

**Emma Serrano**  
Area Coroner  
Stoke on Trent and  
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**National Medical Director**  
NHS England  
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**9th March 2026**

Dear Coroner,

**Re: Regulation 28 Report to Prevent Future Deaths – Dhananji Denawakage Dona who died on 2<sup>nd</sup> October 2025.**

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 21<sup>st</sup> January 2026 concerning the death of Dhananji Denawakage Dona on 2<sup>nd</sup> October 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mrs Dona’s family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mrs Dona’s care have been listened to and reflected upon.

Your Report raises concerns that although the specialist National Early Warning Score (NEWS) matrix for prenatal women should be used within all departments of a hospital, it still was not in this case, and there were no plans to introduce this within a reasonable timescale. Your report does not specify Mrs Dona’s gestation, but references that she had miscarried.

NHS England has developed the national [Maternity Early Warning Score](#) (MEWS) in direct response to findings from the [Confidential Enquiries into Maternal Deaths](#) in the UK, which have consistently highlighted the need for a dedicated, standardised early warning system for pregnancy and the postnatal period. These enquiries show that delayed recognition and escalation of clinical deterioration remain important, recurring themes.

Currently, the [National Early Warning Score 2](#) (NEWS2) is the mandated scoring system used across the NHS for detecting deterioration in adults who are not pregnant. NEWS2 is widely implemented in care settings outside of acute maternity services. However, physiological parameters in pregnancy differ significantly from those of the non-pregnant population. Normal ranges for heart rate, blood pressure, respiratory rate and oxygen saturation change during pregnancy and the early postpartum period.

Applying non-pregnant thresholds to pregnant women can therefore:

- Delay early recognition of deterioration
- Generate unnecessary false-positive escalations

- Create variation and risk in the clinical response

To address this, NHS England has developed MEWS as a separate scoring tool using evidence-based, pregnancy-specific thresholds, which more accurately reflect physiological changes from conception to four weeks postpartum. This ensures deterioration can be recognised and escalated appropriately and consistently.

The national MEWS matrix removes variation by providing a single, standardised tool for use across England in all care settings where a woman may present, including those outside maternity units (e.g. emergency departments, general wards, ambulance service environments).

In October 2025, when Mrs Dona passed away, there was no published NHS England guidance on the use of the national MEWS in non-maternity clinical areas due to initial focus being on implementation in acute maternity services.

The National Institute for Health and Care Excellence (NICE) had previously published a [Medtech Innovation Briefing \(MIB205\)](#) in February 2020. This briefing clearly stated that NEWS2 should not be used for pregnant women, as the physiological changes of pregnancy make NEWS2 inappropriate and potentially misleading for this population.

However, this important caution is not clearly articulated in either:

- NICE Clinical Guideline CG50 (2020) Acutely ill adults in hospital: recognising and responding to deterioration <https://www.nice.org.uk/guidance/cg50> ; or
- The revised NICE Guideline NG255 (2025) Suspected sepsis in pregnant or recently pregnant people: recognition, diagnosis and early management <https://www.nice.org.uk/guidance/ng255> .

NICE has confirmed that it plans to review the use of Modified Obstetric Early Warning Scores (MEOWS) and consider making recommendations on it within guideline [NG255](#). The current guideline version addresses the management of suspected sepsis both outside and inside acute hospital settings. NHS England will engage with NICE throughout the guideline update process to ensure that considerations regarding the use of MEWS / MEOWS in non-maternity care environments are appropriately reflected. This updated guidance is expected to be published in February 2027.

MEWS implementation forms part of wider national commitments to improve maternity and neonatal safety.

In March 2023, NHS England published the [Three-Year Delivery Plan for Maternity and Neonatal Services](#). MEWS implementation is a key requirement within Theme 4: Standards and structures that underpin safer, more personalised, and more equitable care.

NHS England has developed national digital specifications to support the implementation of the national MEWS across both maternity and non-maternity clinical environments. These specifications are designed to ensure consistency and interoperability across electronic patient record (EPR) systems, reducing variation in how deterioration is recognised, recorded, and escalated.

Draft versions of the specifications have already been circulated to digital suppliers via the NHS Futures platform ahead of their planned formal publication in Spring 2026. This early dissemination aims to enable suppliers and organisations to begin aligning or configuring their systems in preparation for national rollout, thereby supporting safer and more consistent digital recognition of deterioration in pregnant and recently pregnant women across all care settings.

Further to this, NHS England published the [Maternal Care Bundle](#) (MCB) in January 2026. This sets out evidence-based standards across five key clinical areas to be implemented nationally by March 2027. MEWS is an essential component of Element 2: Pre-hospital and Acute Care.

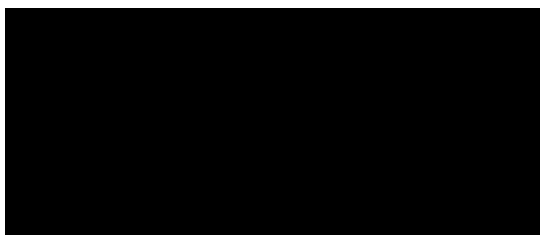
This element requires:

- The implementation of the national MEWS across all settings for women who are, or have been, pregnant within the previous four weeks
- Timely obstetric and/or obstetric physician review in accordance with MEWS escalation timeframes based on total score and clinical concern

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 Mrs Dona, 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