NHS
Coventry and
Warwickshire Partnership
NHS Trust

[redacted]

9 July 2026

Ms Linda Lee
Acting Area Coroner for Coventry and Warwickshire
Cheylesmore Manor House,
Manor House Drive,
Coventry,
CV1 2ND

Dear Ms Lee,

Re: Inquest touching the death of Ms. Natalia Violet Cestaro – Response to Regulation 28 Report.

I am writing in response to the Regulation 28: Prevention of Future Deaths Report issued following the inquest into the death of Ms. Natalia Violet Cestaro and received by the Trust on 14 May 2026.

I am grateful for the careful consideration you have given during the inquest process and have reflected fully on the concerns raised within the Prevention of Future Deaths Report. We recognise the significance of these concerns and the responsibility placed upon us to identify learning, strengthen our systems and processes, and take meaningful action to reduce the likelihood of similar events occurring in the future.

Throughout the inquest, we were pleased to assist the Court by providing evidence regarding both Natalia's care and the improvements already underway across our services. The concerns identified have been carefully considered within the context of our broader patient safety and quality improvement agenda, and we welcome the opportunity to provide assurance regarding the actions taken in response.

You identified three specific areas of concern, which I address below.

1. Proactive scope of risk assessment for impulsive ingestion (CWPT)

As part of the learning identified through the review of Natalia’s care and treatment, we recognised the need for more consistent assessment of impulsivity as a contributory risk factor, particularly where self-harm or suicide risk has been identified.

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We will continue to undertake daily environmental audits across our mental health wards to identify, address and remove potential and foreseeable hazards. These audits are completed electronically, updated in real time and enable immediate escalation of environmental concerns requiring Estates intervention.

Our safety (risk) assessment, formulation and planning framework has undergone multidisciplinary review to ensure alignment with National Institute for Health and Care Excellence (NICE) Guideline NG225. The framework incorporates a formulation-based approach that considers factors which may predispose individuals to unsafe behaviours, perpetuate risk, or act as protective influences. Impulsivity is specifically considered within this formulation process.

This approach supports a more comprehensive exploration of dynamic triggers, access to means, decision-making capacity, protective factors and the function of harmful behaviours, enabling appropriate risk mitigation measures to be implemented promptly. The resulting safety plan promotes a person-centred, strengths-based approach that empowers individuals to manage their own safety, with appropriate support from clinical teams.

Our training programme supports this formulation-based approach to safety and risk management, with a strong emphasis on professional curiosity, multidisciplinary collaboration and triangulation of information obtained from those important to the individual and those involved in their care. The training encourages staff to consider a broader range of factors that may influence safety and wellbeing and supports a move away from historical documentation and approaches, such as the Skills-based Training on Risk Management (STORM) and Working with Risk (WWR) tools.

The quality of risk assessments is routinely monitored through our Audit Management and Tracking (AMaT) system. Audits are undertaken by ward management teams, with additional assurance provided through separate Matron-led audits.

2. Interface working and demonstrable liaison between mental health and acute services (CWPT and UHCW)

We acknowledge the importance of robust communication arrangements and the need for clear, agreed transfer processes between acute and mental health services.

As part of the Safety Improvement Plan accompanying the Patient Safety Incident Investigation (PSII) report, an action was agreed to develop a Standard Operating Procedure (SOP) to provide guidance on communication, care and treatment arrangements for patients open to our services who are conveyed to University Hospital Coventry and Warwickshire (UHCW).

CWPT and UHCW are signatories to a Memorandum of Understanding (MoU) setting out arrangements for patients receiving inpatient mental health care who require physical healthcare treatment within a local acute hospital setting.

Escalations during core hours (Monday to Friday, 08:00–17:00) are managed by the Clinical Matron or a nominated deputy. Out-of-hours and weekend concerns are managed through established on-call arrangements. Compliance with the MoU is subject to monthly monitoring, with the frequency of review to be reconsidered after six months, informed by performance data and escalation trends.

The MoU is supported by the SOP, which clearly sets out staff responsibilities when a patient requires transfer to an acute hospital, whether as an emergency or as part of planned care and treatment. It also outlines the responsibilities of the respective care teams and includes a checklist that accompanies patients returning from the acute setting to one of our mental health wards.

3. Assurance and auditing of expected communication processes (CWPT)

Adherence to the SOP will be embedded within ward safety huddles, team handovers and ward governance processes.

Oversight is maintained through daily assurance meetings involving Matrons. Outcomes from these meetings inform the Trust's twice-daily Operational Pressures Escalation Level (OPEL) calls, ensuring organisational awareness and timely escalation where required.

Any individual care concerns or communication issues identified will be managed through local incident reporting processes and subject to review in accordance with the Trust's incident management framework. Learning identified through these reviews will be used to inform ongoing procedural improvements and workforce education and training requirements.

In addition, compliance with the agreed communication and transfer processes will be monitored through local governance arrangements, providing assurance that expectations are understood, consistently applied and embedded within routine practice. Any themes or trends identified through this monitoring will be escalated through the Trust's governance structures to support continuous improvement and organisational learning.

I trust this response provides assurance that we have carefully considered the concerns identified by the Court and have taken proportionate and meaningful action to address them. The measures outlined above form part of our wider commitment to strengthening patient safety, improving partnership working, and ensuring robust governance and oversight of care delivery.

While we recognise that no single intervention can eliminate risk entirely, we remain committed to embedding the learning arising from Natalia's death across our

services and to continuously reviewing the effectiveness of the actions implemented. We are grateful for the opportunity to reflect on the findings of the inquest and will continue to work collaboratively with partner organisations to improve the safety and quality of care for the people who use our services.

Yours sincerely,

[redacted], Chief Executive

Copy to:

[redacted], Chief Nursing Officer, NHS Coventry and Warwickshire and NHS Herefordshire and Worcestershire.

[redacted], Chief Executive, University Hospitals Coventry and Warwickshire NHS Trust.