

Women and Equalities Committee

Cosmetic procedures

Eleventh Report of Session 2024–26

HC 869

Women and Equalities Committee

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Contents

Summary	1
Introduction	3
1 Breast implant safety	4
The PIP implant scandal	4
Data collection and informed consent	10
BIA-ALCL	13
Post-surveillance	14
Breast Implant Illness	15
Cosmetic surgery training standards	19
2 Non-surgical cosmetic procedures	21
Safety of non-surgical cosmetic procedures	21
Licensing system	23
Training and qualifications	27
Devolved administrations	29
3 Cosmetic tourism	31
Impact on the NHS	32
Education	34
4 Body image	36
Body dysmorphic disorder and psychological screening	36
Social media	38
Filters and AI	38
Influencers and advertising	39
Education	41

Conclusions and recommendations	44
Formal Minutes	50
Witnesses	52
Published written evidence	54
List of Reports from the Committee during the current Parliament	57

Summary

Demand for cosmetic procedures has grown significantly in recent decades. However, regulation has not kept pace, allowing inadequately trained individuals to carry out high-risk procedures, too often with devastating consequences. In this inquiry we consider the safety of surgical cosmetic procedures, such as breast implants, and non-surgical cosmetic procedures such as fillers and liquid Brazilian butt lifts (BBLs).

For the majority of women, breast implants are a safe procedure with significant positive impacts. However, there is emerging concern that a minority may experience debilitating symptoms following implantation and, in still rare cases, develop a cancer of the immune system. There is a lack of research into the cause of these health complications and incomplete tracking of the results of implantation.

The Government needs to commission clinical and longitudinal research, mandate use of the Breast and Cosmetic Implant Registry and regularly publish data from it. Cooling off periods should be required before surgical cosmetic procedures can take place and those who carry out that surgery should be certified to do so. The Poly Implant Prothèse (PIP) breast implant scandal, in which 47,000 women in the UK received substandard implants, demonstrates the importance of rigorous testing and surveillance. Post-surveillance regimes should include regular testing of approved products.

Currently, there is no regulation as to who can perform non-surgical cosmetic procedures. These are defined as procedures that do not require incisions and are commonly used to refer to injectables, such as Botox or dermal fillers, laser therapy or chemical peels. This has led to a 'wild west' in which procedures have reportedly taken place in Airbnbs, hotel rooms, garden sheds and public toilets, leading to many individuals experiencing serious harm. The Government must act quickly to legislate in this area. High-harm procedures such as the liquid Brazilian butt lift (BBL), which has resulted in fatalities, should be banned immediately without further consultation. A licensing system for lower-risk procedures, in which only those suitably qualified can perform them, should be introduced within this Parliament.

Travelling abroad to undergo cosmetic procedures or treatments, known as 'cosmetic tourism', has surged in popularity in recent years as a low-cost way for people to access cosmetic procedures. Despite some countries having stronger regulations than the UK, there have been growing numbers of people needing corrective treatment by the NHS following complications

from procedures undertaken overseas. This is placing additional burden on the NHS. More needs to be done to educate the public on the potential risks of cosmetic tourism and how they can do so safely.

Recent studies have shown that body image, particularly amongst young women and girls, has worsened over recent years. This is causing more young women and girls to be drawn to cosmetic procedures, with a 2024 survey finding that just over a quarter of girls aged 11–16 would consider altering their appearance through cosmetic procedures within the next 20 years and almost half of 17–21-year-olds. Research has found that increased use of social media, face editing apps and filters is contributing to both worsening body image and driving the demand for cosmetic surgery. There is also evidence of the widespread advertising of cosmetic procedures on social media, both by practitioners and influencers. Many of these advertisements utilise digitally altered photographs and minimise the risks involved with cosmetic procedures. Evidence-based body image and social media literacy programmes need to be adopted into school curricula to tackle the growing pressures on children to change their bodies once they reach adulthood.

Introduction

1. Cosmetic procedures are no longer the domain of the rich and famous. The last 20 years have seen a rapid increase in the number of people, particularly young women, undertaking both surgical and non-surgical procedures in the UK and overseas. Regulation has not kept pace, allowing inadequately trained individuals to carry out high risk procedures, often with devastating consequences. In response to a rising number of reports of procedures having serious adverse consequences, we launched an inquiry to review the industry and scrutinise the Government's proposals for reform. We also considered emerging evidence on health risks around breast implants, including for those women affected by the PIP breast implant scandal, some of whom continue to face serious health impacts more than 13 years later.
2. We held four evidence sessions and received written submissions from individuals, academics, practitioners and organisations. We are grateful to everyone who assisted us in our inquiry, particularly to Sasha Dean and the other women who generously shared their lived experience of cosmetic procedures.

1 Breast implant safety

3. Breast implant surgery is the most common cosmetic procedure undertaken by women in the United Kingdom. In 2024, over 17,000 women had implants fitted for both aesthetic and reconstructive purposes by the National Health Service (NHS) and independent providers.¹ For the majority of women, breast implants are a safe procedure with significant, positive impacts, but this is not true for all women. The safety of breast implants has been a source of concern for several decades. As products, surgical techniques, and patient experiences have evolved, so too have questions about the long-term risks associated with implants, particularly those implants known to be substandard. Concerns centre on impacts on the immune system such as Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL) and a condition that is not formally recognised known as ‘breast implant illness’.

The PIP implant scandal

4. In 2010, silicone implants made by the French company Poly Implant Prothèse (PIP) were banned after they were found to have an increased risk of rupture. The increased risk was caused by the fraudulent use of low-grade silicone in their manufacture. Some of the PIP implants were also manufactured without an adequate silicone envelope, increasing risk of breakdown. It is estimated that 47,000 women in the UK received PIP implants, among 400,000 globally.² Around 900 of those implants were put in by the NHS, the remainder by private providers.³
5. There have been a range of responses to the PIP scandal. In 2011, the French government urged 30,000 women in France with these implants to seek their removal.⁴ The UK ruled out routine removal citing a lack of evidence of a safety concern, and a similar approach was taken by Australia. The Food and Drug Administration in the United States had banned the use of implants from PIP a decade earlier due to a lack of data on the safety of their saline implants and the finding of multiple failings during an inspection

1 Breast and Cosmetic Implant Registry, [Breast and Cosmetic Implant Registry - January to December 2024](#), October 2025

2 BBC, [PIP implant victims ‘elated’ by compensation win](#), May 2021

3 [Q120](#) (Professor Fowler)

4 BBC, [Implants: France recommends removal but UK does not](#), December 2011

of the factory in France. A US survey of PIP's saline implants had found a failure rate of 70%.⁵ It is unclear why the FDA's warnings about PIP in 2000 did not trigger wider scrutiny of the company's activities.⁶

6. A report into the MHRA's handling of concerns around PIP noted that up until March 2010 there was no evidence available to the MHRA that PIP were acting fraudulently over the content of its implants and that no other European regulator had such evidence or suspicion. The agency had however received 269 adverse incident reports related to the implants, primarily with regard to rupture, which it had continued to investigate up to the time that the fraudulent use of low-grade silicone came to light and the products were withdrawn. The report concluded that the MHRA acted appropriately.⁷
7. Following the product's withdrawal, the Department of Health appointed an expert group on breast implants led by Professor Sir Bruce Keogh, then medical director of the NHS in England, to investigate the safety of PIP implants. The group published an interim report in January 2012 and a final report in June 2012. The group concluded that although PIP implants "are significantly more likely to rupture or leak silicone than other implants, by a factor of around 2–6" and are "clearly substandard [...] there is no evidence of a significant increased risk of clinical problems in the absence of rupture."⁸
8. The final report noted that PIP implants have higher concentrations of the synthetic compounds known as siloxanes but that this "does not present a health risk".⁹ In the event of rupture, the report stated that there may be local reactions around the implant area in a small proportion of women, which can result in symptoms such as tenderness or swollen lymph glands but that there was no evidence that this causes any more significant general health concerns.¹⁰
9. Following the publication of the group's interim report in January 2012, the NHS in England and Scotland made the following offer:

5 Reuters, [Exclusive: The troubled history of PIP's implants man in America](#), 11 January 2012

6 NBC News, [FDA warned French plant on implant safety in 2000](#), 27 December 2011

7 Department of Health, [Poly Implant Prothèse \(PIP\) silicone breast implants: Review of the actions of the Medicines and Healthcare products Regulatory Agency \(MHRA\) and Department of Health](#), 14 May 2012

8 Department of Health, [Poly Implant Prothèse \(PIP\) breast implants: final report of the Expert Group](#), June 2012

9 Department of Health, [Poly Implant Prothèse \(PIP\) breast implants: final report of the Expert Group](#), June 2012

10 Department of Health, [Poly Implant Prothèse \(PIP\) breast implants: final report of the Expert Group](#), June 2012

- All women who received an implant from the NHS will be contacted to inform them that they have a PIP implant and to provide relevant information and advice. If NHS patients seek information about the make of their implant in the meantime, it will be provided free of charge.
- Women who wish to can seek a consultation with their GP or the surgical team that carried out the original implant to get clinical advice on the best way forward.
- If the woman chooses, this could include an imaging examination to see if there is any evidence that the implant has ruptured.
- The NHS will support the removal of PIP implants if, informed by an assessment of clinical need, risk, or the impact of unresolved concerns, a woman, with her doctor, decides that it is the right thing to do.
- The NHS will replace the implants if they performed the original operation.¹¹

10. The Medicines and Healthcare products Regulatory Agency (MHRA), the Department of Health and Social Care’s executive agency charged with ensuring medicine and medical devices are safe, accepted the expert group’s conclusion that there is no evidence of long-term health impacts from PIP implants. The MHRA told us it stands by this conclusion. Dr Alison Cave, Chief Safety Officer at the MHRA, stated:

Obviously we are continuing to look at any evidence as it emerges, but we have no current evidence that PIP implants carry greater risk of either cancer or other symptoms than any other breast implant.

[...]

There was a specific analysis of the implants undertaken in 2012, and then subsequently again in 2013 by the European body, which is the Scientific Committee on Emerging and Newly Identified Health Risks. It looked at the composition of the breast implants, including the presence of these cyclic siloxanes D4, D5, and D6, which are actually commonly present in a number of domestic products, and they concluded there was no convincing medical toxicology or other data which would justify removal of these implants and there is no additional increased risk from these implants versus others.¹²

11 The [initial NHS offer](#) in Wales in 2012 was to offer both removal and replacement of PIP implants even if a patient had received their initial implant privately. The [current offer](#) by NHS Wales is same as that of England and Scotland (only removal not replacement of implants received privately).

12 [Q118](#) [Dr Cave]

11. We questioned witnesses on the MHRA’s position. Professor Michael Coleman, Professor of Toxicology at Aston University, described the NHS and MHRA’s stance as “ludicrous.”¹³ He disagreed that siloxanes were not harmful:

Even if the implants are removed, silicones from the implants can be detected in women’s blood for years afterwards. The silicones enter the body and leave very slowly indeed. So the idea that this is not a problem is simply wrong. [...] Once silicone is released into the body, we know that silicone or siloxanes—which are the components of the implants—appear to have an effect known as the adjuvant effect. They stimulate the immune system in many, though not all, women. [...] hence the overactivity of the immune system seen in breast implant illness. This is also partly linked to the cancer related to these implants, so there is no doubt at all that releasing silicone in those quantities into women’s bodies is a very significant hazard.¹⁴

12. A 2013 study of 676 explanted PIP implants found a rupture rate of 35%; in total 144 ruptured implants were removed from 119 patients.¹⁵ The study noted that the rupture rate increased for those implants inserted after 2003. Professor Prabath Nanayakkara, Professor in Acute Internal Medicine at Amsterdam University Medical Centre, described a patient he had recently seen whose PIP implants were removed in 2012: “She still has silicone deposits all over the body and she is still suffering. I am sure there are women walking around with lots of complaints, but we are not looking for them.”¹⁶

13. While studies have shown that siloxanes have some negative effects on animals, including on their reproductive systems, Professor Coleman explained that not enough was known about the impacts of the siloxanes on the human body, particularly the reproductive and immune systems.¹⁷ We note that these siloxanes have been considered substances of ‘very high concern’ since 2018.¹⁸ D4 has been identified as having ‘persistent, bioaccumulative and toxic’ properties and is now being banned by the EU in cosmetic and cleaning products. Derogations are in place for its continued use in medical devices. Professor Coleman suggested that “from a scientific perspective, that is not very consistent.”¹⁹ Professor Carl Heneghan, Director of the Centre for Evidence-Based Medicine at University of Oxford, also criticised the MHRA’s stance:

13 [Q2](#) [Professor Coleman]

14 [Q3](#) [Professor Coleman]

