

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

The Leeds Teaching Hospitals NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/1/2025 to 31/3/2025

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 26

Summary of reviews**

Stillbirths and late fetal losses				
Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
16	3	1	12	0

Neonatal and post-neonatal deaths				
Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
19	2	5	12	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 24)

Perinatal deaths reviewed	Gestational age at birth						Total
	Ukn	22-23	24-27	28-31	32-36	37+	
Late Fetal Losses (<24 weeks)	0	2	--	--	--	--	2
Stillbirths total (24+ weeks)	0	0	5	2	3	0	10
<i>Antepartum stillbirths</i>	0	1	5	2	3	0	11
<i>Intrapartum stillbirths</i>	0	1	0	0	0	0	1
<i>Timing of stillbirth unknown</i>	0	0	0	0	0	0	0
Early neonatal deaths (1-7 days)*	0	0	2	1	1	4	8
Late neonatal deaths (8-28 days)*	0	1	0	0	0	1	2
Post-neonatal deaths (29 days +)*	0	0	0	0	1	1	2
Total deaths reviewed	0	3	7	3	5	6	24
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	2	2	3	7
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	1	0	0	1
Not Applicable	0	3	7	0	3	3	16
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	2	7	3	4	6	22
No	0	1	0	0	0	0	1
Missing	0	0	0	0	1	0	1
Parental perspective of care sought and considered in the review process:							
Yes	0	3	7	3	5	6	24
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house							
Booked for care in-house	0	0	2	1	1	5	9
Mother transferred before birth	0	1	0	0	0	0	1
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally							
Neonatal palliative care planned prenatally	0	0	0	0	1	1	2
Neonatal care re-orientated	0	1	2	1	0	4	8

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 24)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	2	5	2	3	0	12
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	2	5	2	3	0	12
Hospital post-mortem declined	0	2	3	1	2	0	8
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	1	1	0	2
Limited and targeted post-mortem	0	0	1	0	0	0	1
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	1	0	0	0	1
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	1	2	1	0	2	6
No	0	0	0	0	1	4	5
Not answered	0	0	0	0	1	0	1
Death discussed with the coroner/procurator fiscal	0	0	0	1	1	0	2
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	1	2	1	1	6	11
Hospital post-mortem declined	0	1	2	0	1	6	10
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	1	0	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	1	0	0	0	1
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	2	1	1	0	4
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	2	5	2	3	0	12
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 12)

Role	Total Review sessions	Reviews with at least one
Chair	10	83% (10)
Vice Chair	1	8% (1)
Admin/Clerical	17	100% (12)
Ambulance Team	0	0%
Bereavement Team	17	100% (12)
Community Midwife	0	0%
External	20	100% (12)
Management Team	15	100% (12)
Midwife	75	100% (12)
MNVP Lead	0	0%
Neonatal Nurse	0	0%
Neonatologist	1	8% (1)
Obstetrician	42	100% (12)
Other	13	100% (12)
Risk Manager or Governance Team	32	100% (12)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 12)

Role	Total Review sessions	Reviews with at least one
Chair	6	50% (6)
Vice Chair	1	8% (1)
Admin/Clerical	17	91% (11)
Ambulance Team	0	0%
Bereavement Team	20	91% (11)
Community Midwife	6	16% (2)
External	8	41% (5)
Management Team	7	33% (4)
Midwife	42	91% (11)
MNVP Lead	10	75% (9)
Neonatal Nurse	3	16% (2)
Neonatologist	44	91% (11)
Obstetrician	37	91% (11)
Other	38	91% (11)
Risk Manager or Governance Team	21	91% (11)
Safety Champion	0	0%
Sonographer or Radiographer	1	8% (1)

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 24)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	2	3	0	1	0	6
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	2	1	2	0	5
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	1	0	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	2	1	1	1	0	5
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	4	0	2	0	6
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	1	0	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	1	1	2	4
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	2	0	0	4	6
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	1	0	0	0	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	1	0	1
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	1	1	1	4	7
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	1	0	0	2	4
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	1	0	1
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	2	1	1	4	8
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	1	0	0	0	2	3
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	1	0	1

Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 24)

