NHS England

Mr Simon Burge,
Assistant Coroner for
Nottingham City and Nottinghamshire
HM Coroner's Service
The Council House
Old Market Square
Nottingham
NG1 2DT

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

17th August 2026

Dear Mr Burge,

Re: Regulation 28 Report to Prevent Future Deaths – Rianna Poiana-Lazarec who died on 4th January 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 2nd July 2026 concerning the death of Rianna Poiana-Lazarec on 4th January 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Rianna's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Rianna's care have been listened to and reflected upon.

Your report raises concerns about the ease with which the towelling provided in a mental health facility was capable of being torn by hand and the absence of a system to control a patient's access to material which can be adapted for self-harming purposes.

NHS England published the Staying Safe from Suicide: Best Practice Guidance for Safety Assessment, Formulation and Management on 4th April 2025. It promotes a shift towards a more holistic, person-centred approach rather than relying on risk prediction, which is unreliable because suicidal thoughts can change quickly. Instead, it recommends using a method based on understanding each person's situation and managing their safety. The purpose of this guidance is to enable mental health practitioners to adopt best practice principles in working with people of all ages to stay safe from suicide. Training has been made available to all mental health practitioners to incorporate the principles of this guidance into their practice. This complements existing local training on suicide prevention, and a number of other national e-learning products that are already available.

NHS England also commissioned The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH) through the National Culture of Care programme to support every provider of NHS commissioned inpatient services to move to personalised safety planning in line with the latest evidence.

In addition to this, NHS England will be publishing guidance in response to the Health Services Safety Investigations Body (HSSIB) recommendations following their investigation into creating conditions for learning from deaths in mental health inpatient services on the importance on defining the therapeutic relationship and guidance on responding to the use of non-anchored ligature points.

Anti-tear products, including [redacted], are available within NHS healthcare settings, although they are not typically supplied through standard laundry providers due to their specialised nature. Decisions regarding the use of strengthened or specialist linen are primarily clinical matters and should be informed by an assessment of an individual patient's risks, needs and care requirements.

There is no single national specification that mandates a minimum tear-resistance standard for all strengthened bedding, towels or similar products. Requirements are typically determined at a local level, informed by clinical risk assessments, service needs, and procurement decisions. In practice, such products would not generally form part of routine provision within a standard adult mental health unit and would only be considered where an individual's assessed clinical risks and needs indicate that their use is appropriate.

Regional response

Nottinghamshire Healthcare NHS Foundation Trust remains subject to significant NHS England oversight due to ongoing quality and patient safety concerns and the Nottingham Inquiry. The Trust is currently subject to national oversight arrangements, with regular engagement between the Trust and NHS England Midlands regional colleagues to monitor delivery of improvement plans and provide assurance regarding the effectiveness and sustainability of improvement activity.

Midlands regional colleagues have advised that regional oversight has, since 2024, been via a monthly Improvement Oversight and Assurance Group which included routine review of patient safety, quality, governance and leadership issues though established assurance mechanisms, including oversight meetings, escalation processes and monitoring of key improvement actions. Ongoing escalated oversight is now managed via a monthly Provider Review Meeting. As part of the oversight structure, the Trust is required to demonstrate progress against identified areas of concerns, including the quality of clinical risk assessment, observation practices, and implementation of learning from patient safety events. Midland regional colleagues are discussing this Report with the Trust to ensure that enhanced observations compliance is captured and escalated as appropriately through their quality monitoring processes.

In response to the concerns raised by the Coroner, NHS England Midlands regional colleagues will continue to seek assurance that learning has been embedded across inpatient mental health services and that actions to reduce the risk of recurrence are being implemented and monitored effectively.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical

Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Rianna, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

National Medical Director
NHS England