15 Quaba O, Quaba A., [PIP silicone breast implants: rupture rates based on the explantation of 676 implants in a single surgeon series](#), Journal of Plastic, Reconstructive & Aesthetic Surgery, 2013

16 [Q8](#) [Professor Nanayakkara]

17 [Q7](#) [Professor Coleman]

18 European Chemicals Agency, [Cyclosiloxanes](#), accessed February 2026

19 [Q20](#) [Professor Coleman]

Anybody who says no evidence is basically saying we've systematically failed to take this seriously and collect the right data and the right evidence. This is an area that is under-researched.²⁰

14. Campaigners representing women with PIP implants contend that the Keogh group's stance on the risks of implants, "ignored patients reporting autoimmune symptoms, silicone migration, and systemic inflammation, by framing their distress as 'anxiety.'"²¹ Many women who had received PIP implants told us that they had suffered years of various physical and mental consequences due to their PIP implants. One contributor to our inquiry, who had PIP implants in 2003 and began to experience symptoms a year later, told us that her implants had drastically impacted her life for the last 22 years, both in terms of the physical pain she continues to experience and the mental health impact. She told us:

I remain traumatised, I will never be able to live a fulfilled normal everyday life. PIP breast implants have affected my life. In a way I do not have a life, I feel I simply exist, suffering with continual pain I endure daily along with fatigue, discomfort and severe exhaustion. [It] is so difficult to try and get through the day.²²

15. Similarly, another contributor told us that she experienced years of both long term physical and mental impacts stemming from her PIP implants. She explained that despite having her implants removed in 2012, she continues to "live with chronic pain" and has "endured countless hospital appointments, mammograms, and procedures to have fluid drained with syringes". She also stated that the experience has left her "traumatised" and with "acute fear and anxiety surrounding anything medical."²³ Women with PIP implants who have health impacts also report having their concerns dismissed.²⁴ We were told that the lack of an offer of replacement for women who hadn't received their implants on the NHS left them facing a choice between enduring ongoing symptoms or radically changing their appearance.²⁵
16. NHS advice is for breast implants to be changed after around 10 years.²⁶ Many women who received PIP implants may therefore already have had their implants replaced. However, the PIP Action Campaign told us that they were aware of women who are still living with their PIP implants and that there are women within their support group who have been refused care and/or removal of their PIP implants by the NHS. They stated that "no efforts

20 Professor Heneghan, [Woman's Hour podcast](#), 29 October 2025, 39:40

21 Jan Spivey, Co-Founder of PIP Action Campaign ([BIP0142](#))

22 Leanne Schofield ([BIP0121](#))

23 Mrs Carolyn Diboll (Nurse Associate at NHS) ([BIP0110](#))

24 Jan Spivey, Co-Founder of PIP Action Campaign ([BIP0142](#))

25 [Q79](#) [Dr Ruth Holliday]

26 NHS, [Breast enlargement \(implants\)](#), accessed 6 January 2026

have been made to communicate, inform, guide or update any women in the UK with PIP breast implants by the MHRA or NHS.”²⁷ Due to poor data collection, it is not known how many women still have PIP implants, and some may still be unaware they were fitted with them (see later section on data collection).

17. We questioned Professor Aidan Fowler, National Director of Patient Safety at NHS England and Deputy Chief Medical Officer at the Department for Health and Social Care on the NHS decision not to offer replacement for privately fitted implants. He explained:

If you remove an implant, should you replace it at a cost to the NHS and that is a judgment of where you would then take that cost from and what it would mean we could not provide on the NHS as a result of spending money in that way. That judgment was made at the time. Is there sufficient merit to review that decision at this point where very many of those implants will have been removed or replaced? They may have been removed and replaced privately, and so on. That would be a judgment for the wider system as to how to prioritise spend.²⁸

Dr Fowler emphasised that explantation itself is not without risk, including anaesthetic risk. He reiterated the NHS guidance and offer:

The advice is that you should have an annual check-up and the advice remains that. You may have it explanted if you are anxious about it or if it ruptures, and while normally we would encourage people to go back to the original surgeon who carried out the procedure, if people are unable to do that or if they are refused treatment, then the NHS would explant the implant at their request. That guidance remains, but it is very clear that if these rupture, they should be removed.²⁹

Rieka Taghizadeh, Chair of the British Association of Plastic, Reconstructive and Aesthetic Surgeon’s Breast Special Interest and Advisory Group, was clear in her view that “From both an NHS and a self-pay perspective, PIP implants should be removed”.³⁰

27 [PIP Action Campaign \[BIP0006\]](#)

28 [Q247](#) [Professor Fowler]

29 [Q118](#) [Professor Fowler]

30 [Q171](#) [Rieka Taghizadeh]

18. CONCLUSION

The PIP implant scandal exposed failures that continue to affect women more than a decade later. Official assurances that PIP implants pose no health risks appear to be based on limited long-term research and underplay the mental health impacts on women of having a substandard product inside them. Many women report enduring physical and psychological harm, compounded by inadequate follow-up and dismissal of symptoms. Shortcomings on data collection and recording mean that the NHS does not know who received PIP implants and many women may not be aware they have them. The need for further research and improved data collection on implantation must be addressed.

19. RECOMMENDATION

While there is a judgement to be made over whether the NHS should offer replacement implants to women affected by the PIP implants scandal, women with PIP implants who wish to have them removed should be able to have that request met by the NHS as stated by its own guidance. Reports that such requests are being turned down are troubling, not least given the evidence of the benefits of explantation for some women. The NHS should remove PIP implants from women who wish to have them explanted.

Data collection and informed consent

- 20.** Following the PIP scandal, and the subsequent Keogh Review, the Breast and Cosmetic Implant Registry (BCIR) was opened on 10 October 2016. The registry records the details of any individual who has breast implant surgery, so they can be traced in the event of a product recall or other safety concern relating to a specific type of implant. It also allows the identification of possible trends and complications relating to specific implants. The registry collects data on all types of breast implant and explant (removal) surgery, including revisions and reconstructions. However, the registry is not mandatory and is currently used to record data for around 80% of breast implants. We were told by multiple stakeholders that the registry should be made mandatory for patient safety.³¹
- 21.** The NHS website defines ‘informed consent’ as “the person must be given all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead.”³² Professor Carl Heneghan, Director of the Centre for Evidence-Based Medicine at the University of

31 For example Mr Nigel Mercer [[PIP0001](#)]; [Q142](#) [Professor Fowler]

32 NHS, [Consent to treatment](#)

Oxford, told us that because the registry is not yet mandatory and it does not regularly publish its findings (such as rates of adverse outcomes by implant type), a surgeon is currently unable to adequately inform a patient of the risks of an implant. He explained how, in his view, this makes it impossible for a patient to give fully informed consent.³³ He compared the situation with breast implants with other devices:

There are lots of uncertainties because of our failures to collect and report an evidence base, as we do for many other implants; the national joint registry for hips and knees does a much better job monitoring the failings of metal hips. My perspective is that because this is considered a cosmetic intervention, it is not an issue that the NHS takes seriously. However, we are in a world now where the complications are increasing, and we have a duty to do something about that in terms of collating the evidence and reporting it appropriately.³⁴

The national joint registry publishes annual information on interventions and outcomes.³⁵

- 22.** Many women told us that they felt that they had not been properly informed of the risks prior to receiving their implants. One contributor described her experience:

I was not given the information that accurately informed me of the risks involved in putting in implants – and, in particular, as I had only just finished chemotherapy. I never received any device manufacturer safety information and nothing about risks of complications, failure rates or what to look out for. Had I been given this information, my decision to choose implants for reconstruction would have been very different.³⁶

Dr Fowler acknowledged both the importance and problems with the registry, including it being “really very onerous” to complete. He noted that work is underway to improve it, that completion should be mandatory and that “over time [it] will become compulsory”.³⁷

- 23.** To ensure fully informed consent, some witnesses recommended introducing a mandatory cooling-off period between the initial consultation and the surgery.³⁸ This would give patients time to reflect, avoid feeling pressured

33 [Q35](#) [Professor Heneghan]

34 [Q5](#) [Professor Heneghan]

35 [Q9](#) [Professor Heneghan]

36 Amy Walkers ([BIP0086](#))

37 [Q142](#) and [Q252](#) [Professor Aidan Fowler]Q141 / Q252 Fowler

38 [Q178](#) [Rieka Taghizadeh]

into a decision, and reassure them that they can change their mind at any stage. While General Medical Council best practice currently advises a minimum two-week cooling-off period, this guidance is not compulsory.³⁹

24. CONCLUSION

Without mandatory participation in the Breast Implant Registry and the regular publication of outcome data, surgeons cannot provide patients with comprehensive risk information. This undermines the principle of informed consent. Many individuals feel inadequately informed before surgery and the absence of a cooling-off period further increases the risk of rushed decisions. As the PIP scandal demonstrates, a lack of data collection makes it more difficult to identify products with increased risks and those who have received them.

25. RECOMMENDATION

The Government should introduce mandatory recording of breast implant and explant procedures and instances of adverse outcomes in the Breast and Cosmetic Implant Registry by the end of 2026. We welcome the Government's acknowledgement that the registry requires improvement. The Government should work with practitioners to ensure the registry meets the needs of surgeons and patients, including on ease of use. Data on adverse outcomes by implant type should be published annually to support informed consent and improve patient safety.

26. RECOMMENDATION

We note that the registry is currently overseen by the soon-to-be abolished NHS England. The Government should take steps to ensure that the improvements we call for are not delayed by internal reorganisation.

27. RECOMMENDATION

A mandatory cooling-off period of at least two weeks should be introduced between the initial consultation and surgery for breast implants, ensuring patients have sufficient time to consider risks and alternatives before making a commitment.

39 [Q163](#) [Nora Nugent]

BIA-ALCL

28. Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL) is a type of non-Hodgkin lymphoma that grows in response to the body's reaction to a breast implant.⁴⁰ The World Health Organisation first defined it as a lymphoma variant in 2016.⁴¹ It is not a form of breast cancer but a rare cancer of the immune system.
29. As of 31 December 2024, the MHRA had received 114 reports of confirmed BIA-ALCL where the breast implant surgery occurred in the UK and 6 reports where the surgery occurred outside of the UK.⁴² The current estimated incidence of BIA-ALCL, based on confirmed cases where surgery occurred in the UK, is 1 per 12,187 implants sold.⁴³ Rates of BIA-ALCL are higher in textured implants. Almost all of the 1,100 cases of BIA-ALCL that have been reported across the world involved textured implants. The number of cases of BIA-ALCL may be higher than the reported figures suggest. Professor Nanayakkara, Professor in Acute Internal Medicine at Amsterdam University Medical Centre, warned:
- The problem with BIA-ALCL is that you have to look for it to find it. When most private clinics remove the implant and remove the capsule, they do not check it under a microscope. So there is definitely an under-reporting of ALCL.⁴⁴
30. Several countries, including France and Australia, have either banned or heavily restricted the sale of textured implants.⁴⁵ Allergan, a major implant manufacturer, withdrew its Biocell textured implant from sale in July 2019. The move followed Canada's suspension of licences for their use.⁴⁶ The UK has not banned textured implants citing the low risk of cancer and their advantages over smooth implants, including lack of movement and reduced risk of scar capsule formation. Instead, the UK advocates for informed patient consent.⁴⁷

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- 40 Plastic, Reconstructive and Aesthetic Surgery Expert Advisory Group [Information about BIA-ALCL for people with breast implants](#), December 2021
- 41 MHRA, [Guidance: Breast implant associated anaplastic large cell lymphoma \(BIA-ALCL\)](#), July 2017
- 42 Department of Health and Social Care, [Breast implant associated anaplastic large cell lymphoma \(BIA-ALCL\)](#), 11 December 2025
- 43 Department of Health and Social Care, [Breast implant associated anaplastic large cell lymphoma \(BIA-ALCL\)](#), 11 December 2025
- 44 [Q25](#) [Professor Nanayakkara]
- 45 BBC, [Breast implants: France bans designs linked to rare cancer](#), April 2019
- 46 American Society of Plastic Surgeon, [Allergan Biocell Device Withdrawal](#) accessed 16 December 2025
- 47 Gov.uk, [Information about BIA-ALCL for people with breast implants](#), December 2021

31. Clinicians have a legal obligation to discuss the potential risk of BIA-ALCL when seeking informed consent of new patients and with any patient returning for review of their breast implants. The MHRA has developed a cosmetic breast augmentation risk awareness tool which sets out areas which should be explained to the patient by the surgeon, including surgery risks, that implants do not last a lifetime and risks of BIA-ALCL and breast implant illness.⁴⁸ As with other countries, the UK does not advise people with textured implants to have them removed.⁴⁹

