

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

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

1.	CORONER I am Simon BURGE, Assistant Coroner, for the coroner area of Nottingham City and Nottinghamshire.
2.	DATE OF REPORT 02 July 2026
3.	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
4.	THIS REPORT IS BEING SENT TO 1. Nottinghamshire Healthcare Trust - NHCT 2. NHS England You are under a duty to respond to this report within 56 days of the date of this report, namely by September 3, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	YOUR RESPONSE Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary .
6.	SUMMARY OF CORONER'S CONCERN

7.	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	INVESTIGATION AND INQUEST On 10 January 2025 I commenced an investigation into the death of Rianna POIANA-LAZAREC aged 20. The investigation concluded at the end of the inquest on 15 June 2026. The conclusion of the inquest was that: See attached
9.	CIRCUMSTANCES OF DEATH See attached
10.	CORONER'S CONCERNS During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows: Rianna had a long history of dangerous self-harming behaviour and a diagnosis of Emotionally Unstable Personality Disorder. On 4th January 2025, she self-ligated [REDACTED], which had been provided for her by a member of staff at Beech Ward, Sherwood Oaks Hospital, Mansfield, [REDACTED]. However, whilst unobserved in her room, [REDACTED]. She had done this on several previous occasions in the preceding eight weeks but had always been interrupted. The ease with which a) [REDACTED] and b) the complete absence of any system for controlling a vulnerable patient's access to material which can easily be adapted for self-harming purposes, is a real concern. The staff gave evidence to the effect that they had no other [REDACTED] available to give patients.
11.	COPIES AND PUBLICATION OF THIS REPORT I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: <i>[please do not use individual's names, but instead roles/titles]</i> • NHS England • Mother of Rianna

	• Father of Rianna • Nottinghamshire Healthcare Trust - NHCT I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	SIGNATURE  Simon BURGE Assistant Coroner for Nottingham City and Nottinghamshire