PE1651/AAAAA
Dr Andonis Yannakopoulos submission of 4 January 2018

Our daughter Catherine died in November 2010, she was 29. She was given a cocktail of psychiatric drugs over a period of 5 months and sadly took her own life.

She experienced adrenal exhaustion after returning from a 6 month world trip in April 2010. She had jet lag and had been only getting 2 hours sleep a night for weeks. Her wedding in Greece was to be the 2nd July and she had a breakdown 2 weeks before we were due to fly out to Santorini. There were many stressors also besides the wedding preparations. Catherine was diagnosed with MS in January 2009.

Catherine was given Benzodiazapines initially for anxiety and then prescribed Escitalopram for the anxiety and to help her sleep but that's when her nightmare began. After being on that drug for just over 2.5 months she had bought weed killer with the intention of killing herself. We requested and Professor Andrew Herxheimer kindly wrote a report for the coroner. From my understanding of his report, that 'escitalopram and its almost identical predecessor citalopram are linked with suicidal ideas and behaviour'. And that in his conclusion 'We cannot ask Catherine what made her kill herself, but it is very possible and even likely that her suicidal thoughts and feelings were induced by aripiprazole and mirtazapine. Their effects would have been additive.'

More and more drugs were added. It wasn't till after she died that we began to find out about the drugs which Catherine was taking. We realised soon after, that it was probably the cocktail of these powerful mind changing drugs that lead to her death.

Drugs Catherine was taking prior to her death on 24th November 2010 were:

- Aripiprazole 20mg mane
- Mirtazapine 45mg nocte
- Procyclidine 5mg tds
- Haloperidol 5mg mane and 10mg nocte
- Diazepam 5mg pm to tds
- Zopiclone (as needed)

We undertook research about these drugs. The more we read the more we were shaken, with ultimate anger building inside us. All she needed was rest and sleep.

Professor David Healy has highlighted the adverse reactions to some of the drugs in his open letter to coroners in general (see attachment).

Before the inquest I received a report prepared by the expert witness from the coroner. The main emphasis seemed to have centred around Catherine's MS. He concluded that MS was the main factor in Catherine's depression and suicide. He claimed that she had an MS relapse. Professor Scolding, who was Catherine's

neurologist confirmed that Catherine never had a relapse. In fact all the claims made by the expert witness about her MS were totally rejected by Professor Scolding, who is an expert in his field of neurology, and who was also treating our daughter. The expert witness was giving his opinion, about Catherine's MS, which is a neurological condition. He was contradicting Professor Scolding's opinion who is an expert in neurology.

The expert witness never saw or met our daughter and I find the claim, that it was the MS that made Catherine depressed and have suicidal ideas, astonishing. However Professor Scolding did see Catherine, and said in his letter:

'was always impressed by how well she seemed to adjust to the disorder and by her courage and strength of personality'.

Our daughter was a highly intelligent girl, she was loving, kind and gentle. She always showed much concern for her family and friends. She loved life and was looking forward to her future. Catherine had no history of depression or any mental health problems at any time in her life. She was always upbeat and determined and showed such a lot of courage even after the diagnosis of MS. It was totally alien to her to think or even contemplate suicide.

The expert witness in his conclusion cited the key findings from a paragraph from 'CSM Expert Working Group on the Safety of SSRIs 2008'. It states that:

‘There is no clear evidence of an increased risk of self-harm and suicidal thoughts in young adults of 18 years or over.’

The report was published in 2004 and not 2008 as he claimed. It is out of date because that finding no longer applies. In 2008 new trials where carried out to show that it now extends to 25 years and not 18. In effect, he reproduced a finding that no longer applies. I personally find this misleading.

At the inquest, I challenged him on this but he insisted it was 2004. He appeared flustered.

Expert witness report also stated:

‘On 1st November the dose of aripiprazole was doubled to 20mg when she was last seen by the psychiatrist. It was felt that she was improving’

This was contradictory to our observations of our daughter. Catherine was deteriorating and she was thinking about suicide. The team were contacted on Friday 29th October 2010 and this was pointed out to them. This was after Catherine visited a police station with the delusion that she thought she did something wrong. It is unlikely that the following Monday (1st November 2010) she would have improved. Indeed my wife was staying with Catherine at the time. There was certainly no such alleged improvement. In fact the opposite; I saw Catherine on 13th November and I was shocked to see how much she had deteriorated. She was agitated, shuffling as she walked. It was evident she had Akathisia. Akathisia is the extreme inner restlessness which can be caused by antipsychotics and

antidepressant drugs. The affected person feels tortured from within and these drugs can contribute to or directly cause or lead to suicide.