Post-surveillance

32. Since 2020, the US Food and Drug Administration (FDA) has recommended screening of breast implants with MRI or ultrasound five to six years after silicone implant placement and every two to three years thereafter.⁵⁰ These processes can be effective at detecting BIA-ALCL as well as signs of rupture. Such screening would be difficult to implement in the UK due to the high cost of MRI, with the monitoring exceeding the cost of the implant. Professor Heneghan explained that the lack of such follow-up screening made regular reporting from the Breast and Cosmetic Implant Registry vital.⁵¹
33. Professor Heneghan also called for mandatory post-surveillance of medical devices and transparency over the evidence that supported their approval. The FDA has introduced requirements for 10-year follow-up post-surveillance studies in the US. It has increased the number of studies into breast implant risks and side effects that manufacturers must conduct, citing “inadequate progress” made by previous studies.⁵² In March 2023, the FDA noted the emergence of Breast Implant-Associated Squamous Cell Carcinoma, “a rare but potentially aggressive epithelial-based tumor that appears to be associated with breast implants and emanates from the breast implant capsule.”⁵³ The FDA stated it was aware of 19 cases to date and called for increased awareness and reporting.⁵⁴

48 MHRA, [Cosmetic Breast Augmentation- Patient Risk Awareness Tool and Breast Implant Record](#), accessed January 2026

49 Gov.uk, [Information about BIA-ALCL for people with breast implants](#), December 2021

50 US Food and Drug Administration, [Breast Implants - Certain Labeling Recommendations to Improve Patient Communication](#), September 2020

51 [Q28](#) [Professor Heneghan]

52 American Board of Cosmetic Surgery, [What You Need to Know About the New FDA Breast Implant Guidelines](#), December 2021

53 American Society of Plastic Surgeons, [FDA provides update on Breast Implant Associated-Squamous Cell Carcinoma \(BIA-SCC\)](#), March 2023

54 American Society of Plastic Surgeons, [FDA provides update on Breast Implant Associated-Squamous Cell Carcinoma \(BIA-SCC\)](#), March 2023

34. In June 2025, the UK Government strengthened its post-surveillance requirements, including “enhanced data collection, shorter timelines for reporting serious incidents and summary reporting, to enable the MHRA and manufacturers to identify safety issues earlier, as well as clearer obligations for risk mitigation and communication to protect patients and users.”⁵⁵ A regulatory failing with PIP implants was a lack of testing of the implants once they were approved, allowing the substitution of substandard material to continue for many years unnoticed. The MHRA has also formed an expert advisory group—the Plastic, Reconstructive and Aesthetic Surgery Expert Advisory Group (PRASEAG)—to work with the MHRA to review the risks associated with breast implants and to guide any further action.⁵⁶

35. **RECOMMENDATION**

The PIP implant scandal involved substandard implants being given to women for many years without detection. The new post-surveillance regime for breast implants must include regular testing of approved implants to ensure continued compliance with safety standards.

36. **RECOMMENDATION**

The Government should increase the information available on the approval of medical devices to allow interested parties to see not only what devices are approved but the evidence base underpinning the decisions to approve them.

Breast Implant Illness

37. Breast Implant Illness (BII) is a term used to describe a variety of symptoms that some individuals experience after getting breast implants. Although BII is not officially recognized as a medical diagnosis—there is no formally recognised biomarker for diagnosing BII, complicating decision-making about explantation—it is believed to be related to autoimmune or inflammatory responses to the implants in susceptible individuals.⁵⁷ The most reported symptoms for BII are fatigue, joint issues, anxiety, problems with memory or concentration (known as ‘brain fog’), hair loss, depression,

55 MHRA, [MHRA guidance on new Medical Devices Post-Market Surveillance requirements](#), January 2025; Q127 [Dr Cave]

56 Department of Health and Social Care, [Breast implant associated anaplastic large cell lymphoma \(BIA-ALCL\)](#), 11 December 2025

57 Breast Cancer Org, [What Is Breast Implant Illness?](#) February 2025; S.Azahaf, K. A. Spit, C. J. M. de Blok & P. W. B. Nanayakkar, [Increased FGF-19 levels following explantation in women with breast implant illness](#), January 2025

rash and gastrointestinal problems.⁵⁸ The MHRA told us that it was aware of around 1,000 reports since 2008 which could fall under the description of BII—around 0.5% of operations.⁵⁹

- 38.** The wide-ranging symptoms make it difficult to isolate them as being from a particular source. For example, some of them are very similar to symptoms of other health issues such as the menopause, making diagnosis and treatment very challenging and underreporting almost certain. In 2022, in response to reports of BII, the then President of the British Association of Aesthetic Plastic Surgeons (BAAPS), Marc Pacifico stated:

The WHO (World Health Organisation) does not recognise “BII” as a medical diagnosis as it has not fulfilled the criteria to be classified as a disease. No scientific link between breast implants and these symptoms has yet been identified, however, many women who identify as having these symptoms experience varying degrees of relief after their implants are removed. [...]

The symptoms experienced by these women are very real, but we have no medical explanation for the cause of these symptoms, and their symptoms have not been scientifically linked to their implants. It is always hard to prove a negative, but it is likely that some women who identify as having these symptoms have other reasons for them.⁶⁰

- 39.** Due to the lack of a formal diagnosis, many women who experience BII symptoms describe feeling dismissed by their GPs or told it is psychosomatic.⁶¹ One contributor to our inquiry stated that she experienced many new symptoms after receiving her implants (such as headaches, extreme fatigue, brain fog, aching joints etc.) and when she asked her endocrinologist about whether it was possible she had BII and if she should consider having them removed, she was advised to consider taking an antidepressant instead.⁶² Professor Nanayakkara described to the Committee how:

Most patients who come to us are frustrated and angry, and I understand that because they have been sick for, let us say, 10 years. These women lose their jobs, they lose their relationships, they are divorced, they are about 50 years old, and they have nothing.⁶³

58 Breast Cancer Org, [What Is Breast Implant Illness?](#) February 2025

59 [Q129](#) [Dr Cave]

60 BAAPS [Breast Implant Illness \(BII\) Update statement from President of BAAPS, Marc Pacifico](#). October 2022

61 [Experiences of women who self-report Breast Implant Illness \(BII\): a qualitative evidence synthesis](#) Health Psychology Review May 2025; Association of Breast Surgery ([BIP0098](#))

62 Miss Amy Walkers ([BIP0086](#))

63 [Q31](#)[Professor Nanayakkara]

40. There appears to be a link between BII and people with existing autoimmune issues. Professor Michael Coleman, Professor of Toxicology at Aston University, suggested that there should be warnings given to women with these pre-existing conditions:

We should also be concentrating on warning women who are prospective implant recipients that there is enough evidence to suggest that women who have potential autoimmune issues, even something like asthma, are at greater risk of developing problems several years down the line. Women are not properly informed of the risks of implants in terms of triggering an almost unending engagement with their own immune systems.⁶⁴

41. Professor Nanayakkara agreed with this, stating, “it is probably genetically predetermined as not every woman who gets the implants gets the disease. In our cohort we showed that almost 70% had pre-existent allergies that got worse after implantation.”⁶⁵ Many women who reported BII-like symptoms also reported a reduction in symptoms following removal.⁶⁶ One 2022 study showed that explantation led to “significant symptom relief in approximately two-thirds of patients suspected of having BII”. The study noted that the reasons for the improvement remained poorly understood.⁶⁷
42. Professor Nanayakkara noted that in the cohort of women he had studied he found that “if the implant is older than 10 years, they are less likely to get better because the point of no return has probably been reached.”⁶⁸ At that point, women with implants may have a high burden of silicon residue throughout their bodies, including in their lymph nodes, a particular risk to those who had the weaker PIP implants.⁶⁹
43. Professor Heneghan called for a prospective study to better understand the symptoms women are facing and how they might be caused by their implants “where at the time of implantation you consent people to be followed up and you start to understand and ask them about their symptoms [...] we need one of those in the UK to fully understand what is happening and the issues at hand.”⁷⁰ Professor Coleman echoed the need for further research:

64 [Q12](#) [Professor Coleman]

65 [Q18](#) [Professor Nanayakkara]

66 Miss Amy Walkers ([BIP0086](#)); [Q17](#) [Professor Heneghan]

67 S. Azahaf, K. A. Spit, C. J. M. de Blok & P. W. B. Nanayakkara, [Increased FGF-19 levels following explantation in women with breast implant illness](#), January 2025

68 [Q19](#) [Professor Nanayakkara]

69 [Q1](#) [Professor Nanayakkara]

70 [Q17](#) [Professor Heneghan]

We need to do more research into strengthening, or having more understanding of, that link so that women in the future can be spared having years and years of suffering as a result of having an implant that is fundamentally likely to be incompatible.⁷¹

We note that some research is being carried out, such as Professor Nanayakkara's recent work examining the potential for biomarker proteins to aid the diagnostic process. While making some potentially valuable observations, that research team called for further research to be undertaken.⁷²

44. CONCLUSION

There is growing concern that a number of women are experiencing serious health impacts after receiving breast implants, with many reporting symptom improvements following explantation. While evidence of a definitive link between these symptoms and breast implants has not been established, this does not mean there is not a connection.

45. CONCLUSION

Evidence of concentrations of siloxanes in women's bodies outside of their implants is particularly concerning. The mental health impacts of knowing that chemicals, which are being banned in other uses due to their toxicity, are circulating in your body should not be underestimated or dismissed. This is particularly true for women who received PIP implants, which have higher rupture rates, lower grade silicone and higher levels of D4 siloxane.

46. RECOMMENDATION

The Government should commission research to better understand the health impacts of breast implants, including their potential impacts on women with pre-existing auto-immune conditions. The research needs to be a mix of clinical research, including on the health impacts of siloxanes, and longitudinal, following a cohort of women over a period of time. Such studies are necessary to improve patient safety, diagnosis and treatment and for the purposes of informed consent. At present, we do not believe that enough information is available about breast implants for women to genuinely be able to give informed consent to receiving them.

71 [Q31](#) [Professor Coleman]

72 S.Azahaf, K. A. Spit, C. J. M. de Blok & P. W. B. Nanayakkar, [Increased FGF-19 levels following explantation in women with breast implant illness](#), January 2025

47.

RECOMMENDATION

The Department of Health and Social Care should make primary care workers aware of the potential for a link between autoimmune conditions and breast implants to ensure that women presenting with symptoms following implantation are not dismissed.

Cosmetic surgery training standards

48. Following the PIP scandal, Sir Bruce Keogh was asked to review regulation in the cosmetic interventions sector, his final report recommended the Royal College of Surgeons (RCS) establish an Interspecialty Committee on Cosmetic Surgery “to set standards for cosmetic surgery practice and training, and make arrangements for formal certification of all surgeons regarded as competent to undertake cosmetic procedures, taking account of training and experience.”⁷³ In response to that recommendation, the RCS established the Intercollegiate Cosmetic Surgery Certification Scheme in January 2017. The initiative aimed to address significant patient safety concerns and the lack of regulation in cosmetic surgery practice in the UK.⁷⁴
49. Professor Vivien Lees told us that “a lot of time and effort has gone into building this programme” and that the certification “has been supported by the four Royal Colleges, including that of Ireland and of the relevant surgical specialty associations.”⁷⁵ However, the scheme remains voluntary and currently any doctor on the medical register can legally undertake cosmetic surgery in the private sector, including highly invasive cosmetic operations such as breast implants or reduction, rhinoplasty, facelifts, and liposuction.⁷⁶
50. In 2023, Maniram Ragbir, deputy president of the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) said, “I would be willing to bet that a significant proportion, if not more than 50% of people who are claiming to be cosmetic surgeons, will not be on a specialist register or would be ineligible for a job [as a plastic surgeon] in the NHS.”⁷⁷ Similarly, Mr Nigel Mercer, a consultant plastic surgeon and former President of both BAAPS and BAPRAS, told us:

73 Department of Health, [Review of the Regulation of Cosmetic Interventions: Final Report](#), April 2023, p8

74 Royal College of Surgeons of England, [Background - cosmetic surgery certification](#), accessed February 2026

75 [Q49](#) [Professor Lees]

76 Royal College of Surgeons ([BIP0122](#))

77 The Guardian, [Regulating cosmetic surgery in UK is a nightmare, says top surgeon](#), 30 September 2025

In the United Kingdom, I cannot work as a GP by law, but a GP or any doctor with minimal training in surgery is allowed to perform invasive cosmetic surgery. We would not allow a GP, or a doctor with little surgical training to perform neuro or cardiac surgery but the GMC (General Medical Council) and the law have double standards when it comes to cosmetic treatments, including surgery. [...] Registration should be made compulsory to protect patients. Protecting patients is more important than protecting practitioners' incomes.