Timing of death	Cause of death
Late fetal losses	2 causes of death out of 2 reviews
	PPROM and oligohydramnios with cord prolapse. Histological evidence of severe acute chorioamnionitis with funisitis
	Placental insufficiency, in an existing small placenta, with evidence of placental abruption
Stillbirths	10 causes of death out of 10 reviews
	Severely Hypercoiled cord
	Deep hypercoiling of umbilical cord with histological evidence of fetal vascular malperfusion Oligohydramnios - no cause identified
	Severe Early Onset Growth Restriction
	Placental Abruption
	Maternal Hypovolaemic Shock
	Maternal vascular malperfusion including placental hypoplasia, widespread infarction, and subacute abruption. Clinically - pre-eclampsia.
	Cord entanglement (very long cord)
	The cause of death was undetermined
	Fetal Akinesia
	Hypercoiled Cord in a very small Placenta
Neonatal deaths	9 causes of death out of 10 reviews
	1a) Congenital Heart Disease (hypoplastic left heart and hypoplastic arch) 1b)16p13.11 microdeletion
	1a) Left sided CDH, pulmonary hypoplasia
	1) e.Coli sepsis 2) Extreme prematurity and extremely low birth weight
	a) Pulmonary Hypoplasia, Pulmonary Hypertension b) Mosaic Ring Chromosome 14 with Monosomy Chromosome 14
	1a) Congenital Respiratory Abnormality. b) Duodenal Atresia, Cardiomegaly
	1a) Thanatophoric Dysplasia
	a) Severe Respiratory Distress Syndrome b) Extreme prematurity (24+4 weeks), Gram negative Bacteraemia
	a. Intraventricular haemorrhage bilaterally b. metabolic acidosis e. Extreme prematurity, extreme low birth weight
	Right sided congenital diaphragmatic hernia Pulmonary hypoplasia
Post-neonatal deaths	2 causes of death out of 2 reviews
	1a) Respiratory Failure secondary to inflammatory lung disease 1b) Type 3 laryngomalacia, Aspiration secondary to GORD 2) Trisomy 21, Bilateral pulmonary stenosis branches
	Trisomy 18

Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
During resuscitation the baby required intubation but there were difficulties with the intubation	1	No action entered
The baby was cold on arrival in the neonatal unit	1	No action entered
The mother had poor/no English and a mixture of family members and an interpreter were used to interpret during the first 24 hours that her baby was on the neonatal unit	1	No action entered
The mother should have been referred to the obstetric / haematology team for further investigations to be performed, due to abnormally high Haemoglobin levels.	1	ACTION: Identified theme with several cases where appropriate referral to specialist teams has not taken place at booking. Thematic review of all cases to be performed to identify barriers and learning. (Leads to be confirmed) ACTION: To escalate this case to the Trust Risk Management and Quality Teams, and request a PSIRF investigation with the involvement of the family. (Completed 25/07/2025)
This mother did not give birth in a setting appropriate to her and/or her baby's clinical needs	1	see above
This mother had preterm labour or had preterm prelabour rupture of membranes during her pregnancy and there was a delay in the diagnosis	1	ACTION: Sharing the Learning - All women reporting PVB (pink loss) in pregnancy to be invited in for assessment regardless of amount, particularly if preterm PVB, if reasonable to call YAS especially if there are language barriers. ACTION: Individual feedback for the Midwife who took the MAC call.
This mother had preterm labour or had preterm prelabour rupture of membranes during her pregnancy which was not managed according to national or local guidelines	1	See above

<p>This mother had recurrent antepartum haemorrhage during her pregnancy which was not managed according to national or local guidelines</p>	<p>1</p>	<p>ACTION: Review of the relevant Maternity Assessment Centre guidance to ensure clarity for staff in relation to the importance of inviting mothers into hospital when they report a vaginal bleed (however small, and including 'pink' loss), or a blood stained mucus show <37 weeks as this may be a sign of possible threatened pre-term labour, or premature rupture of membranes. ACTION: Development of a Standard Operating Procedure (SOP) to clarify allocation and follow up of specialist midwifery teams following the loss of a baby. This is to ensure that mothers who have had a spontaneous preterm labour and birth will receive prompt follow up and advice around planning future pregnancies. ACTION: To share in the next pre-term newsletter - the importance of inviting mothers into hospital when they report a vaginal bleed (however small, and including 'pink' loss), or a blood stained mucus show <37 weeks as this may be a sign of possible threatened pre-term labour, or premature rupture of membranes. ACTION: Share this case with the Consultant Midwife for Health Equity, to identify any further actions required in relation to the language barrier. ACTION: The maternity findings of the PMRT review to be shared with the parents, by the Consultant Obstetrician. The mother is pregnant again, and currently out of the country, findings to be shared when she attends clinic.</p>
--	----------	---

