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The Coroner's Court,
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E17 8QP

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
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[redacted] [redacted]

18 July 2023

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Conrad Richard James Colson who died on 2 March 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 26 May 2023 concerning the death of Conrad Richard James Colson on 2 March 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Conrad's family and loved ones. NHS England is keen to assure the family and the coroner that the concerns raised about Conrad's care have been listened to and reflected upon.

NHS England's Highly Specialised Severe Obsessive-Compulsive Disorder and Body Dysmorphic Disorder Service

The NHS England Highly Specialised Severe Obsessive-Compulsive Disorder (OCD) and Body Dysmorphic Disorder (BDD) Service (Adults and Adolescents) (hereafter "Service") is resourced and commissioned via the provision/service specification C09/S(HSS)/a (Publication Date: 2012/2013): https://www.england.nhs.uk/wp-content/uploads/2018/08/Severe-obsessive-compulsive-disorder-and-body-dysmorphic-disorder-service-adult-and-adolescent.pdf.

The Service is a national service and treats patients with severe BDD who have failed to respond to evidence-based treatment in locality-based and regional centres according to need. It comprises five integrated centres based at the following Trusts; South London and Maudsley NHS Foundation Trust (SLAM) adults, SLAM children and adolescents, Hertfordshire Partnership NHS Foundation Trust (HPFT), the Priory Hospital North London and South West London and St George's Mental Health NHS Trust (SWLSTG). Each centre is led by a consultant psychiatrist and a multidisciplinary team specialising in the treatment of BDD, and each centre specialises in different aspects of care – some offer inpatient care, others residential, home-based or outpatient-based care. The Service covers children, adolescents, and adults with no upper age limit.

Referral pathways into the service emanate from secondary or tertiary care. Patients are ordinarily referred to the Service by a senior member of their local mental health team. They are expected to have a care coordinator and consultant psychiatrist

actively involved for managing their overall psychiatric care and associated risks at the time of referral and during the waiting phase. The care coordinator and consultant are expected to remain involved throughout the care under the service, who liaise closely with them throughout care planning and discharge.

The national Service operates a monthly case allocation meeting at which new referrals are allocated to the centre that best meets their clinical need. Following referral, the patient is assessed, and a decision made as to whether the service is clinically appropriate. If they are accepted, there may be a further wait before treatment starts. Waiting times for assessment and for treatment vary across the service, depending on the centre and the kind of treatment provided. For example, inpatient care usually has a longer waiting time than outpatient-based care and cognitive behaviour therapy has a longer waiting time than pharmacotherapy.

Current waiting times for assessment range from 1-4 months (SLAM adults, HPFT, Priory Hospital, SWLSTG inpatient care) to around 7 months (SLAM child and adolescents), measured from the date of referral. Waiting times for treatment range from 1-6 months (HPFT outpatient or home-based care, Priory H outpatient care, SLAM outpatient care, SWLSTG inpatient care) to around 16 months (SLAM child and adolescents service, SWLSTG home based care) from referral. Waiting times are kept under regular review and, where possible, patients are allocated to the centre where the waiting time is the shortest e.g., for home-based care.

While there has recently been a perceived increase in the overall number of referrals to the NHS England Highly Specialised Severe OCD/BDD Service for children and adolescents at SLAM, a similar pattern of increased BDD referrals has not so far been seen in the adult Service, but it may simply be a matter of time before the perceived increased occurrence in younger people filters through to adult mental health services, highlighting a probable need to consider building greater capacity for treating BDD at primary and secondary mental healthcare levels, which we will continue to monitor.

The clinicians in the NHS England Highly Specialised Severe OCD/BDD Service consider this issue highly important because BDD is common, estimated at 0.5-3.2% in the general population, 1.3-5.8% in student cohorts, 4.9- 21.1% in general dermatology cohorts, and 2.9- 57% in cosmetic surgery cohorts. It is also a dangerous condition with a markedly high suicide rate; 0.3% per annum prospectively end their life and about 25% have made a past attempt on their life, and it can be very difficult to treat. The Service therefore engages in education and training activities for relevant healthcare professionals and aspires to expand these education and training activities as well as the future development of regional specialist centres, to disseminate best practice more widely, conditional on additional resourcing.

Aesthetic and cosmetic treatment risks and BDD

Regarding your concern that patients with BDD should be fully informed of the risks of seeking aesthetic dermatology treatment and that, wherever possible clinics who are providing treatments should be made aware of the BDD diagnosis, there is clear guidelines from the National Institute for Healthcare Guidance (NICE) on this issue. The guidelines (NICE Clinical guideline [CG31]) include the following paragraphs:

2.6.5.4 For people known to be at higher risk of BDD (such individuals with symptoms of depression, social phobia, alcohol or substance misuse, OCD or an eating disorder), or for people with mild disfigurements or blemishes who are seeking a cosmetic or dermatological procedure, healthcare professionals should routinely consider and explore the possibility of BDD.

2.6.5.6 People with suspected or diagnosed BDD seeking cosmetic surgery or dermatological treatment should be assessed by a mental health professional with specific expertise in the management of BDD.

2.6.5.9 Specialist mental health professionals in BDD should work in partnership with cosmetic surgeons and dermatologists to ensure that an agreed screening system is in place to accurately identify people with BDD and that agreed referral criteria have been established. They should help provide training opportunities for cosmetic surgeons and dermatologists to aid in the recognition of BDD. [GPP]

10.3.1.3 Specialist OCD/BDD teams should collaborate with people with OCD or BDD and their families or carers to provide training for all mental health professionals, cosmetic surgeons and dermatology professionals. [GPP]

There can however be barriers to implementation of the NICE guidance, where patients do not consent for private providers and their mental health professionals to disclose information to each other.

NHS England's existing national Clinical Reference Group (CRG) for OCD & BDD is intending to convene with relevant wider stakeholders in light of the concerns raised in your Report. This will include consideration at a national level of the issues of patients with BDD who access aesthetic dermatology treatments.

Other concerns

In terms of the matters of concern specific to Conrad, NHS England are unable to comment on the absence of liaison between the Centre for Anxiety Disorders and Trauma (CADAT) team at SLAM and the stepdown services provided by North East London NHS Foundation Trust (NEFLT), nor the adequacy of communication, information sharing between the two Trusts or the training of staff employed by NELFT, who are the appropriate organisations to respond to your concerns. NHS England has however been sighted on NELFT's Serious Incident Report into the matters surrounding Conrad's death and note that there have been learnings and recommendations made, including improvements to information sharing. We have also asked to be sighted on the response to you Report from both NEFLT and SLAM and will consider these carefully.

I would also like to provide further assurances on national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key

learnings and insights around preventable deaths are shared across the NHS at both a national and regional level and helps us pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

National Medical Director