The GMC has refused to accept that core and specialist surgical training is required to perform cosmetic surgical procedures. Any surgical procedure has complications and the surgeon must be able to recognise and instigate treatment for those complications. Training as a doctor to full GMC registration does not equip the individual to perform surgery, let alone deal with the complications.⁷⁸

51.

CONCLUSION

Currently, any doctor on the medical register can legally perform highly invasive cosmetic surgery in the private sector, regardless of specialist training or competence. This is a risk to patient safety. Despite the introduction of the Intercollegiate Cosmetic Surgery Certification Scheme in 2017, participation remains voluntary.

52.

RECOMMENDATION

The Government should require all practitioners performing invasive surgical cosmetic procedures to have specialist training and hold appropriate board certification in the procedures they undertake.

2 Non-surgical cosmetic procedures

53. The Royal College of Surgeons defines non-surgical cosmetic procedures as procedures that “do not require incisions and are commonly used to refer to injectables, such a Botox or dermal fillers, laser therapy or chemical peels. They require minimal recovery time allowing individuals to resume daily activities almost immediately.”⁷⁹ In recent years there has been exponential growth in non-surgical cosmetic procedures—the Department of Health and Social Care has estimated 900,000 Botox injections are carried out in the UK each year.⁸⁰ In 2021, the British College of Aesthetic Medicine reported a 100% rise in dermal filler procedures carried out by its members compared to the previous 12 months.⁸¹

Safety of non-surgical cosmetic procedures

54. While non-surgical cosmetic procedures have become increasingly popular and widely accessible, this growth has been accompanied by a rise in reports of adverse outcomes. For example, in June 2025, 28 people in the north-east of England were left with potentially fatal botulism after having anti-wrinkle injections. Many of the victims were hospitalised and local hospitals exhausted their supplies of antitoxin.⁸² Save Face, a government-approved register of trusted and qualified aesthetic practitioners, told us that since they were established in 2014, they have assisted over 15,000 members of the public either with “unwanted outcomes or adverse reactions and complications” stemming from non-surgical cosmetic procedures.⁸³ Ashton Collins, Director of SaveFace, told us that non-surgical procedures have become increasingly trivialised, especially among the younger age group:

79 Royal College of Surgeons ([BIP0122](#))

80 Department of Health and Social Care, [Consultation launched into unregulated cosmetic procedures](#) September 2023

81 The Guardian, [‘They’ve lost the plot’: leading cosmetic doctor says under-30s are overdoing Botox and fillers](#), December 2022

82 BBC, [‘I was poisoned by Botox’](#), 20 June 2025; BBC, [Women poisoned by fake Botox get apology from beautician](#), 3 July 2025

83 [Q41](#) [Ashton Collins]

They see them as an extension of their beauty regime, like getting your hair or your nails done. They do not have any medical association at all, and so that group are vulnerable to being exploited into thinking that this is a transactional-type treatment.⁸⁴

55. Concerns have been raised over a lack of effective regulation, which has created an increasingly unsafe environment for consumers. This is seen in the multiple reports of procedures taking place in Airbnbs, hotel rooms, garden sheds and public toilets.⁸⁵ In 2013, the Keogh Review of the Regulation of Cosmetic Interventions stated that “a person having a non-surgical cosmetic intervention has no more protection and redress than someone buying a ballpoint pen or a toothbrush.”⁸⁶ More than a decade later, progress remains minimal, and regulation has not kept pace with the sector’s rapid expansion.
56. The range of practitioners offering cosmetic procedures includes regulated healthcare professionals such as doctors, dentists and nurses and non-healthcare professionals such as beauty therapists. Healthcare professionals that offer cosmetic procedures are subject to general requirements set out by their professional regulator—for example, the General Medical Council is the regulator for doctors in the UK. However, no comprehensive legislative framework or consistent standards exist for qualifications and training across the non-surgical cosmetic procedures sector. This absence limits enforcement powers for bodies responsible for public safety and leaves consumers without reliable systems of redress when procedures go wrong. Where regulations do exist, such as for Botox which can only be prescribed by a qualified prescriber, Ashton Collins explained that “We are also seeing a huge increase in people now circumventing that prescription element altogether”, and that the rules are “grossly under enforced” and “under-policed”.⁸⁷
57. We heard evidence from Sasha Dean, who experienced severe complications following a ‘liquid BBL’ procedure—a non-surgical buttock augmentation procedure where dermal fillers, such as hyaluronic acid, are injected to increase volume and shape the buttocks—performed by a practitioner without any healthcare qualifications in a non-sterile home studio. Sasha was in coma for five days after her body went into septic-shock following

84 [Q58](#) [Ashton Collins]

85 [Q54](#) [Ashton Collins]; Sunday Mirror, [Unregistered DIY Botox clinic exposed operating out of a garden shed](#), 12 August 2017; BBC, [Warning over filler injections in public toilets](#), 18 June 2025

86 Department of Health, [Review of the Regulation of Cosmetic Interventions: Final Report](#), April 2023 p.5

87 [Q60](#) [Ashton Collins]

the procedure and was left unable to work for a year due to her ongoing health issues. She explained that she has been unable to access any form of redress.⁸⁸

- 58.** Professor Vivien Lees, Consultant Plastic Surgeon and Vice President at the Royal College of Surgeons of England, told us that she had “seen things like a young woman with infected filler injections in the lips having to have chunks of her lip cut out. You can imagine what that will be like for her over a lifetime [...] That lands up with the NHS.”⁸⁹ Studies have shown that incorrect application of fillers can lead to tissue death and, in rare cases, blindness.⁹⁰

Licensing system

- 59.** The previous Government set out plans to use powers made available in Section 180 of the Health and Care Act 2022 to introduce a new licensing scheme for non-surgical cosmetic procedures. Between September and October 2023, the Department of Health and Social Care held a public consultation seeking views on the remit of a future licensing scheme. The proposed scheme would be operated by local authorities in England and would require practitioners to be licensed to perform specified non-surgical cosmetic procedures. The premises from which they operate would also need to be licensed.⁹¹
- 60.** The then Government said that a licensing scheme “must strike a balance between protecting the public and building confidence in the safety of the aesthetic industry, while respecting consumer choice and encouraging innovation”. The licensing scheme would ensure that those who offer specified procedures:
- are suitably knowledgeable, trained and qualified;
 - hold appropriate indemnity cover;
 - operate from premises which meet the necessary standards of hygiene, infection control and cleanliness.⁹²
- 61.** The Government consulted on placing cosmetic procedures in red, amber or green categories according to the level of risk and therefore who can carry them out.

88 [Q51](#) [Sasha Dean]

89 [Q72](#) [Professor Lees]

90 BBC News, [Warning over cosmetic face fillers as scans reveal new details of risks](#), 3 December 2025

91 Department for Health and Social Care [The licensing of non-surgical cosmetic procedures in England](#) September 2023

92 Department of Health & Social Care, [The licensing of non-surgical cosmetic procedures in England: consultation document](#) August 2025

- Green procedures: these would be procedures with the lowest risk of complications, such as micropigmentation (semi-permanent make up), intense pulsed light (IPL) and light emitting diode (LED) therapies. All practitioners would be eligible to carry these procedures out, provided they meet agreed standards.
- Amber procedures: these would be procedures with a medium risk of complications, such as the injection of botulinum toxins and semi-permanent dermal fillers into the face. Non-healthcare professionals would need to be licensed and be supervised by a named, regulated healthcare professional. That professional would need to have gained an accredited qualification to prescribe, administer and supervise cosmetic procedures. Regulated healthcare professionals would be able to perform these procedures without supervision, provided they meet the agreed standards.
- Red procedures: these would include procedures with the highest risk of complications, such as hair restoration surgery, and procedure aimed at augmenting the body with the patient’s own fat or dermal fillers. These procedures would be brought under regulation by the Care Quality Commission (CQC) and would be excluded from the licensing scheme. The Government has proposed that red procedures would be restricted to qualified and regulated healthcare professionals only.

62. The Government published the response to the consultation in August 2025 but announced plans for further consultation in this area to begin this year. It stated that “priority will be given to introducing regulations to restrict the highest-risk procedures first—such as fillers injected into breasts and genitals. The consultation will seek views on the range of procedures which should be covered in the new restrictions.”⁹³ The Government has not yet given any indication as to when a licensing system will be introduced.

63. Victoria Brownlie MBE, Chief Policy and Sustainability Officer at the British Beauty Council, told us that her key response to the proposals was that the Government needs to move more quickly in this area and introduce a licensing system within this Parliament.⁹⁴ She stated that the current situation in which the Government has announced plans to regulate the industry but has not yet provided details on the implementation of those plans has led to complacency, particularly regarding the training required to perform procedures in the proposed ‘amber’ category. She told us:

93 DHSC, [Crackdown on unsafe cosmetic procedures to protect the public](#), 6 August 2025

94 [Q219](#) [Victoria Brownlie]

Until we have that, we are going to continue to see problems where we have this policy vacuum. More and more unregulated qualifications are being made, people are offering short courses saying that they are going to be Government compliant, when we do not actually know what the Government are going to require of people.⁹⁵

64. Several stakeholders emphasised the urgent need for regulations on ‘red’ category procedures, given the significant risks they pose to patient safety. They argued these procedures should be restricted to regulated healthcare professionals. Particular concern was raised about ‘liquid BBL’ procedures,⁹⁶ with Save Face calling for a ban following the death of Alice Webb in September 2024, who died due to complications following a liquid BBL.⁹⁷ Ashton Collins stated that in addition to the death of Alice Webb and the serious complications Sasha experienced, Save Face has “helped over 700 women who have fallen foul of these types of practices and have ended up in hospital with sepsis and needed corrective surgery.”⁹⁸ In February 2025, the BBC reported that it had seen the testimonies of more than 30 women who say they had been left with serious complications such as sepsis and necrosis (tissue death) following liquid BBL procedures all performed by the same practitioner.⁹⁹
65. In December 2025, the British Association of Aesthetic Plastic Surgeons (BAAPS) published a statement calling for immediate action to regulate liquid BBLs, stating:

Nobody should be performing BBL procedures if the procedures are outside of their scope of training and practice and this scope lies uniquely within the specialist qualification of GMC registered plastic surgeons (and other individual GMC registered surgeons able to demonstrate their specialization and ongoing competencies to perform BBL). There must be consequences for those who act with impunity and disregard for the safety of others. The consequences must be severe enough to act as a deterrent. With the continually increasing demand for dermal filler enhancements, we are sitting on the edge of a public health catastrophe if we do not act now.¹⁰⁰

95 [Q192](#) [Victoria Brownlie]

96 Save Face, [Urgent Ban Needed on Dangerous liquid BBL’s and Breast Augmentation Procedures](#) accessed 16 December 2025

97 The Guardian, [Tributes to woman thought first to die from ‘liquid Brazilian butt lift’ in UK](#), 26 September 2024

98 [Q46](#) [Ashton Collins]

99 BBC News, [Celebrity butt-lift injector who left women with sepsis exposed by BBC](#), 4 February 2025

100 BAAPS, [The BAAPS Calls For Urgent Regulation Of BBL Procedures](#), 3 December 2025

66. Victoria Brownlie welcomed the Government’s proposal to limit ‘red’ procedures to regulated medical professionals saying it would effectively amount to a ban on liquid BBLs. She explained that “the opinion across the board for more respected practitioners is that they would not do that [procedures such as BBLs] under any circumstances because of the risk.”¹⁰¹
67. The Government has indicated it intends to accelerate progress in this area. Minister of State for Secondary Care, Karin Smyth MP, told us in October 2025 that the Government plans to consult on this category first, stating, “We want to bring this forward as soon as possible and, hold me to a date, but what we are looking to do is consult on those early in the new year, realistically.”¹⁰² However, this approach means that these high-risk procedures will continue to remain available and unregulated for many more months, if not longer.

68. **CONCLUSION**

We welcome the proposals for a licensing scheme put forward in the Government’s consultation, including the proposed categories and the need for a practitioner to acquire appropriate indemnity cover and premises which meet the necessary standards of hygiene, infection control and cleanliness to obtain a licence.

69. **CONCLUSION**

However, the Government is not moving quickly enough in introducing such a system. At present, individuals without any formal training can carry out potentially harmful interventions, placing the public at risk. Successive Governments have failed to act swiftly enough to legislate in this area allowing further harms to occur. The Government’s announcement of yet another consultation will cause more delays. This lack of timely action is fostering complacency in self-regulation within the industry and is compromising patient safety.

101 [Q195](#) [Victoria Brownlie]

102 [Q220](#) [Karin Smyth MP]

70.

