



REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

1. THIS REPORT IS BEING SENT TO

1. Chief Executive, Coventry and Warwickshire Partnership NHS Trust (CWPT)
2. Chief Executive, University Hospitals Coventry and Warwickshire NHS Trust (UHCW)

2. CORONER

I am Linda Lee, Acting Area Coroner for Coventry and Warwickshire.

3. CORONER'S LEGAL POWERS

I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

4. INVESTIGATION AND INQUEST

The investigation into the death of Natalia Violet Cestaro (known as "Tali"), aged 18, who died on 15 November 2023 at University Hospital Coventry & Warwickshire, was opened on 28 November 2023 and concluded on Friday 1 May 2026.

The conclusion reached at inquest was: Medical misadventure against a background of delayed recognition and escalation of post-procedural deterioration, delayed imaging, and failure to maintain nil-by-mouth instructions.

The medical cause of death was:

- 1a Septicaemia and Multi Organ Failure
- 1b Gastric Perforation
- 1c Ingestion of Foreign Object

5. CIRCUMSTANCES OF THE DEATH

Natalia Violet Cestaro ("Tali") was an inpatient under the care of Coventry and Warwickshire Partnership NHS Trust with complex mental health needs and a known history of impulsive ingestion of foreign objects. During the same admission in September 2023, she had previously ingested [REDACTED], one of which was removed endoscopically and the other surgically.

On 5 November 2023, Tali ingested a [REDACTED] and was transferred to University Hospitals Coventry and Warwickshire NHS Trust for endoscopic removal. The [REDACTED] was removed endoscopically. During the procedure a partial-thickness tear to the stomach wall was suspected. At that stage it was not considered to be a full-thickness perforation and immediate surgical intervention was not undertaken.

The period following the procedure was critical. Tali experienced increasing pain and clinical deterioration. Diagnostic imaging was planned but did not take place at the time intended. Concerns arising during this period were not escalated to the surgical team, and Tali was not consistently maintained nil by mouth following the procedure.

By the time the gastric perforation and associated sepsis were fully recognised, Tali had deteriorated significantly. Emergency intervention took place, but her condition was no longer reversible, and she died on 15 November 2023. It was acknowledged by UHCW that on the balance of probabilities, Tali would have survived if there had been an appropriate referral to the surgical team.

Evidence was given by witnesses from CWPT and UHCW regarding the steps taken following Tali's death. In particular, the evidence from UHCW described significant changes to escalation arrangements, diagnostic pathways and governance oversight. Those matters have been taken into account when determining whether the statutory criteria are met in respect of this report and, if so, the scope of the concerns identified.

6. MATTERS OF CONCERN

In my opinion, the following matters give rise to a concern that there is a risk of future deaths.

a) Proactive scope of risk assessment for impulsive ingestion (CWPT)

The evidence raised a concern that risk assessments may focus primarily on specific previously ingested items, rather than undertaking a sufficiently proactive assessment of a wider range of swallowable items within the inpatient environment. Where a patient is known to present a persistent risk of impulsive ingestion, a predominantly reactive approach risks foreseeable hazards not being identified and mitigated in advance.

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

The evidence before the inquest disclosed limited detail demonstrating how liaison, shared responsibility, and specialist input are consistently achieved in practice when a mental health inpatient is transferred to an acute hospital for physical healthcare. While both organisations described mechanisms for access to advice and communication, there was relatively limited evidence of how these arrangements operate reliably, how compliance is assured, and how lapses are detected and addressed. This creates a risk that relevant mental health risks are not consistently carried through the acute admission.

c) Assurance and auditing of expected communication processes (CWPT)
The evidence raised concern that processes described as standard practice, including regular contact following transfer, may not be subject to routine auditing or assurance. Reliance on the existence of a process alone, without effective oversight of whether it is consistently carried out in practice, risks failures persisting undetected.

7. ACTION

In my opinion, action should be taken to prevent future deaths, and I believe your organisations have the power to act.

8. RESPONSE

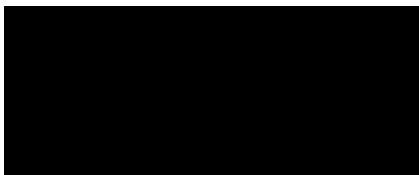
You are under a duty to respond to this report, setting out what consideration you have given to the concerns raised, namely by [date].(assuming this goes out tomorrow it is 56 days from that date -9 July 2026)

9. COPIES

A copy of this report is being sent to the Chief Coroner. It may be published on the judiciary website.

It is also being sent to the following Interested Persons:

- The family of the deceased



Linda Lee
Acting Area Coroner for Coventry and Warwickshire
14 May 2026