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Table 8: Top 10 issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned**

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	12	No action entered
		ACTION: Work in progress to ensure that all parents are offered the opportunity to take their baby home. Audit underway. Poster to be displayed in the delivery suite bereavement suite (in the midwife's paperwork room), to be added to the CSU newsletter, and shared with delivery suite team leaders and coordinators to share in handovers with all staff.
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		ACTION: Routine Enquiry not performed (missed opportunity as alone at booking) To clarify with K2 Midwife as to what alerts come up for staff when this is not completed. To scope whether further alerts can be added to remind staff.
		ACTION: Work in progress to ensure that all parents are offered the opportunity to take their baby home. Audit underway. Poster to be displayed in the delivery suite bereavement suite (in the midwife's paperwork room), to be added to the CSU newsletter, and shared with delivery suite team leaders and coordinators to share in handovers with all staff.
		Work in progress to ensure that all parents are offered the opportunity to take their baby home. Audit underway. Poster to be displayed in the delivery suite bereavement suite (in the midwife's paperwork room), to be added to the CSU newsletter, and shared with delivery suite team leaders and coordinators to share in handovers with all staff.
		Current work in place to ensure that all parents are offered the opportunity to take their baby home. No bereavement checklist within the notes. Audit underway. Poster to be displayed in the delivery suite bereavement suite (in the midwife's paperwork room), to be added to the CSU newsletter, and shared with delivery suite team leaders and coordinators to share in handovers with all staff.
		No action entered
There is no evidence in the notes that this mother was asked about domestic abuse at booking	8	No action entered
		No action entered
		No action entered
		No action entered

		No action entered
		No action entered
		No action entered
		No action entered
There were no specific contraindications to organ donation but this was not discussed with the parents as part of end of life care for their baby as procedures for organ donation are not available	4	No action entered
		No action entered
		No action entered
		No action entered
This mother lives with family members who smoke but they were not offered referral to smoking cessation services because there is no service available	4	No action entered
		No action entered
		No action entered
		No action entered
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	3	No action entered
		No action entered
		No action entered
The opportunity to discuss post mortem with the parents prior to their baby's death as part of end of life care was not taken	3	No action entered
		No action entered
		No action entered
There were no specific contraindications to organ donation but this was not discussed with the parents as part of end of life care for their baby	3	No action entered
		No action entered
		No action entered
This mother booked late. Are there any organisations to consider in relation to her booking late?	3	No action entered
		No action entered
		No action entered
This mother booked late. Did this affect her care?	3	No action entered
		No action entered
		No action entered
This mother had poor/no English and family members were used as interpreters on occasions during her antenatal care	2	No action entered
		No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

** There are further issues which can be downloaded directly as a spreadsheet using the Extract Issues/Factors button

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Guidelines, Policies and Procedures - Not adhered to / not followed	1	This mother had recurrent antepartum haemorrhage during her pregnancy which was not managed according to national or local guidelines
		This mother had preterm labour or had preterm prelabour rupture of membranes during her pregnancy and there was a delay in the diagnosis
Patient Factors - Clinical Conditions - Complexity of condition	1	During resuscitation the baby required intubation but there were difficulties with the intubation
No contributory factor entered	1	This mother had preterm labour or had preterm prelabour rupture of membranes during her pregnancy which was not managed according to national or local guidelines
Patient Factors - Clinical Conditions - Complexity of condition	1	This mother did not give birth in a setting appropriate to her and/or her baby's clinical needs
Communication - Verbal communication	1	The mother had poor/no English and a mixture of family members and an interpreter were used to interpret during the first 24 hours that her baby was on the neonatal unit