MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Chief Executive Officer, South London & Maudsley NHS Foundation Trust (SLAM), Michael Rutter Centre, London SE5 8AZ** **2. [redacted] Acting Chief Executive Officer, North East London Foundation Trust** **3. [redacted], President, Royal College of Psychiatrists, London Office, 21 Prescot Street, London, E1 8BB** **4. [redacted] National Medical Director, NHS England** **[redacted]** 5. **Rt Hon Steve Barclay MP, Ministerial Correspondence and Public Enquiries Unit, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU**
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

	http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 11 March 2022 I commenced an investigation into the death of Conrad Richard James Colson, aged 34 years. The investigation concluded at the end of the inquest on the 18 May 2023. The conclusion of the inquest was a narrative conclusion: *Conrad Colson took his own life whilst suffering from severe body dysmorphic disorder. At the time of his death, he was accessing aesthetic dermatology treatments; he was not receiving a therapeutic level of medication and he was not in receipt of any professional mental health support for his body dysmorphic disorder. He had been discharged from mental health services without any robust risk assessment and without the safety net of a fully considered risk management/relapse plan.*
4	**CIRCUMSTANCES OF THE DEATH** Conrad Colson suffered from severe body dysmorphic disorder (BDD). The symptoms from this condition had led to a serious suicide attempt in February 2020. In 2021, following several months on the waiting list, Conrad received highly specialised therapy from the Centre for Anxiety Disorders and Trauma (CADAT). He made significant progress in managing his BDD symptoms during this therapy, however there was a known risk of relapse. He completed the sessions with his CADAT therapist in November 2021. Before and during this therapy, he had also received support from his local mental health trust's Peer Open Dialogue Team. As he had made such good progress with CADAT and as he had requested discharge from the Peer Open Dialogue Team, he was also discharged from this team in November 2021. There was no joint multi-disciplinary risk assessment and risk management plan on discharge from the teams. The practitioners were aware that Conrad was not taking a therapeutic dose of medication at the time of discharge, but no medical review was arranged for him. At the time of discharge from services, Conrad was also accessing treatment from an aesthetic dermatology clinic. This was not taken into account in his discharge risk assessment. Conrad had raised concerns with the skin clinic about his skin and the treatment, in December 2020; January 2021; March and April 2021. On the 27 and 28 February 2022, Conrad again raised concerns about the appearance of his skin, following treatment at the aesthetic dermatology clinic. His friends became concerned for his welfare when they could not reach him on the 2 March 2022. Emergency services attended and sadly Conrad was found deceased within his home address. The evidence at the inquest revealed that Conrad took his own life.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: 1. A concern arose at the Inquest hearing in relation to the absence of liaison between the highly specialist services of the CADAT team and the stepdown

	services provided by NELFT. There was a lack of full information sharing around risk and joint risk assessment/risk management planning on discharge. 2. Both mental health services were aware that Conrad was accessing aesthetic dermatology treatment. There was a concern that neither service adequately highlighted the risks of accessing such treatment to Conrad or attempted to share information with the skin clinic. The inquest heard that patients with BDD should be fully informed of the risks of seeking aesthetic dermatology treatment and wherever possible, clinics who are providing treatment should be made aware of the BDD diagnosis. 3. The Inquest heard that there is a need for training to be provided to step-down service teams in relation to the diagnosis of BDD and the risks associated with it. 4. The inquest heard that there is a lack of national resources for BDD. The highly specialised service at South London and Maudsley has a very long waiting list (several months). This is on a background of concerns of a likely increase in BDD. In light of this concern, I am also providing this report to the Royal College of Psychiatrists, to the Department for Health & Social Care and to NHSE.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **20 July 2023**. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested persons; Family of Mr Colson and the [redacted] Aesthetic Dermatology Clinic. I have also sent a copy to the local Director of Public Health who may find it useful or of interest and to the CQC. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.

	You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**26 May 2023**