Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 The Secretary of State for Health and Social Care: The Rt Hon Steve Barclay MP** **House of Commons** **London** **SW1A OAA** **2 The Department of Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU**
1	**CORONER** I am Jacqueline LAKE, HM Senior Coroner for the coroner area of NORFOLK
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 09 December 2019 I commenced an investigation into the death of Melissa Hannah KERR aged 31. The investigation concluded at the end of the inquest on 12 September 2023. **The medical cause of death was:** 1a) Pulmonary Thromboembolism and Fat Embolism 1b) Elective Cosmetic Surgery (Gluteal Augmentation) 1c) 2) **The conclusion of the inquest was:** Melissa Kerr died following cosmetic surgery to the thigh and buttock area on 19 November 2019. Ms Kerr was not seen by a surgeon or clinician prior to the date of the procedures. Ms Kerr underwent a limited assessment prior to the procedures. Ms Kerr was provided with limited information regarding the risks and mortality rate associated with the procedures. There is limited documentary evidence as to the procedures performed. Certain techniques used during the Brazilian Buttock Lift procedure increased the risk of fat embolus occurring, namely the choice of access incision for the augmentation cannula and the decision to inject fat into the superficial muscle.
4	**CIRCUMSTANCES OF THE DEATH** Melissa Kerr was admitted to Private Medicana Kadikoy Hospital, Istanbul on 19 November 2019 and underwent surgery to harvest fat from the abdomen, thighs and the jowl area of her face. Ms Kerr was not seen by a surgeon or clinician prior to the 19 November 2019. Evidence revealed that Ms Kerr underwent a limited assessment prior to the procedures. The evidence is that Ms Kerr was provided with limited information regarding the risks and mortality rate associated with the procedures. The fat was collected and processed before it was injected into her buttocks; a liposuction procedure and a Brazilian Buttock Lift procedure. During surgery Ms Kerr became unwell. Her condition deteriorated and she was

	declared dead. There is limited documentary evidence as to the procedures performed. Expert evidence was heard that certain techniques used during the Brazilian Buttock Lift procedure increased the risk of fat embolus occurring, namely the choice of access incision for the augmentation cannula and the decision to inject fat into the superficial muscle.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. Expert evidence was heard that the findings in this case are consistent with findings in other cases where patients have died following autologous fat transfer to the gluteal area during an operation colloquially known as Brazilian Buttock Lift. I understand from the evidence heard that due to the high mortality associated with this procedure a voluntary moratorium on the practice of this procedure has been introduced in the UK. Recommendations for safer practices have emerged that recommend significant changes to practice. 2. I am concerned that patients travelling to Turkey for this procedure are not being made aware of the risks and the high mortality rate associated with this surgery 3. I am also concerned that patients are travelling abroad where there are no or limited controls with regard to such surgery taking place. Evidence was heard there Ms Kerr was not seen by a surgeon before the date of the procedure. There was limited psychological and physical assessment prior to the procedure proceeding. 4. I appreciate the UK Government has no control over what happens abroad. However I am concerned that citizens are travelling abroad for such procedures unaware of the risks involved and that practices are used which are regarded as unsafe in the UK.
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 November 07, 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 [redacted] – Mother. I have also sent it to Private Medicana Haznedar Hospital The British Association of Aesthetics and Plastic Surgeons [redacted] - Expert who may find it useful or of interest. 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 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 by the Chief Coroner.
9	**Dated: 13/09/2023** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH