ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] C/O Joseph Hill, Solicitors, 220 High Road, Tottenham, London N15 5AJ** **2. The Secretary of State for Health, Mr Mathew Hancock** **3. The General Medical Council**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, West Yorkshire (East), for the Coroner area of West Yorkshire.
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.
3	**INVESTIGATION and INQUEST** On 5 September 2018 an investigation was commenced into the death of LEAH LOUISE CAMBRIDGE aged 29. The investigation concluded at the end of the Inquest on 22 November 2019. The conclusion of the Inquest was a narrative. The medical cause of death was: 1a Adipose tissue (fat) embolism. 1b Cosmetic surgical procedure.
4	**CIRCUMSTANCES OF THE DEATH** Leah L Cambridge aged 29 travelled to Izmir Turkey to undergo a cosmetic surgical procedure under general anaesthetic, known as a Brazilian Butt Lift ('BBL'). The surgery commenced on Monday 27 August 2018 some 90 minutes after she was admitted to the hospital at 08:17 hours. The BBL entailed harvesting fat from her stomach using liposuction and then reinserting the fat, (once purified) into her buttocks and thighs using a cannula. A complication arose during the procedure resulting in her being pronounced dead at approximately 13:00 hours the same day. A post mortem examination carried out in England revealed some fat had entered veins in her body leading to a fat embolism, which then caused her death. Evidence provided at the Inquest from an expert plastic surgeon indicated BBL procedures involve risks considerably greater than any other cosmetic procedure. In consequence, a reputable professional association of plastic surgeons in the UK has declared a voluntary moratorium on BBLs. The Inquest found that she was asked to sign her name some three dozen times on pages of documents written in Turkish and English without being afforded time to read and digest the contents. As the risks had not been adequately explained to her she undertook the BBL procedure without appreciating the risks involved.

5	**CORONER'S CONCERNS** During the course of the Inquest evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) Notwithstanding (a) the death of Ms Cambridge on 27.8.18; and (b) concerns expressed in relation to the risks involved in BBL procedures by a task force established under the auspices of the Aesthetic Surgery Education and Research Foundation (ASERF); and (c) a voluntary moratorium declared by the British Association of Aesthetic and Plastic Surgeons ('BAAPS') The Inquest heard evidence that some plastic surgeons in the UK continue to carry out BBL procedures. Furthermore, that Elite Aftercare continue to facilitate other clients to travel to Turkey for the purpose of BBL procedures to be undertaken by surgeons such as [redacted]. I am concerned at the lack of intervention and control of BBL procedures by the regulatory authorities in the UK. (2) In order to make an informed decision as to the wisdom of undertaking effective cosmetic surgical procedures such as BBL, it is important that the person involved receive adequate information regarding the mortality and morbidity risks involved. In order to read and absorb such information it needs to be provided prior to any commitment being made or expense incurred. The Inquest into the death of Ms Cambridge heard that she was provided with a substantial quantity of material (some of which was written in Turkish) on the morning of the surgery and required to sign each page. The Inquest found she had insufficient time to digest this complex material, even if she was in a frame of mind to try, shortly before being taken to theatre. My concern is that informed consent is not obtained. (3) If BBL procedures continue to be permitted in the UK, I consider there is a need for the regulatory authorities to consider providing guidance on the surgical techniques to be employed and the information to be provided before a person incurs expense.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 1 February 2020. 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, the family of Leah Louise Cambridge. I have also sent it to the following who may find it useful or of interest. 1. British Association of Aesthetic and Plastic Surgeons (BAAPS) F.A.O. [redacted]

	[redacted], The Royal College of Surgeons of England, 34-43 Lincoln's Inn Fields, London WC2A 3PE. 2. [redacted], Hospital of St John and St Elizabeth, 60 Grove End Road, St John's Wood, London NW8 9NH. 3. The American Society of Aesthetic and Plastic Surgeons (ASAPS). 4. [redacted]o, 38 Newbury Street, Boston, Mass 02116, USA. 5. [redacted], Izmir Ozel Can Hastanesi, Ataşehir Mahallesi, 8019/16. Sk. No:18, 35630 Çiğli/Izmir, TURKEY 6. [redacted]r, Izmir Ozel Can Hastanesi, Ataşehir Mahallesi, 8019/16. Sk. No:18, 35630 Çiğli/İzmir, TURKEY 7. BBC 8. Yorkshire Post Newspapers I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	**[DATE]** **[SIGNED BY CORONER]** 29 November 2019