NHS
University Hospitals of North Midlands
NHS Trust

[redacted]

Royal Stoke University Hospital
Executive Suite
Springfield
Newcastle Road
Stoke-on-Trent
Staffordshire
ST4 6QG

17 March 2026

STRICTLY PRIVATE & CONFIDENTIAL
Ms Emma Serrano
Area Coroner
Stoke-on-Trent and Staffordshire

[redacted]

[redacted]

Dear Ms Serrano

Dhananji Denawakage DONA

Further to your letter dated 21 January 2026, I am pleased to provide a response under paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013, addressing your concerns surrounding the death of Dhananji Denawakage Dona.

Recorded Circumstances of the Death
"Mrs Dona attended the Royal Stoke University Hospital, Stoke on Trent. She was pregnant and had noticed bleeding and was suffering from abdominal pain. She was suffering from SEPSIS as well as miscarrying. There was a delay in her assessment in the A&E department, and the SEPSIS screening tool was not used.

There is a specific National Early Warning Score matrix for prenatal women. This was not used in the A&E department as, despite national guidance to say this should be used in all departments of a hospital, it was only used in the maternity department of the Hospital.

This led to a delay in her diagnosis and treatment of SEPSIS.

She continued to deteriorate whilst in hospital and passed away on the 2 October 2025.

Evidence heard at inquest was that earlier diagnosis and treatment for SEPSIS would have meant that Mrs Dona would have survived."

Concerns
During the course of the inquest, you felt that evidence revealed matters giving rise for concern. In your opinion, matters for concern are as follows.

"That although the specialist National Early Warning Score matrix for prenatal women, should be used within the whole of the hospital, it still was not, and there were no plans to introduce this within a reasonable timescale."

You reported this matter under Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroner's (Investigations) Regulations 2013. In your opinion, action should be taken to prevent future deaths.

Action Taken
The University Hospitals of North Midlands NHS Trust has taken the issues highlighted during the inquest seriously and indeed, I am grateful that you have raised your concerns to which a response is provided below.

Across the UK, the national direction for maternity safety is being driven by the Saving Babies' Lives Care Bundle and includes national maternity safety initiatives, which emphasise early identification and escalation of maternal deterioration. As part of this, the national Maternity Early Warning Score (MEWS) has been mandated for adoption across

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all NHS Trusts (by March 2027) to ensure consistent, standardised monitoring of pregnant, and recently pregnant, women in every clinical setting.

Nationally, progress has been slower than intended due to delays in digital supplier readiness and variation in local electronic patient record capabilities. UHNM is on a similar trajectory to other Trusts across the UK. NHSE is responsible for the safety improvement programme across England.

The current digital systems used across UHNM are unable to support the introduction of the new National Maternal Early Warning Score (MEWS). We have engaged with our supplier colleagues, System C, and with regional and national colleagues regarding options; they have confirmed the inability of our current systems to be adapted to accommodate the MEWS.

However, in response to the Regulation 28 received, and the national directive to implement the national MEWS, UHNM have established an operational group to develop a Trust wide approach which is appropriate for all applicable clinical areas.

In the short-term, a paper-based MEWS process will be rolled out across the organisation ensuring that this is fully implemented by the national directive timeframe of March 2027. This roll-out will be supported by appropriate training and will be aligned with national guidance and local governance processes. Clearly, as this safety critical pathway must be implemented consistently and reliably across all areas of the organisation where pregnant patients may present (including the Emergency Department, Acute Medicine, Surgical areas, and any outpatient or assessment settings), it is essential that a robust, Trust wide training programme is delivered prior to implementation. This will ensure that staff across all clinical environments understand the escalation framework, associated clinical triggers and the governance requirements linked to MEWS.

Our longer-term strategy will look at progressing work to explore the development of an in-house digital solution to support implementation of the MEWS, whilst also awaiting the provider of the existing digital observations platform to complete the required software updates; we will endeavour to implement whichever appropriate digital solution is available first.

I do hope that the above information provides assurance that the Trust has taken the concerns raised at the inquest seriously and that you are content with the response that has been provided.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me directly.

Yours sincerely

[redacted]

Chief Executive

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Kind Excellent Together