REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Royal Stoke University Hospital; and** **2. NHS England.**
1	**CORONER** I am Emma Serrano, Area Coroner, for the Area Coroner for Staffordshire.
2	**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.
3	**INVESTIGATION and INQUEST** On the 3rd October 2024, I commenced an investigation into the death of Mrs Dhananji Denawakage Dona. The investigation concluded at the end of the inquest on 20 January 2026. The conclusion of the inquest was a short form conclusion a natural cause, with a neglect rider. The cause of death was: 1a. Septic shock and Disseminated Intravascular Coagulopathy I b Urine infection and Septic Miscarriage
4	**CIRCUMSTANCES OF THE DEATH** i) 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. ii) 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. iii) This led to a delay in her diagnosis and treatment of the SEPSIS. iv) She continued to deteriorate whilst in hospital and, passed away on the 2 October 2024. v) Evidence heard at inquest was that, earlier diagnosis and treatment for SEPSIS would have meant that Mrs Dona would have survived.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In

	my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 1. 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 March 2026. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: 1. Family of the deceased.
9	**21 January 2026** [redacted] **Miss Emma Serrano** **Area Coroner** **Staffordshire**