RECOMMENDATION

The Government should accelerate regulatory action. Procedures that are deemed high risk such as liquid BBLs and liquid breast augmentations, which have already been shown to pose a serious threat to patient safety, should be restricted to appropriately qualified medical professionals immediately. Given the lack of appetite among medical professionals to carry out these procedures, this will act as a de facto ban in all but the most essential cases. A licensing system for ‘green’ and ‘amber’ non-surgical cosmetic procedures should be introduced within this Parliament.

Training and qualifications

71. There is currently no legislative framework to instil common standards for qualifications and training across the non-surgical cosmetic procedure sector. In its consultation response, the Government reported that many respondents believed training providers needed regulating. Respondents cited concerns around the quality and variability of existing training, particularly the prevalence of online courses and one- or two-day programmes, and the ease with which individuals can present themselves as ‘qualified’ aesthetic practitioners by completing inadequate courses.¹⁰³
72. Lesley Blair MBE, CEO and Chair at British Association of Beauty Therapy and Cosmetology (BABTAC), highlighted the variability of current training, noting that “at the moment, you can go and do a half-day peel training or skin-needling training.”¹⁰⁴ She also stated that in her opinion being a doctor does not automatically confer competence in these procedures, and advocated for an even playing field where medics, beauty therapists and beauty professionals train to consistent standards and work within their defined scope of practice.¹⁰⁵
73. This was echoed in the Government’s consultation response which highlighted that some stakeholders disagreed that a medical qualification alone should make someone qualified to perform aesthetic treatments:

Many respondents felt that aesthetic practice falls outside of the remit of many regulated healthcare professionals’ scope of professional practice and were concerned that regulated healthcare professionals

103 Department for Health and Social Care, [The licensing of non-surgical cosmetic procedures in England: consultation response](#) 7 August 2025

104 [Q194](#) [Lesley Blair MBE]

105 [Q194](#) [Lesley Blair MBE]

are being unfairly seen as automatically more skilled at aesthetic practice purely by virtue of their professional standing rather than on an assessment of skill and experience specific to aesthetics.¹⁰⁶

- 74.** In its response to a report on body image from the Health and Social Care Committee in 2022, the Government noted that the Joint Council for Cosmetic Practitioners (JCCP) had developed a competency framework for high-risk non-surgical cosmetic procedures. It also highlighted that only a limited number of organisations, including universities, colleges and private training companies, are currently able to offer courses in these areas. A range of qualifications approved by the Office of Qualifications and Examinations Regulation (Ofqual) are also available. The Government stated that it would work with the JCCP and other stakeholders to assess whether further education and training requirements are necessary.¹⁰⁷
- 75.** Concerns were raised with us about the financial impact that future regulation may have on the largely women-owned aesthetics sector, particularly for non-medical practitioners who have already invested significant time and money in training. Vikki Soloman, an independent aesthetic practitioner, cautioned that new requirements could “impact those who have invested time, money, and resources in their businesses and education.” She also emphasised the lack of accessible university pathways for those seeking to train in non-surgical cosmetic procedures.¹⁰⁸
- 76.** Victoria Brownlie similarly highlighted the need for training routes to remain accessible and affordable for the current, largely female, workforce:

There has to be safety but also accessibility for people. In our industry, we are an over 80% female-led industry. They are working mothers doing this in and around other responsibilities in their lives. [...] It should not be that you can only get these qualifications if you are prepared to go to university. There has to be an apprenticeship route, a level 1, 2, 3 and 4 route where you can work your skills up, but it should just be through the proper training methods rather than a two-day course.¹⁰⁹

106 Department for Health and Social Care, [The licensing of non-surgical cosmetic procedures in England: consultation response](#), 7 August 2025

107 Health and Social Care Committee, [Government response to the House of Commons Health and Social Care Committee’s second report of session 2022 to 2023 on the impact of body image on mental and physical health](#), February 2023

108 Vikki Soloman [[BIP0010](#)]

109 [Q200](#) [Victoria Brownlie]

77. CONCLUSION

The absence of a legislative framework for training and qualifications in the non-surgical cosmetic sector has resulted in significant variability in standards, with justified concerns about short courses, online training, and the ease of entry into practice.

78. RECOMMENDATION

The Government should bring forward consistent, enforceable standards for the non-surgical cosmetic sector that prioritise patient safety and competency, while ensuring training routes remain accessible and affordable for a predominantly female-led workforce. Training routes should include Ofqual-approved qualifications and apprenticeship models, including funded apprenticeship places in SMEs in the beauty industry, to ensure affordability and accessibility, particularly for the existing workforce, while eliminating short, inadequate courses.

Devolved administrations

79. In December 2024, the Scottish Government launched a consultation on introducing a new licensing scheme and regulatory framework for non-surgical cosmetic procedures. These proposals closely mirrored those previously set out in England. The consultation response, published in June 2025, outlined key recommendations.

Private non-surgical cosmetic procedures should take place either:

- in an independent clinic or other healthcare setting regulated by Healthcare Improvement Scotland (HIS), or
- in premises licensed by the local authority.

Procedures must be carried out by a suitably trained and qualified practitioner or an appropriate healthcare professional.

- In licensed premises, this would be ensured by requiring the practitioner to hold a licence.
- In HIS-regulated settings, compliance would be monitored through existing HIS processes.¹¹⁰

80. By contrast, Wales and Northern Ireland have not yet announced plans to introduce similar regulatory measures. This lack of alignment has raised concerns among stakeholders about potential inconsistencies across the

¹¹⁰ Scottish Government, [Regulation and licensing of non-surgical cosmetic procedures: consultation analysis and response](#), June 2025

four nations. Professor David Sines told us that “anything less” than one standard across the four nations “would be totally unacceptable and would be a failure in patient safety and public protection.”¹¹¹ In August 2025, the Professional Standards Authority (PSA) echoed these concerns, warning that regulatory gaps in Wales and Northern Ireland could encourage ‘cosmetic tourism’, with individuals seeking treatments from unregulated providers in jurisdictions with weaker protections.¹¹² Lesley Blair emphasised the importance of cross-border consistency to enable the creation of a national register for practitioners operating without a license.¹¹³

81. CONCLUSION

While Scotland has taken steps to introduce a licensing scheme for non-surgical cosmetic procedures, Wales and Northern Ireland have yet to announce similar plans. This lack of regulatory alignment across the UK creates significant risks, including inconsistent safety standards and the potential for ‘cosmetic tourism’ within the UK, where individuals seek treatments in jurisdictions with weaker protections.

82. RECOMMENDATION

The Government should work with the devolved administrations to ensure regulatory alignment across all UK nations on legislation governing non-surgical cosmetic procedures.

111 [Q176](#) [Professor David Sines]

112 Professional Standards Authority, [PSA welcomes Government commitments to strengthening regulation for non-surgical cosmetics in England and Scotland, but urges a consistent UK-wide approach](#), 7 August 2025

113 [Q212](#) [Lesley Blair MBE]

3 Cosmetic tourism

- 83.** Cosmetic tourism involves traveling outside one’s home country to undergo cosmetic procedures or treatments. In recent years it has surged in popularity as a relatively low-cost way for people to access cosmetic procedures. In 2024, it is estimated that 524,000 UK residents undertook overseas travel to seek medical treatment, including cosmetic procedures such as abdominoplasty, breast augmentation, liposuction and buttock lifts, an increase from 431,000 in 2023.¹¹⁴
- 84.** Evidence suggests that most people who travel abroad for cosmetic surgery are happy with the results. Professor Ruth Holliday, Professor of Gender and Culture at University of Leeds, told us that in a survey she conducted on people who had engaged in cosmetic tourism, 97% of the patients were happy with their results and would recommend their surgeon to a friend.¹¹⁵
- 85.** However, data indicates that growing numbers of people are returning to the UK with complications ranging from delayed wound healing to life-threatening sepsis.¹¹⁶ In the four years up to 2022, the British Association of Aesthetic Plastic Surgeons report that 324 people needed surgery after they returned from treatment in overseas countries, mostly following procedures done in Turkey.¹¹⁷ Since 2019, 28 British nationals have died following medical treatments in Turkey.¹¹⁸
- 86.** Turkish clinics have opened sales offices in the UK to help recruit patients. An undercover investigation by *The Times* newspaper into one of these sales offices found pressurised sales techniques and ‘consultations’ delivered by people with no medical training. In response to the death of a Dutch woman following cosmetic surgery in Turkey, Edin Hajder, a surgeon and director of the Dutch Society for Plastic Surgery, raised concern about the role of online recruiters who promote treatments abroad with any medical training:

114 Office for National Statistics, [Estimated number of visits by residents of Great Britain to overseas countries for medical treatment, 2024](#), 19 September 2025

115 [Q106](#) [Dr Ruth Holliday]

116 Wounds UK, [Cosmetic tourism: the cost of going ‘under the knife’ abroad for cosmetic surgery](#), 5 November 2025

117 BAAPS, [Cosmetic tourism update](#), November 2023

118 The Times, [How I was pressured to sign up for high-risk plastic surgery in Turkey](#), September 2024

Influencers try to sell things like VIP service, home pick-up service, all-inclusive plastic surgery holidays. They also advertise with a kind of stacking discount. The more surgery you take, the higher your discount, but I only see the risks piling up.¹¹⁹

- 87.** We note that the Care Quality Commission (CQC) is investigating whether organisations hosting appointments in England have been operating unlawfully. The 2024 investigation by *The Times* found that Turkish clinics are using unregulated meetings in England to sign people up for surgery in Turkey with sales staff without medical qualifications promoting a range of high-risk operations. The sales staff offer discounts if people sign up swiftly, with a limited cooling off period or psychological check. It also found companies recruiting patients for Turkish clinics via WhatsApp who encouraged patients to pay for multiple surgeries in ‘package deals’. However, there is concern that the CQC may not be able to act as current legislation means that only registered healthcare professionals fall within its scope.¹²⁰

Impact on the NHS

- 88.** A number of studies have sought to estimate the cost to the NHS of corrective treatment, including that which is life-saving. BAAPS estimate that the average cost to the NHS per person is £15,000, but costs can be up to £100,000.¹²¹ They estimated that the total cost to the NHS of corrective treatment for surgeries done abroad in the four years up to 2022 as around £4.8 million.¹²² Research carried out in an NHS breast unit in 2022–23 showed that 20 out of 25 patients requiring corrective surgery had undergone the initial surgery in Turkey, at a cost of more than £37,000 per patient. Common complaints were infection and a failure of wounds to heal.¹²³
- 89.** A recent study of relevant research published between 2012–24 found reports of 655 patients treated by the NHS as a result of complications following medical tourism. 90% of the cases were women and the most common destination was Turkey. Nearly half of the cases involved cosmetic procedures. The study estimated that the costs to the NHS ranged from

119 The Times, [Online recruiters blamed as woman dies after cosmetic surgery in Turkey](#), 16 August 2024

120 The Times, [Turkish plastic surgery clinics let sales staff do assessments in UK](#), 13 September 2024

121 BAAPS, [Cosmetic tourism update](#), November 2023

122 The Telegraph, [The five most dangerous ops to have abroad costing the NHS £4.8 million](#) July 2024

123 Daniel Ahari, Zara R Zaccariah, Michael Preston, Lyndsey Highton, [The impact of cosmetic tourism across one year on an NHS breast surgery unit](#), *Journal of Plastic, Reconstructive and Aesthetic Surgery*, 2024

£1,058 to £19,549 per patient.¹²⁴ A study of 81 patients who presented to NHS Scotland with complications following cosmetic surgery tourism estimated total costs of £755,559.68 with an average of £9,327.90 per patient.¹²⁵

90. Responding to reports of the growing impact on the NHS, the Health Secretary said that “The NHS is never going to turn away people who are in need of care, but this is another pressure that the NHS doesn’t need.”¹²⁶ Professor Sir Stephen Powis, NHS England’s national medical director, also stated:

It is not fair that the NHS is left to pick up the pieces of botched Brazilian butt lifts. Not only are they potentially fatal, having the highest death rate of all cosmetic procedures, but dodgy procedures mean the NHS then has to repair the damage, landing taxpayers with a hefty bill too. NHS resources are precious, and I’d urge anyone considering a BBL to think twice before taking up an offer that seems too good to be true.¹²⁷

91. Elaine Sassoon, a plastic surgeon and board member of the British Association of Aesthetic Plastic Surgeons (BAPRAS), recommended that in order to gain a better understanding of the scale of the issue, the NHS should begin to record instances in which it performs medical treatment for cosmetic surgery undertaken abroad.¹²⁸ We asked Professor Aidan Fowler, National Director of Patient Safety at NHS England and Deputy Chief Medical Officer at the Department of Health and Social Care, whether the NHS plans to begin recording instances when it performs corrective surgery on patients who have received cosmetic procedures in the UK and abroad. He told us that it would be for the Department of Health and Social Care to decide whether the NHS should collect that data, and “if we do collect it, what we should do with it. It would give us an idea of what is going on, but it would not necessarily give us the ability to reclaim that funding.”¹²⁹ He added he would not want to introduce a policy that may result in people

