

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:

1/4/2025 to 30/6/2025

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: 15

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
6	0	2	4	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
12	2	7	3	1

*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 = 7)

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

*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 = 7)

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	1	2	0	0	1	4
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	1	2	0	0	1	4
Hospital post-mortem declined	0	1	1	0	0	1	3
Hospital post-mortem carried out:							
Full post-mortem	0	0	1	0	0	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	2	0	0	1	0	3
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	2	0	0	1	0	3
Hospital post-mortem declined	0	2	0	0	1	0	3
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
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	0	0	0	0	0
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	1	0	0	0	1
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	1	2	0	0	1	4
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 = 3)

Role	Total Review sessions	Reviews with at least one
Chair	2	66% (2)
Vice Chair	0	0%
Admin/Clerical	3	100% (3)
Ambulance Team	0	0%
Bereavement Team	3	100% (3)
Community Midwife	0	0%
External	2	66% (2)
Management Team	5	100% (3)
Midwife	16	100% (3)
MNVP Lead	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	9	100% (3)
Other	5	100% (3)
Risk Manager or Governance Team	3	100% (3)
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 = 4)

Role	Total Review sessions	Reviews with at least one
Chair	1	25% (1)
Vice Chair	0	0%
Admin/Clerical	5	75% (3)
Ambulance Team	0	0%
Bereavement Team	6	100% (4)
Community Midwife	0	0%
External	9	100% (4)
Management Team	3	75% (3)
Midwife	30	100% (4)
MNVP Lead	1	25% (1)
Neonatal Nurse	0	0%
Neonatologist	12	75% (3)
Obstetrician	17	100% (4)
Other	14	100% (4)
Risk Manager or Governance Team	8	100% (4)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

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 = 7)

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	0	0	0	0	0	0
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	1	3
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	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	0	1	0	0	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	1	1	0	0	1	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	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	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	1	0	2
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	1	0	0	0	0	1
Not graded	0	0	0	0	0	0	0
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	2	0	0	0	0	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	1	0	1
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	0	0	0
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	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	2	0	0	1	0	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	0	0	0

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 = 7)

Timing of death	Cause of death
Late fetal losses	1 causes of death out of 1 reviews
	Intrapartum death at extreme prematurity
Stillbirths	3 causes of death out of 3 reviews
	Delayed Villous Maturation
	Placental abruption in an abnormal placenta and small baby
	Severe early onset growth restriction Lumbo-sacral myelomeningocele (spina bifida) Pre-eclampsia / HELLP syndrome Following PMRT Review also noted: Maternal vascular malperfusion in conjunction with Pre-eclampsia or HELLP Syndrome
Neonatal deaths	3 causes of death out of 3 reviews
	Hydrops Possible underlying genetic / neuromuscular disorder (paucity of movements and abnormal posture of limbs antenatally, dysmorphism) Prematurity (32 weeks)
	1a. Extreme Prematurity (22+3 weeks)
	a. Extreme prematurity 22+2 weeks c. Spontaneous onset of preterm labour
Post-neonatal deaths	0 causes of death out of 0 reviews

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
This mother has a history of preterm birth <34 weeks gestation and her antenatal care was not appropriate given this history	2	ACTION: To escalate this case to the Trust Risk Management and Quality Teams, and request a PSIRF investigation with the involvement of the family.
		This case was escalated to the Trust risk management team at the time of the incident and a PSIRF Patient Safety Rapid Review took place. A decision agreed to perform a thematic review in the form of a PSIRF Patient Safety Learning Review. This review is currently being organised and findings will be added to this review when completed and approved.
The type of care this mother was booked for was inappropriate for her risk allocation at booking	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. (Lead to be confirmed).
This mother had a history of adverse pregnancy outcome but her care in this pregnancy was not appropriate given her history	1	as above
This mother had pre-eclampsia/eclampsia during her pregnancy which was not managed according to national or local guidelines	1	ACTION: Review of guidance in relation to the pathway and treatment for chronic hypertension when BP is newly raised <20 weeks
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	ACTION: To escalate this case to the Trust Risk Management and Quality Teams, and request a PSIRF investigation with the involvement of the family.

*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
This mother had poor/no English and language line was used to interpret during her labour and birth	3	No action entered
		No action entered
		No action entered
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	2	ACTION: Current work in place with the bereavement midwives to ensure that all parents are offered the opportunity to take their baby home
		No action entered
There is no evidence in the notes that this mother was asked about domestic abuse at booking	2	No action entered
		No action entered
During the resuscitation the baby's temperature was not maintained within an appropriate range	1	Ongoing work around thermoregulation.
GP Services Issue - The mother received multiple distressing automated text alerts for appointments for herself and her baby, despite these being requested to be cancelled.	1	ACTION: Feedback to GP services in relation to the mother receiving multiple distressing automated text alerts for appointments for herself and her baby, despite these being requested to be cancelled. To also discuss at LMNS
The available bereavement care pathway was not followed	1	No action entered
The baby was cold on arrival in the neonatal unit	1	Ongoing work around thermoregulation. Additional challenges with accurate temperature measurement in patients with significant hydrops
The mother had poor/no English and language line was used to interpret during the first 24 hours that her baby was on the neonatal unit	1	No action entered
The mother had poor/no English and other family members were used as interpreters during the first 24 hours that her baby was on the neonatal unit	1	ACTION: The Bereavement Nurse to develop a patient story for staff learning around the issue that the father and family were interpreting information to the mother at the time that the baby was very poorly, and the impact that this has on the family, to reiterate the importance of ensuring that an interpreter is requested promptly.
The mother reported that her experience of attending the dating scan was poor, lacking in compassion and with poor communication. In contrast, her experience at the anomaly scan was excellent.	1	ACTION: To communicate patient feedback to the sonography team for future learning (parent feedback about a poor experience at the dating scan)

*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	The type of care this mother was booked for was inappropriate for her risk allocation at booking
		This mother has a history of preterm birth <34 weeks gestation and her antenatal care was not appropriate given this history
Task Factors - Guidelines, Policies and Procedures - Not adhered to / not followed	1	This mother has a history of preterm birth <34 weeks gestation and her antenatal care was not appropriate given this history
		This mother had a history of adverse pregnancy outcome but her care in this pregnancy was not appropriate given her history
Task Factors - Guidelines, Policies and Procedures	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
Task Factors - Guidelines, Policies and Procedures	1	This mother had pre-eclampsia/eclampsia during her pregnancy which was not managed according to national or local guidelines