for tapentadol (resulting in it being dispensed to her on 21 occasions). On 19 occasions, the dose prescribed and dispensed was 50mg; and 100mg on the remaining two occasions. The CPU also noted that 16 of the 21 dispensing events resulted from prescriptions that did not attract a PBS contribution; only five dispensing events for tapentadol appeared on the PBS records. The medical records did not disclose why Dr Akol regularly prescribed tapentadol on non-PBS prescriptions.

31. The tapentadol was dispensed, on Dr Akol's instructions, in both immediate and slow release formulations. According to Dr Akol's statement, this was done to avoid using multiple analgesic agents to treat Ms Connolly's ongoing pain. Accordingly, on six occasions both immediate and slow released tapentadol tablets were dispensed at the same time.

32. Ms Connolly was directed to take one 50mg immediate release tapentadol three times a day and one 50mg slow release tablet twice a day making a total of tapentadol 250mg a day.

33. However, the CPU noted that 704 tapentadol tablets were dispensed to Ms Connolly between 2 July 2018 and 1 October 2018. This was an amount equivalent to approximately 345mg of tapentadol per day between 2 July 2018 and her apparent overdose on 20 October 2018.

34. The CPU contacted the Medicines and Poisons Regulation **(MPR)** section of the Victorian Department of Health and established that it had no record of reports that Ms Connolly was drug-seeking or drug-dependent.

35. The CPU advised me that the amount of tapentadol prescribed and dispensed to Ms Connolly in the period proximal to her death was not excessive on the basis of Dr Akol's directions for consumption.

Tramadol

36. The CPU identified that, between 19 September and 19 October 2018, tramadol was dispensed to Ms Connolly on five occasions. The sole prescriber was Dr Onibokun. On each occasion the amount dispensed was 20 x 50mg tablets and the clinical directions were to take one tablet three times a day.

Pregabalin

37. The CPU noted that between 19 July and 31 August 2018, pregabalin was prescribed to Ms Connolly on three occasions:

38. On 19 July 2018, Dr Akol prescribed pregabalin 56 x 25mg tablets with five repeats. The prescription was dispensed on 3 August, 10 September and 11 October 2018. The remaining repeats do not appear to have been dispensed.

39. On 3 August 2018, Dr Akol prescribed pregabalin 56 x 26mg with one repeat and this prescription and its repeat were both dispensed on the same day (total 112 tablets).

40. On 1 October 2018, Dr Akol prescribed pregabalin 56 x 25mg with one repeat which were dispensed together on the same day (total 112 tablets).

41. The clinical directions were to take one tablet twice a day, a total of 50mg daily. However, between 19 July and 20 October 2018, a total of 392 x 25mg pregabalin tablets was dispensed; equivalent to 105mg per day – more than double the amount she was clinically directed to take.

42. In his statement, Dr Akol stated that:

> "*I discussed the regulation surrounding the limit of daily dosage and restriction of early prescriptions with Miss Connolly, but due to her business commitments and frequent and often unpredicted timings of travel to Bali, Indonesia, there were times when more than two weeks' worth of prescriptions and sometimes early prescriptions were supplied".*

43. I have noted that, in his statement, Mr Connolly makes no comment about Ms Connolly travelling to Bali in the months prior to her death and indeed, his description of his wife during this period is inconsistent with a person well enough to make overseas business trips. The purported trips may have been a (successful) ploy by Ms Connolly to persuade Dr Akol to provide additional prescriptions and/or allow for dispensation of double the number of tablets at one time.

44. The CPU expressed concern about the amount of pregabalin prescribed and dispensed to Ms Connolly which it considered to be significantly in excess of therapeutic need.

Clonazepam

45. The CPU identified that, between 4 June and 17 October 2018, clonazepam was prescribed to Ms Connolly to treat anxiety/depression on three occasions:

46. On 4 June 2018, Dr Akol prescribed clonazepam 0.5mg x 100 tablets with three repeats which were dispensed on 4 June, 29 June, 26 July and 21 August 2018.

47. On 18 July 2018, Dr Akol prescribed clonazepam 0.05mg x 100 tablets with three repeats which were dispensed on 18 July, 3 August, 28 August and 24 September 2018.

48. On 17 October 2018, Dr Akol prescribed clonazepam 0.05mg x 100 without repeats. It was dispensed on the same day.

49. The clinical directions were to take one tablet three times daily. None of the above were PBS prescriptions. The total number of clonazepam tablets dispensed to Ms Connolly was 900 tablets, equivalent to 3.2mg per day, over double the amount she was clinically directed to take and considered by the CPU to be well in excess of therapeutic need.

Other medications

50. Diazepam was only prescribed to Ms Connolly on one occasion in the twelve months prior to her death, being on 21 June 2018. She was prescribed 5mg x 50 tablets.

51. Temazepam was prescribed to Ms Connolly on three occasions between 20 July and 15 October 2018 by Dr Onibokun. On each occasion, he prescribed 25 x 10mg tablets.

52. The CPU found no evidence that valproic acid was ever prescribed to Ms Connolly in the year prior to her death although it is possible that it had been prescribed at an earlier time.

53. Trimethoprim was prescribed to Ms Connolly by both Dr Akol and Dr Onibukon.

54. The CPU advised me that pregabalin and clonazepam appeared to have been prescribed and dispensed to Ms Connolly in excess of therapeutic need. The concurrent prescribing of these medications, which are central nervous system stimulants, increased the possibility of overdose.

55. The CPU did not consider the prescribing of tapentadol, temazepam, diazepam and trimethoprim to be problematic in and of itself.

56. The CPU also noted that Dr Akol sought to investigate other treatment possibilities for Ms Connolly. Notably, on 21 September 2018 he referred her to a pain management specialist. There is no evidence that Ms Connolly followed up on this referral.

57. The CPU did not identify any concerns relating to Dr Onibukon's prescribing.

58. The CPU advised me that, ultimately, it did not identify systemic opportunities for prevention to be pursued in this case. Although Ms Connolly attended two doctors simultaneously, most

medications were prescribed by Dr Akol. Neither did the two clinicians prescribe any of the same drugs in the period proximal to Ms Connolly's death.

59. Furthermore, the CPU referred me to the SafeScript Real-Time Prescription Management (**RTPM**) system which was introduced in Victoria on 1 April 2020. Such a system would have enabled Ms Connolly's doctors to instantly find out which other clinics she had attended and the drugs she had been prescribed by other doctors.

60. As I have noted in other findings [11]regarding deaths from similar medication overdoses, pregabalin is not included as one of the drugs monitored by SafeScript. I consider that inclusion of pregbalin in the SafeScript RTPM scheme may well prevent deaths in the future, by drawing the attention of clinicians to excessive prescribing of the drug, of which they would have otherwise been. Accordingly, I make the recommendation below.

61. The RMH clinical records relating to Ms Connolly's admission reveal that Mr Connolly advised staff that he discovered that 20 tapentadol 50mg tablets were missing from a pack originally containing 50 tablets dispensed to Ms Connolly on 17 October 2018 and that Mr Connolly reported that Ms Connolly had been depressed:

"due to leg injury, felt down and that she is a burden to her husband has now expressed suicidal thoughts".

62. An entry in the clinical records by *"Social Work*" records a discussion with Mr Connolly who advised that Ms Connolly had been taking analgesia and that "*Tim feels that pt took medication got disorientated and took wrong medication again".* Another entry in the clinical progress notes records that Ms Connolly expressed suicidal ideation four days previously.

63. I have noted that in his statement, Mr Connolly does not refer to his wife being depressed or suicidal.

64. When excessive prescribed medication and chronic overuse of prescription medication is involved it is often difficult to determine whether a person decided to deliberately end their own life or whether death was the advertent consequence of taking more than a prescribed amount of medications. A finding of suicide ought only to be made on the basis of clear cogent evidence of intent. Whilst the coronial brief contains some circumstantial evidence supporting the contention that Ms Connolly took her own life, it does not contain sufficient

[11] For example see: Diane Hillgrove COR 2018 3264

evidence for me to so find that Ms Connolly deliberately took an excessive amount of prescribed medication, including pregabalin intending to end her own life and I make no such finding.

RECOMMENDATIONS

65. Pursuant to section 72(2) of the *Coroners Act 2008* (Vic), I recommend that:

    1. In order to reduce the risk of harm associated with pregabalin, the Victorian Department of Health and Human Services consider the inclusion of pregabalin in the scope of drugs monitored in the Safe Script real-time prescription monitoring scheme.

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

FINDINGS AND CONCLUSION

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

    (a) the identity of the deceased was Sharni Dee Connolly, born 16 January 1981;

    (b) the death occurred on 22 October 2018 at Royal Melbourne Hospital, 300 Grattan Street, Parkville, Victoria, 3052, from multiple drug toxicity; and

    (c) the death occurred in the circumstances described paragraphs 19 – 64 above.

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

Mr Timothy Connolly, Senior Next of Kin;

Dr Yor Akol Dak, Hillcrest Family Medicine;

Dr Humsha Naidoo, LaTrobe Regional Hospital;

Professor Euan Wallace, Department of Health (Vic); and

Senior Constable Wade McNeill, Victoria Police, Coroner's Investigator

Signature:

Date: 1 May 2021

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.