124 England C, Bromham N, Needham-Taylor A, et al, [Complications and costs to the UK National Health Service due to outward medical tourism for elective surgery: a rapid review](#), BMJ Open 2026

125 Jessica L Roberts, Martyn Eckersley, Kerry J Davies, Adam Gilmour, [The cost of cosmetic surgery tourism complications to the NHS: A retrospective analysis](#), Journal of the Royal Colleges of Surgeons of Edinburgh and Ireland, October 2024

126 The Guardian, [Streeting warns Britons against having cheap cosmetic surgery abroad](#), November 2024

127 The Guardian, [Streeting warns Britons against having cheap cosmetic surgery abroad](#), November 2024

128 [Q187](#) [Elaine Sassoon]

129 [Qq158-159](#) [Professor Fowler]

being less likely to seek medical help “with potentially dangerous infections because of the risk of costs” and that collecting the data would be a significant administrative burden on the NHS.¹³⁰

Education

92. Stakeholders told us that it is essential to ensure the public is well informed about both the risks of travelling abroad for procedures and how to choose a trusted and reliable practitioner. Miss Reika Taghizadeh, a consultant plastic, reconstructive and aesthetic surgeon, explained that any educational material needs to be as widely available as possible:

Education plays such an immense part, not just through our organisations, the British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS) and the British Association of Aesthetic Plastic Surgeons (BAAPS), but also through a wider media setting whereby with awareness of generalised coverage of these problems some of us are featuring in more widespread media coverage. The population really needs to be educated about what can catastrophically go wrong.¹³¹

93. In August 2025, it was announced that, as parts of its wider strategy for educating the public about cosmetic tourism, the Government was partnering with TikTok to create content with medical influencers to educate people on the potential risks of cosmetic tourism and how make trips as safe as possible. Minister of State for Health and Social Care, Karin Smyth MP, said the partnership with TikTok would help people “make safer and more informed choices before they go under the knife – wherever that may be.”¹³²

94. **CONCLUSION**

The increasing number of cases requiring medical treatment after cosmetic surgery abroad raises serious concerns for patient safety and places additional financial strain on the NHS. However, the true extent will remain unknown until comprehensive data is collected.

130 [Q243](#) [Professor Fowler]

131 [Q185](#) [Reika Taghizadeh]

132 BBC, [Government turns to TikTokers to advise on cosmetic surgery abroad](#), August 2025

95.

RECOMMENDATION

The Government should review the need for the NHS to systematically record data on complications arising from cosmetic procedures performed abroad. Publishing such data in an annual release would enable a comprehensive assessment of the financial impact on the NHS and provide robust evidence to better inform and educate the public about the risks associated with cosmetic tourism. Where possible, the data set could include details of the clinic or practitioner that performed the original procedure to help further protect UK nationals.

96.

CONCLUSION

We welcome Government action on educating the public on the risks of travelling abroad for cosmetic procedures and providing guidance on how to do so as safely as possible and its use of social media channels to do so. With the number of people engaging in cosmetic tourism growing rapidly, this effort must be sustained, and educational materials should remain simple and widely accessible and supported by the data release we recommend.

97.

RECOMMENDATION

The Government should assess whether outlets in the UK that are recruiting patients for medical treatment overseas should be brought into a regulatory regime and be subject to investigation and, where necessary, sanction.

4 Body image

- 98.** Body image is commonly defined as “a person’s perceptions, thoughts, and feelings” about their body.¹³³ Evidence suggests that levels of body dissatisfaction have increased in recent years.¹³⁴ The Nuffield Council on Bioethics report on cosmetic procedures, published in 2017, highlighted that concerns about body image and a desire to improve self-esteem are significant factors influencing people’s decisions to pursue cosmetic procedures.¹³⁵
- 99.** Recent UK data indicates that these pressures are particularly acute among girls and young women. A 2024 Girlguiding survey of 2,734 girls and young women found that just over a quarter of girls aged 11–16 would consider altering their appearance through cosmetic procedures within the next 20 years; this proportion rose to almost half among 17–21-year-olds.¹³⁶ Similarly, another survey of UK adolescents reported that 36% of young people agreed they would do “whatever it took” to look good, with 10% stating they had already considered cosmetic procedures.¹³⁷

Body dysmorphic disorder and psychological screening

- 100.** Body Dysmorphic Disorder (BDD) is a mental health condition characterised by excessive preoccupation with perceived flaws in one’s appearance, even if those flaws are barely noticeable to others. Individuals with BDD are more likely to pursue cosmetic surgeries to remedy their perceived flaws and more likely to be unsatisfied with the outcome of a procedure.¹³⁸
- 101.** In written evidence submitted to the Committee’s previous inquiry into body image in August 2020, the Body Dysmorphic Disorder Foundation stated:

133 Grogan, S., [Body Image: Understanding Body Dissatisfaction in Men, Women and Children \(4th Edition\)](#), November 2021, p.5

134 Girlguiding, [Girls’ attitudes survey](#), 2016; TJL Solicitors, [What’s Changed? Exploring the Rise in Body Dissatisfaction](#) July 2025

135 Nuffield Council on Bioethics, [Cosmetic procedures: ethical issues](#) June 2017 p. 92

136 Girlguiding, [Girls as young as 11 consider future cosmetic procedures as appearance pressures soar](#) July 2024

137 BeReal, [Somebody Like Me: A report investigating the impact of body image anxiety on young people in the UK](#), January 2017

138 International OCD Foundation, [Cosmetic Treatments and Body Dysmorphic Disorder](#)

The majority of people with BDD are not satisfied after the outcome of their chosen procedure. This can lead to a preoccupation with further surgery to try to get a better result, which in some cases will do more harm to a person's appearance and emotional wellbeing than good. Even when sufferers are happy with the improvement to one area, the focus of their BDD often moves to another area of their appearance. The key message here of course is that BDD is a psychological or psychiatric problem and thus needs psychological or psychiatric treatment, not treatments or interventions of a physical nature.¹³⁹

102. In February 2025, Dr Christopher Rowland Payne, a consultant dermatologist and president of the Royal Society of Medicine's aesthetic medicine and surgery section, emphasised the need for mental health checks before aesthetic treatments, noting that some patients would be better served by psychological interventions rather than cosmetic procedures.¹⁴⁰ Similarly, Dr Toni Pikoos, an Australian clinical psychologist, has argued that mental health screening should be mandatory for all cosmetic procedures, including non-surgical procedures. She warned that these procedures, often perceived as low risk, can pose heightened dangers due to their accessibility and low cost, making vulnerable individuals more susceptible to harm.¹⁴¹

103. Currently, there is no statutory requirement for mental health screening prior to surgical or non-surgical cosmetic procedures. Providers are only obliged to take voluntary steps to ensure that their services are delivered appropriately. In written evidence to the Health and Social Care Committee's inquiry into the impact of body image on mental and physical health, the Joint Council for Cosmetic Practitioners reported that, among individuals seeking non-surgical procedures, 22% did not have any pre-treatment consultation and nearly four in five patients were not asked about body image or psychological/emotional challenges.¹⁴²

104. CONCLUSION

There appears to be a gap in safeguarding mental health in the cosmetic procedures sector. The absence of mandatory psychological screening prior to procedures, combined with evidence of inadequate consultations, increases the risk of harm, particularly for vulnerable individuals such as those with Body Dysmorphic Disorder, who are more likely to want cosmetic surgery and less likely to be satisfied with the outcome.

139 Body Dysmorphic Disorder Foundation [[MISS0056](#)]

140 [Q95](#) [Dr Christopher Rowland Payne]

141 The Guardian Australia, [Botox patients should undergo mental health screening, experts say](#) September 2022

142 Joint Council for Cosmetic Practitioners ([IBI0003](#))

105. RECOMMENDATION

Training curricula required to obtain a licence to perform non-surgical cosmetic procedures should include mandatory modules on informed consent and psychological screening, with a specific focus on identifying Body Dysmorphic Disorder and other vulnerabilities.

Social media

- 106.** Studies have found that social media is contributing to both worsening body image and an increased desire for cosmetic procedures, particularly in younger women and girls.¹⁴³ A meta-analysis of studies looking at the connection between social media use and cosmetic procedures found that the “engaging and interactive features of social media, including likes, comments, and shares, further reinforce the desire to conform to [beauty standards], driving individuals to consider cosmetic enhancements to align with the prevalent aesthetic ideals.”¹⁴⁴ For example, in the weeks following the release of the Barbie film the hashtag #barbiebotox reached 9.4 million views on TikTok.¹⁴⁵

Filters and AI

- 107.** In written evidence to us, Professor Rosalind Gill, Research Lead in Inequalities in Media, Culture and Creative Industries at Goldsmiths, University of London, highlighted the impact of face-editing applications such as Facetune, and the widespread use of filters on platforms including TikTok and Snapchat.¹⁴⁶ She described how these tools have both a negative effect on young women’s body image and a direct influence on their decision-making about cosmetic surgery and other cosmetic procedures.¹⁴⁷ Professor Gill explained that many young women experience increased feelings of shame or dissatisfaction with their appearance after editing a photo, as this idealised version of themselves becomes a point

143 Body Image, [A systematic review of the impact of the use of social networking sites on body image and disordered eating outcomes](#) June 2016

144 Andreea Mironica, Codruța Alina Popescu, Delaca George, Ana Maria Tegzeșiu, and Claudia Diana Gherman, [Social Media Influence on Body Image and Cosmetic Surgery Considerations: A Systematic Review](#), July 2024

145 Forbes, [What To Know About New TikTok Beauty Trend ‘Barbie Botox’: From Effects To Cost](#), 18 August 2023

146 A filter is an image overlay that can alter a user’s appearance. It can be used to make aesthetic adjustments, add colouring grading or add digital elements such as animated dog ears, text, sparkles, or virtual backgrounds.

147 Professor Rosalind Gill [[BIP0109](#)]

of comparison with their real appearance. A participant in a 2025 study on young people’s everyday experiences on their phones conducted by Professor Gill described this experience:

You look at that idealized version of yourself and you just want it – you just want it to be real [...] the more you do it, the better you get at it and the more subtle your editing is the easier it is to actually see yourself as that version. You go “I look good” and then you do that little button that takes it back to how the photo actually was and it’s like blunt – your flaws that you’ve just fixed literally blow up straight in front of you and you go oh Jesus like – yeah. Yeah.¹⁴⁸

Professor Gill explained that this cycle of dissatisfaction can drive young women’s desire to seek out cosmetic procedures to make this edited, idealised version of themselves a reality.¹⁴⁹

- 108.** Professor Gill also expressed concern at the growing use of AI filters, such as the ‘Bold Glamour’ filter on TikTok,¹⁵⁰ warning that as this technology becomes increasingly embedded, it is making young women’s pressures regarding physical appearance become “even more intense still.”¹⁵¹ She called for more research on the potential impact of AI on photo-editing and in turn on appearance pressure.

Influencers and advertising

- 109.** We also heard concerns that social media has led to a ‘normalisation’ of cosmetic procedures amongst young women, in part through the downplaying of associated risks by influencers and some practitioners. In written evidence, Dr Natalie Haworth, a medical doctor with 13 years of aesthetic medicine experience, described how “social media marketing continues to glamorise high-risk procedures like BBLs and facial injectables, often with no mention of risks [...] These advertisements often employ unrealistic imagery, digitally altered photographs, and unverified testimonials to promote unattainable ideals of beauty.”¹⁵² We note that,

148 Professor Rosalind Gill [BIP0109]

149 Professor Rosalind Gill [BIP0109]

150 The ‘Bold Glamour’ filter is a filter on TikTok that uses AI to analyse and enhance a user’s facial features (unlike a traditional filter which would just overlay an image). It typically narrows the face, makes the nose appear smaller, sculpts cheekbones, and lifts the eyes. It also smooths the skin and adds make up (defines eyebrows, plumps and contours lips, and whitens teeth).

