	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) British Association of Aesthetic & Plastic Surgeons** **(2) British Association of Plastic, Reconstructive & Aesthetic Surgeons** **(3) National Institute for Care Excellence**
1	**CORONER** I am James Bennett Area Coroner for Birmingham and Solihull.
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 10/09/2019 I commenced an investigation into the death of Renee Simone Brooks. The investigation concluded at the end of an inquest on 14th January 2020. The Conclusion of the inquest was that she died from a recognised but rare complication (fat embolism syndrome) of a necessary procedure, contributed to by pre-existing cardiac issues.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Brooks had debilitating lipoedema from the waist down and in her upper limbs, causing significant mobility impairment and pain. Her BMI was 46.1. She underwent rehabilitation and functional liposuction procedures in June, July and August 2018 and January 2019. These procedures were uneventful, she recovered well, and benefited from an improvement in her quality of life. On 29 August 2019 she underwent what was intended to be the final procedure on her legs. The risks, including fat embolism syndrome, were considered and consented to. The risk of mortality was considered low. The procedure took about 4 hours and was performed as planned. At the end of the procedure she suddenly went into cardiac arrest and after about 7 minutes was resuscitated and taken to Birmingham Heartlands Hospital. She remained very poorly and despite maximum treatment died on 30 August 2019. Post-mortem tests revealed she had a pre-existing significantly enlarged heart and fat embolisms were found in her lungs. Having heard evidence from the pathologist and her treating clinicians, the Coroner determined the medical cause of death to be: 1a MULTIPLE ORGAN FAILURE (PERI-OPERATIVE CARDIAC ARREST) 1b FAT EMBOLISM SYNDROME. 1c LIPOEDEMA (LARGE VOLUME LIPOSUCTION PROCEDURE) 2. COR PULMONALE. OBESITY CARDIOMYOPATHY.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern: Large volume liposuction is the recognised treatment for patients with lipoedema performed by a small number of specialist surgeons. UK guidance is limited to cosmetic procedures. There are no UK guidelines for lipoedema related liposuction and practices amongst surgeons vary considerably. I heard evidence from [redacted] - consultant plastic and reconstruction surgeon, [redacted] – Spire's Group Clinical Director, and [redacted] - investigation lead for Spire Parkway Hospital. All expressed concern about the absence of UK guidance relating to indications for safe practice. In particular, in relation to: (a)

	the frequency of procedures on a single patient, (b) the amount of fluid to put into the patient during the procedure, (c) the amount of fluid to remove from the patient during the procedure, and (d) the post procedure patient recovery plan. Spire Group have since the death of Mrs Brooks created their own internal standard guidance. The majority of procedures are performed on privately paying patients, although the NHS will refer a small number of patients for the procedure funded by the NHS. My ongoing concern is that absence of UK guidance relating to indications for safe practice for lipoedema related liposuction is putting patients' lives at risk. 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
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 27th March 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: (1) The next of kin. (2) Spire Parkway Hospital. (3) [redacted], consultant plastic and reconstructive surgeon. I have also sent it to Dr [redacted] – Regional Medical Examiner, NHS England, and Dr [redacted], VASER Lipo surgeon and aesthetic doctor, who may find it useful or of interest. 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	31/01/2020 Signature  James Bennett Area Coroner Birmingham and Solihull