REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Nicholas WALKER, HM Area Coroner, for the coroner area of Hampshire, Portsmouth and Southampton.
2.	**DATE OF REPORT** 01 September 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. [redacted] 2. Secretary of State for Culture, Media and Sport 3. Secretary of State for Health 4. General Medical Council GMC You are under a duty to respond to this report within 56 days of the date of this report, namely by October 23, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6.	**SUMMARY OF CORONER'S CONCERN** I am concerned that citizens travelling abroad for cosmetic surgery are not fully informed of the risks involved in advance of travel and when abroad are subject to last minute upselling of further procedures that carry significant risk. I recognise that there can be no regulation of what happens beyond this country but there appears to be a lack of information about the risks involved for these 'cosmetic tourists'.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 24 October 2023 I commenced an investigation into the death of Hayley Pamela Dowell who was 38 when she died due to complications from elective liposuction surgery at a clinic in Türkiye. I found her cause of death to be: 1a Respiratory Failure 1b Pulmonary Fat Embolism 1c Elective Liposuction Procedure performed in Türkiye I concluded that Hayley died from complications arising out of elective cosmetic surgery abroad.
9.	**CIRCUMSTANCES OF DEATH** Hayley chose to travel Türkiye for a 'tummy tuck' and liposuction, mainly due to the cost of the procedure and, according to her husband, because "lots of people were doing it" and she "went with the trend". The surgery was booked through an intermediary company based in Germany who in return received a percentage of the total cost of surgery. The deceased travelled to Türkiye and attended the clinic where she signed consent forms for the procedures the night before surgery during a ten or fifteen-minute consultation. The following day she attended hospital and, minutes before the operation was to start, she met her surgeon who offered to perform a surgical fat transfer (also known as BBL) at a reduced price. She had only minutes to agree to the clinic's offer and did so. The deceased was taken to surgery and died several hours later due to a fat embolism caused by the liposuction procedure. I also heard evidence that a number of UK citizens are repatriated following unsuccessful cosmetic surgery performed abroad. I was told that there is currently no data held on the numbers of people involved. There is also no code that could identify the patient as a failed cosmetic tourist on admission to hospital, meaning that the scale of the problem is hard to determine.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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:

	I am concerned that: 1. UK citizens can travel abroad for cosmetic surgery without having an awareness of the risk of the procedure before they set off. Being presented with that information in the hours before surgery does not allow for reasoned thought or reflection, research or consultation with others or assessment by the medical professionals of their suitability for the operation. 2. The upselling of procedures, sometimes combined with a financial incentive, and with only a very short time before the surgery starts allows no time properly to consider the consent they give. In this case, the deceased was 'marked up' and ready to go to theatre when she was offered another procedure and given the card machine to complete the transaction. I am concerned that there is a risk of future deaths. Cosmetic tourists are not fully informed that dangerous procedures such as BBLs are being offered with no opportunity to consider the consequences and provide informed consent.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: • [redacted] • Secretary of State for Culture, Media and Sport • Secretary of State for Health • General Medical Council GMC I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE** [redacted] **Nicholas WALKER** **HM Area Coroner for**

	Hampshire, Portsmouth and Southampton