151 Professor Rosalind Gill [BIP0109]

152 Dr Natalie Haworth [BIP0094]

in January 2025, a cosmetic procedure practitioner was forced to apologise after posting online to his 250,000 followers about how a pop star’s appearance could be improved with cosmetic surgery.¹⁵³

110. Ashton Collins from Save Face told us that social media is a “constant source of misinformation about how safe these treatments are” and a “hotbed for unscrupulous practitioners to prey on and target women into believing that they need these types of procedures.”¹⁵⁴ Sasha Dean, who suffered severe complications from a liquid BBL, agreed with this sentiment, explaining that social media had influenced her decision to undergo a liquid BBL procedure. She told us that “seeing so many women have it done and it being deemed safe, that is what spurred me on to do it.”¹⁵⁵
111. In May 2022, new restrictions came into force banning the advertising of cosmetic procedures to under 18s. Such adverts cannot appear in other non-broadcast media where under-18s make up over 25% of the audience or appear during or adjacent to programmes commissioned for, principally directed at or likely to appeal particularly to under-18s.¹⁵⁶ The new restrictions were announced weeks after the Botulinum toxin and Cosmetic Filler (Children) Act 2021 came into force which made it illegal for under 18s to get Botox and fillers. While such restrictions are welcome, witnesses to our inquiry suggested further work was required.
112. Dr Beth Daniels, Professor and Director of the Centre for Appearance Research at University of the West of England Bristol, called for further regulation of social media companies with regard to adverts for cosmetic procedures. She stated that “the expectation that industry will self-regulate is a fool’s errand.”¹⁵⁷ Dr Daniels explained:

The social media companies are not doing things that would help to mitigate some of the mental health impacts that their platforms generate, and the idea then is that Government have to regulate, to step in and say, “We’re going to limit your capacity to just do whatever because you’re not making choices.” Not allowing clinics to advertise directly through social media influencers and not allowing them to give discounts to people to turn on to social media and then say, “This is the clinic I got my procedure at,” would be ways to limit the impact.¹⁵⁸

153 BBC News, [Cosmetic surgeon sorry for picking apart singer Troye Sivan’s looks on TikTok](#), 25 January 2026

154 [Q40](#) [Ashton Collins]

155 [Q41](#) [Sasha Dean]

156 Advertising Standards Authority, [Strict new rules for ads for cosmetic interventions](#), 25 November 2021

157 [Q111](#) [Dr Beth Daniels]

158 [Q84](#) [Dr Beth Daniels]

Multiple stakeholders suggested that the Advertising Standards Authority (ASA), the UK’s advertising regulator, should take stronger action against practitioners and influencers who use harmful promotional tactics, both in promoting unrealistic body ideals and in marketing cosmetic procedures.¹⁵⁹

- 113.** The ASA has taken steps to address the online advertising of cosmetic procedures. In April 2025, the ASA acted against six UK companies after its artificial intelligence monitoring system flagged a series of Facebook and Instagram adverts for liquid BBLs and similar procedures that used time-limited deals to “irresponsibly pressurise” customers into booking.¹⁶⁰ The ASA also investigated and ultimately removed four TikTok videos posted by influencer Millie Bracewell to her 1.7 million followers about her breast augmentation at the Erdem Clinic in Istanbul in August 2023; one of the videos included a 20% discount code to encourage bookings.¹⁶¹ TikTok confirmed that the promotion of cosmetic surgery was prohibited under their Branded Content Policy. The videos had not been uploaded as marketing material so were not caught by the platform’s safeguards.
- 114.** Stakeholders told us that the ASA’s work does not go far enough.¹⁶² They argued that the regulator should be more proactive in monitoring social media content, rather than relying predominantly on reactive, complaint-led investigations. Victoria Brownlie, Chief Policy and Sustainability Officer at the British Beauty Council, said that the legislation to make social media sites take more responsibility to prevent the proliferation of harmful beauty standards and misinformation regarding cosmetic procedures does already exist but needs better enforcement. She stated that currently by the time a post is taken down “the damage has already been done. If that person has a following of 20,000 or 30,000 people, then essentially the problem has already happened there.”¹⁶³

Education

- 115.** Witnesses emphasised the importance of education in reducing the risks associated with cosmetic procedures and addressing the societal pressures that disproportionately affect young women and girls. Dr Ruth Holliday, Professor of Gender and Culture at University of Leeds, highlighted that such education could be incorporated into school curricula, noting that “we need to start educating young people about risks and harms, and it is very

159 [Q201](#) [Victoria Brownlie]; [Q88](#) [Dr Beth Daniels]; Mr Nigel Mercer [[BIP0050](#)]; Dr Natalie Haworth [[BIP0094](#)]

160 The Independent, [Advertising regulator bans liquid BBLs ads that ‘irresponsibly pressured women into booking’](#), April 2025

161 BBC, [Millie Bracewell TikTok posts trivialised cosmetic surgery - ASA](#), January 2024

162 Nigel Mercer ([BIP0001](#)); [Q201](#) [Victoria Brownlie]

163 [Q201](#) [Victoria Brownlie]

easy to do.” But she also stressed that this “will have to be done by expert people who really know what they are doing in that educational setting.”¹⁶⁴ Similarly, Dr Natalie Haworth emphasised the importance of targeting education efforts at both schools and universities, particularly because “younger women are disproportionately affected by societal and cultural pressures to undergo cosmetic procedures.”¹⁶⁵

- 116.** Dr Beth Daniels advocated for proactive educational interventions, particularly to help young people critically engage with the images and messages they encounter on social media. She noted that:

There are social media literacy programmes that have been shown to be effective. There are body image curricula out there that need to be in schools as well. We really need to disrupt the broader environment that values and overvalues these idealised images.¹⁶⁶

The Government is aiming to expand mental health support in schools, “particularly for those at the more extreme end who have mental health problems as a result of anxiety related to body image.”¹⁶⁷

117. CONCLUSION

Social media platforms and face-editing technologies are contributing to worsening body image and increasing demand for cosmetic procedures, particularly among young women and girls. The normalisation of high-risk procedures by online influencers and the shaping of beauty standards by algorithms which bombard users which posts on body image are particular concerns. There is no easy solution to these problems, but it is clear that social media platforms must take more responsibility for the content they promote.

118. CONCLUSION

One way of addressing the risks posed by social media around cosmetic surgery and body image is through education. Proactive interventions in an educational setting can equip young people with the skills to critically engage with social media content and challenge unrealistic beauty standards.

164 [Q99](#) [Dr Ruth Holliday]

165 Dr Natalie Haworth [[BIP0094](#)]

166 [Q109](#) [Dr Beth Daniels]

167 [Q155](#) [Professor Fowler]

119.

RECOMMENDATION

In response to the alarming increase in desire for cosmetic surgery among teenagers, the Department of Health and Social Care should work with the Department for Education to integrate evidence-based body image and social media literacy programmes into school curricula. This should include content on risks of cosmetic procedures.

Conclusions and recommendations

Breast implant safety

1. The PIP implant scandal exposed failures that continue to affect women more than a decade later. Official assurances that PIP implants pose no health risks appear to be based on limited long-term research and underplay the mental health impacts on women of having a substandard product inside them. Many women report enduring physical and psychological harm, compounded by inadequate follow-up and dismissal of symptoms. Shortcomings on data collection and recording mean that the NHS does not know who received PIP implants and many women may not be aware they have them. The need for further research and improved data collection on implantation must be addressed. (Conclusion, Paragraph 18)
2. While there is a judgement to be made over whether the NHS should offer replacement implants to women affected by the PIP implants scandal, women with PIP implants who wish to have them removed should be able to have that request met by the NHS as stated by its own guidance. Reports that such requests are being turned down are troubling, not least given the evidence of the benefits of explantation for some women. The NHS should remove PIP implants from women who wish to have them explanted. (Recommendation, Paragraph 19)
3. Without mandatory participation in the Breast Implant Registry and the regular publication of outcome data, surgeons cannot provide patients with comprehensive risk information. This undermines the principle of informed consent. Many individuals feel inadequately informed before surgery and the absence of a cooling-off period further increases the risk of rushed decisions. As the PIP scandal demonstrates, a lack of data collection makes it more difficult to identify products with increased risks and those who have received them. (Conclusion, Paragraph 24)
4. The Government should introduce mandatory recording of breast implant and explant procedures and instances of adverse outcomes in the Breast and Cosmetic Implant Registry by the end of 2026. We welcome the Government's acknowledgement that the registry requires improvement. The Government should work with practitioners to ensure

the registry meets the needs of surgeons and patients, including on ease of use. Data on adverse outcomes by implant type should be published annually to support informed consent and improve patient safety. (Recommendation, Paragraph 25)

5. We note that the registry is currently overseen by the soon-to-be abolished NHS England. The Government should take steps to ensure that the improvements we call for are not delayed by internal reorganisation. (Recommendation, Paragraph 26)
6. A mandatory cooling-off period of at least two weeks should be introduced between the initial consultation and surgery for breast implants, ensuring patients have sufficient time to consider risks and alternatives before making a commitment. (Recommendation, Paragraph 27)
7. The PIP implant scandal involved substandard implants being given to women for many years without detection. The new post-surveillance regime for breast implants must include regular testing of approved implants to ensure continued compliance with safety standards. (Recommendation, Paragraph 35)
8. The Government should increase the information available on the approval of medical devices to allow interested parties to see not only what devices are approved but the evidence base underpinning the decisions to approve them. (Recommendation, Paragraph 36)
9. There is growing concern that a number of women are experiencing serious health impacts after receiving breast implants, with many reporting symptom improvements following explantation. While evidence of a definitive link between these symptoms and breast implants has not been established, this does not mean there is not a connection. (Conclusion, Paragraph 44)
10. Evidence of concentrations of siloxanes in women's bodies outside of their implants is particularly concerning. The mental health impacts of knowing that chemicals, which are being banned in other uses due to their toxicity, are circulating in your body should not be underestimated or dismissed. This is particularly true for women who received PIP implants, which have higher rupture rates, lower grade silicone and higher levels of D4 siloxane. (Conclusion, Paragraph 45)
11. The Government should commission research to better understand the health impacts of breast implants, including their potential impacts on women with pre-existing auto-immune conditions. The research needs to be a mix of clinical research, including on the health impacts of siloxanes, and longitudinal, following a cohort of women over a period of time. Such studies are necessary to improve patient safety, diagnosis and

treatment and for the purposes of informed consent. At present, we do not believe that enough information is available about breast implants for women to genuinely be able to give informed consent to receiving them. (Recommendation, Paragraph 46)

12. The Department of Health and Social Care should make primary care workers aware of the potential for a link between autoimmune conditions and breast implants to ensure that women presenting with symptoms following implantation are not dismissed. (Recommendation, Paragraph 47)
13. Currently, any doctor on the medical register can legally perform highly invasive cosmetic surgery in the private sector, regardless of specialist training or competence. This is a risk to patient safety. Despite the introduction of the Intercollegiate Cosmetic Surgery Certification Scheme in 2017, participation remains voluntary. (Conclusion, Paragraph 51)
14. The Government should require all practitioners performing invasive surgical cosmetic procedures to have specialist training and hold appropriate board certification in the procedures they undertake. (Recommendation, Paragraph 52)

Non-surgical cosmetic procedures

15. We welcome the proposals for a licensing scheme put forward in the Government's consultation, including the proposed categories and the need for a practitioner to acquire appropriate indemnity cover and premises which meet the necessary standards of hygiene, infection control and cleanliness to obtain a licence. (Conclusion, Paragraph 68)
16. However, the Government is not moving quickly enough in introducing such a system. At present, individuals without any formal training can carry out potentially harmful interventions, placing the public at risk. Successive Governments have failed to act swiftly enough to legislate in this area allowing further harms to occur. The Government's announcement of yet another consultation will cause more delays. This lack of timely action is fostering complacency in self-regulation within the industry and is compromising patient safety. (Conclusion, Paragraph 69)
17. The Government should accelerate regulatory action. Procedures that are deemed high risk such as liquid BBLs and liquid breast augmentations, which have already been shown to pose a serious threat to patient safety, should be restricted to appropriately qualified medical professionals immediately. Given the lack of appetite among medical professionals to carry out these procedures, this will act as a de facto ban in all but the

most essential cases. A licensing system for ‘green’ and ‘amber’ non-surgical cosmetic procedures should be introduced within this Parliament. (Recommendation, Paragraph 70)

- 18.** The absence of a legislative framework for training and qualifications in the non-surgical cosmetic sector has resulted in significant variability in standards, with justified concerns about short courses, online training, and the ease of entry into practice. (Conclusion, Paragraph 77)
- 19.** The Government should bring forward consistent, enforceable standards for the non-surgical cosmetic sector that prioritise patient safety and competency, while ensuring training routes remain accessible and affordable for a predominantly female-led workforce. Training routes should include Ofqual-approved qualifications and apprenticeship models, including funded apprenticeship places in SMEs in the beauty industry, to ensure affordability and accessibility, particularly for the existing workforce, while eliminating short, inadequate courses. (Recommendation, Paragraph 78)
- 20.** While Scotland has taken steps to introduce a licensing scheme for non-surgical cosmetic procedures, Wales and Northern Ireland have yet to announce similar plans. This lack of regulatory alignment across the UK creates significant risks, including inconsistent safety standards and the potential for ‘cosmetic tourism’ within the UK, where individuals seek treatments in jurisdictions with weaker protections. (Conclusion, Paragraph 81)
- 21.** The Government should work with the devolved administrations to ensure regulatory alignment across all UK nations on legislation governing non-surgical cosmetic procedures. (Recommendation, Paragraph 82)