On the morning of the day Catherine died, she had an appointment with the Early Intervention Team, they had knocked on her door, received no reply and left. No precautionary attempt was made to contact someone, which would have aroused suspicion that something was wrong. Of course depending on the time involved this may have saved her life.

Indeed, Professor Herxheimer informed me that in his opinion, the level of care that Catherine received was INADEQUATE.

I pointed this out, together with other detailed responses that I made about the expert witness report. I wrote and sent two lengthy and detailed reports to the coroner. They both took extensive time and research from various sources, including articles written by experts who are at the fore front of pharmacology research of these psychiatric drugs.

Both of my reports were also discarded by the coroner.

The coroner continued and made a despicable verdict of suicide. We were hoping for a narrative verdict.

After the inquest I wrote to the MHRA, who published ‘REPORT OF THE CSM EXPERT WORKING GROUP ON THE SAFETY OF SSRIs’. Indeed they confirmed it was 2004, thus showing that the claim made by the expert witness, which he emphatically defended, was wrong.

One drug that Catherine was prescribed was Escitalopram which the expert witness gave his opinion on.

At the beginning of the hearing the Coroner’s officer when reading out her report said that Catherine had a history of depression. I was taken aback but too upset to respond to this. I had lots to think about and I was certainly not accustomed to court hearings. I made it clear that up to June 2010 when Catherine had a breakdown she had no history of depression. When someone says this person has a history of depression one immediately envisages many years. This is totally false. So what was meant by ‘she had a history of depression’?

I wrote a letter to the coroner pointing out all of the above, together with evidence. She wrote back and said she couldn't comment on the points I raised, and that her decision remained.

In summary Professor Herxheimer and Professor Healy have jointly written a paper titled ‘Case Histories as Evidence’, which has been published in 2012 by International Journal of Risk & Safety in Medicine . It explains how it is that many courts have not adequately considered prescribed drugs as a cause of death which I believe to be a very sad state of affairs.

Open Letter to Coroners

Following your expression of interest in the possible links between SSRI antidepressants and both suicides, and unexplained deaths, I am happy to provide the following brief details and will gladly supplement these details on enquiry from you or any of your colleagues.

There is now convincing evidence pointing to a link between suicide and the group of drugs of which Prozac (fluoxetine), Seroxat (paroxetine), Cipramil (citalopram), Cipralex (escitalopram), Effexor (venlafaxine) and Lustral (sertraline) are the most commonly used in this country. These links were obvious from the randomized control trials done in depressed patients to get the drugs on the market in the first place. It also appears that problems can happen on withdrawal.

If asked a straight question can your drug cause suicide, the companies making these drugs are obliged to answer Yes. But when asked if the drug has caused this particular person to kill themselves they will invariably say No and attribute any death the disorder for which the person was being treated or other circumstances. However these drugs have also caused suicide in healthy volunteers or patients being treated for anxiety disorders, obsessive-compulsive disorder OCD, or for weight loss, smoking cessation purposes, and a variety of other purposes in both adults and children – groups who are at minimal, if any, risk of suicide.

Doctors rarely report adverse events leading to death in general and suicide in particular. In the case of suicide this may be because of an understandable bias against recognizing that something the clinician has done may have contributed to an unnecessary death.

Because of this clinical bias, deaths by suicide might be a place where coroners can make a unique contribution. I understand coroners are entitled to complete yellow cards, on all deaths by suicide, indicating whether the individual had been taking a drug of any sort within the previous few weeks.

The risks centre on periods of dose transition rather than actual drug intake *per se.* The risk periods therefore are not only just after beginning on a course of treatment, but also if the dose of treatment has been increased, decreased or stopped. Any of these transitions can lead to what is best perhaps called an activation syndrome.

The rationale for broadening any reporting system beyond antidepressants is that it appears that there is also a risk of suicide with drugs like the acne drug Roaccutane, the anti-malarial Lariam, the contraceptive Dianette, the smoking cessation agent Champix, and anti-asthmatic drug Singulair, while anticonvulsants and antipsychotics also come with warnings as regards suicide.

If it would help, I would be happy to talk to these issues in any forum you thought might be helpful to coroners.

Yours sincerely

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Photo of Catherine Yannakopoulos