Cosmetic tourism

- 22.** The increasing number of cases requiring medical treatment after cosmetic surgery abroad raises serious concerns for patient safety and places additional financial strain on the NHS. However, the true extent will remain unknown until comprehensive data is collected. (Conclusion, Paragraph 94)
- 23.** The Government should review the need for the NHS to systematically record data on complications arising from cosmetic procedures performed abroad. Publishing such data in an annual release would enable a comprehensive assessment of the financial impact on the NHS and provide robust evidence to better inform and educate the public about the risks associated with cosmetic tourism. Where possible, the data set could include details of the clinic or practitioner that performed the original procedure to help further protect UK nationals. (Recommendation, Paragraph 95)

24. We welcome Government action on educating the public on the risks of travelling abroad for cosmetic procedures and providing guidance on how to do so as safely as possible and its use of social media channels to do so. With the number of people engaging in cosmetic tourism growing rapidly, this effort must be sustained, and educational materials should remain simple and widely accessible and supported by the data release we recommend. (Conclusion, Paragraph 96)
25. The Government should assess whether outlets in the UK that are recruiting patients for medical treatment overseas should be brought into a regulatory regime and be subject to investigation and, where necessary, sanction. (Recommendation, Paragraph 97)

Body image

26. There appears to be a gap in safeguarding mental health in the cosmetic procedures sector. The absence of mandatory psychological screening prior to procedures, combined with evidence of inadequate consultations, increases the risk of harm, particularly for vulnerable individuals such as those with Body Dysmorphic Disorder, who are more likely to want cosmetic surgery and less likely to be satisfied with the outcome. (Conclusion, Paragraph 104)
27. Training curricula required to obtain a licence to perform non-surgical cosmetic procedures should include mandatory modules on informed consent and psychological screening, with a specific focus on identifying Body Dysmorphic Disorder and other vulnerabilities. (Recommendation, Paragraph 105)
28. Social media platforms and face-editing technologies are contributing to worsening body image and increasing demand for cosmetic procedures, particularly among young women and girls. The normalisation of high-risk procedures by online influencers and the shaping of beauty standards by algorithms which bombard users which posts on body image are particular concerns. There is no easy solution to these problems, but it is clear that social media platforms must take more responsibility for the content they promote. (Conclusion, Paragraph 117)
29. One way of addressing the risks posed by social media around cosmetic surgery and body image is through education. Proactive interventions in an educational setting can equip young people with the skills to critically engage with social media content and challenge unrealistic beauty standards. (Conclusion, Paragraph 118)

30. In response to the alarming increase in desire for cosmetic surgery among teenagers, the Department of Health and Social Care should work with the Department for Education to integrate evidence-based body image and social media literacy programmes into school curricula. This should include content on risks of cosmetic procedures. (Recommendation, Paragraph 119)

Formal Minutes

Wednesday 11 February 2026

Members present:

Sarah Owen, in the Chair

Alex Brewer

David Burton-Sampson

Rosie Duffield

Dame Nia Griffith

Christine Jardine

Kim Leadbeater

Rebecca Paul

Rachel Taylor

Cosmetic procedures

Draft Report (*Cosmetic procedures*), proposed by the Chair, brought up and read.

Ordered, That the Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 119 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Eleventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjournment

Adjourned till Wednesday 25 February at 2.00pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the [inquiry publications page](#) of the Committee's website.

Wednesday 14 May 2025

Professor Michael Coleman, Professor of Toxicology, Aston University; **Professor Prabath Nanayakkara**, Professor in Acute Internal Medicine, Amsterdam University Medical Center; **Professor Carl Heneghan**, Director of the Centre for Evidence-Based Medicine, University of Oxford [Q1–36](#)

Professor Vivien Lees, Consultant Plastic Surgeon and Vice President, Royal College of Surgeons of England; **Ashton Collins**, Director, Save Face; **Sasha Dean**, Lived experience of severe complications following liquid BBL [Q37–75](#)

Wednesday 25 June 2025

Dr Beth Daniels, Professor and Director at Centre for Appearance Research, University of the West of England (Bristol); **Dr Ruth Holliday**, Professor of Gender and Culture, University of Leeds; **Dr Christopher Roland Payne**, Consultant dermatologist [Q76–117](#)

Wednesday 16 July 2025

Professor Aidan Fowler, National Director of Patient Safety, NHS England, Deputy Chief Medical Officer, Department for Health and Social Care; **Dr Alison Cave**, Chief Safety Officer, Medicines and Healthcare products Regulatory Agency (MHRA); **Andy Morling**, Deputy Director, Criminal Enforcement, Medicines and Healthcare products Regulatory Agency (MHRA) [Q118–160](#)

Elaine Sassoon, Plastic Surgeon and Board Member, British Association of Aesthetic Plastic Surgeons; **Nora Nugent**, Cosmetic Surgeon and President, British Association of Aesthetic Plastic Surgeons; **Professor David Sines**, Executive Chair and Registrar, Joint Council for Cosmetic Practitioners; **Rieka Taghizadeh**, Consultant plastic, reconstructive and aesthetic Surgeon and Chair of British Association of Plastic, Reconstructive and Aesthetic Surgeon's Breast Special Interest and Advisory Group [Q161–190](#)

Wednesday 22 October 2025

Victoria Brownlie MBE, Chief Policy and Sustainability Officer, British Beauty Council (BBCo); **Lesley Blair MBE**, CEO and Chair, British Association of Beauty Therapy and Cosmetology [Q191-219](#)

Gavin Larnner, Director for Workforce, Department of Health and Social Care; **Professor Aidan Fowler**, National Director of Patient Safety at NHS England & Deputy Chief Medical Officer, Department of Health and Social Care; **Karin Smyth**, Minister of State for Health (secondary care), Department of Health and Social Care [Q220-256](#)

Published written evidence

The following written evidence was received and can be viewed on the [inquiry publications page](#) of the Committee's website.

BIP numbers are generated by the evidence processing system and so may not be complete.

1	Advertising Standards Authority	BIP0107
2	Anonymous	BIP0147
3	Association of Breast Surgery	BIP0098
4	Association of Breast Surgery	BIP0004
5	Breast Implant Health	BIP0100
6	Breast Implant Health Symposium	BIP0104
7	Breast Implant Illness Florida Support Group	BIP0103
8	Breast Implant Safety Alliance	BIP0140
9	Brown, Miss Shannon (Member, PIP Action Campaign)	BIP0120
10	Care Quality Commission (CQC)	BIP0119
11	The Medicines and Healthcare Products Regulatory Agency (MHRA)	BIP0003
12	Chartered Institute of Environmental Health	BIP0136
13	Department of Health and Social Care	BIP0143
14	Device Events	BIP0137
15	Diboll, Mrs Carolyn (Nurse Associate, NHS)	BIP0110
16	Farr, Dr Nicholas (Research Fellow, University of Sheffield)	BIP0080
17	Feng, Dr Lu-Jean, M.D. (Plastic Reconstructive Surgeon and Chief Medical Officer)	BIP0126
18	Fleury, Professor Dr Eduardo de Faria Castro, PHD EDBI	BIP0123
19	Elliott, Julie (Founder at MiM Quebec)	BIP0091
20	General Medical Council	BIP0130
21	Gill, Professor Rosalind (University Research Lead in Inequalities in Media, Culture and Creative Industries, Goldsmiths, University of London)	BIP0109

22	Global Patient Advocacy Coalition	BIP0105
23	Haines, Ms Karen	BIP0096
24	Harley, Mr Oliver (Plastic Surgeon, McIndoe Centre, East Grinstead, Sussex)	BIP0116
25	Haworth, Dr Natalie (The Doctor and company)	BIP0094
26	Joint Council for Cosmetic Practitioners (JCCP); and British Beauty Council (BBCo)	BIP0047
27	Khan, Dr Shaher W, MD (Executive Plastic Surgery)	BIP0132
28	Land, Dr Steven (Aesthetic Doctor, Novellus Aesthetics)	BIP0085
29	Leigh Day Solicitors	BIP0095
30	Liverpool University Foundation Trust	BIP0102
31	Maier, Sarah-Kim (FROS CFR, NHS)	BIP0089
32	Medicines and Healthcare products Regulatory Agency (MHRA)	BIP0129
33	Menache, Dr André, (Scientific Consultant to Antidote Europe)	BIP0056
34	Mercer, Mr Nigel (Chair of the Plastic, Reconstructive and Aesthetic Expert Advisory Group (PRASEAG), MHRA)	BIP0124
35	Mercer, Mr Nigel (Consultant Plastic Reconstructive and Aesthetic Surgeon)	BIP0050
36	Mercer, Nigel (Consultant Plastic Reconstructive and Aesthetic Surgeon)	BIP0001
37	Nanayakkara, Professor Dr Prabath (Professor in Acute Internal Medicine, Amsterdam UMC); and Dr Siham Azahaf (MD, PhD Candidate, Amsterdam UMC)	BIP0135
38	NavWellRx PLLC	BIP0101
39	Osian, Mr Sam (Doctoral Researcher, University of Liverpool)	BIP0087
40	Owen, Dr Alison (Lecturer in Psychology, University of Staffordshire)	BIP0088
41	Paraskeva, Dr Nicole (Senior Research Fellow, Centre for Appearance Research, UWE Bristol); Dr Kirsty Garbett (Senior Research Fellow, Centre for Appearance Research, UWE Bristol); Professor Elizabeth (Beth) Daniels (Director, Centre for Appearance Research, UWE Bristol); Professor Nichola Rumsey; and Dr Alex Clarke	BIP0112
42	PIP Action Campaign	BIP0145
43	PIP Action Campaign	BIP0006

44	Patient Safety Learning	<u>BIP0002</u>
45	Rickman	<u>BIP0099</u>
46	Royal College of Surgeons of England	<u>BIP0122</u>
47	Save Face	<u>BIP0063</u>
48	Schofield, Miss Leanne	<u>BIP0121</u>
49	Scott, Mr Sean	<u>BIP0017</u>
50	Schäfers, Birgit (Krank durch Brustimplantate – Wir helfen e.V. Germany)	<u>BIP0054</u>
51	Seifalian, Dr Alexander	<u>BIP0055</u>
52	Sling The Mesh	<u>BIP0008</u>
53	Spivey, Jan (Co-Founder of PIP Action Campaign)	<u>BIP0142</u>
54	Stichting SVS – Meldpunt Klachten Siliconen Nederland	<u>BIP0073</u>
55	The Professional Standards Authority for Health and Social Care	<u>BIP0092</u>
56	Thomas, Mrs Dawn	<u>BIP0067</u>
57	Trogenza, Miss Vicky	<u>BIP0106</u>
58	University of Oxford	<u>BIP0005</u>
59	Vikki Soloman Aesthetics Ltd	<u>BIP0010</u>
60	Walkers, Miss Amy	<u>BIP0086</u>

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the [publications page](#) of the Committee's website.

Session 2024–26

Number	Title	Reference
10th	Discrimination, harassment and abuse against Muslim women	HC 571
9th	Tackling HIV transmission	HC 1249
8th	Female entrepreneurship	HC 711
7th	Female genital mutilation	HC 714
6th	Equality at work: Paternity and shared parental leave	HC 502
5th	Misogyny in music: on repeat	HC 573
4th	Tackling non-consensual intimate image abuse	HC 336
3rd	The rights of older people	HC 414
2nd	Equality at work: Miscarriage and bereavement leave	HC 335
1st	Women's reproductive health conditions	HC 337
9th Special	Tackling HIV transmission: Government Response	HC 1663
8th Special	Female entrepreneurship: Government Response	HC 1640
7th Special	Female genital mutilation: Government Response	HC 1506
6th Special	Equality at work: paternity and shared parental leave: Government Response	HC 1313
5th Special	Misogyny in music: on repeat: Government Response	HC 1302

Number	Title	Reference
4th Special	Tackling non-consensual intimate image abuse: Government Response	HC 911
3rd Special	The rights of older people: Responses from Government, Advertising Standards Authority, Ofcom and IPSO	HC 910
2nd Special	The prevalence of sexually transmitted infections in young people and other high risk groups: Government Response	HC 865
1st Special	Equality at work: Miscarriage and bereavement leave: Government Response	HC 803