

## External Review of Perinatal Deaths at Leeds Teaching Hospitals NHS Trust: Progress Report

**Public Board**  
**29 January 2026**

<b>Presented for:</b>	Approval/Assurance
<b>Presented by:</b>	Magnus Harrison, Chief Medical Officer
<b>Author:</b>	Craig Brigg, Director of Quality
<b>Previous Committees:</b>	None

<b>Link to Strategic Objective</b>	Focus on care quality, effectiveness and patient experience
<b>Link to Provider Capability Assessment</b>	Quality of care
<b>Link to CQC Well-led Statement</b>	Learning, Improvement and Innovation
<b>Regulatory Impact</b>	Regulation 12: Safe care and treatment

<b>Key points</b>	<b>Purpose</b>
1. The Trust has commissioned an independent external review of perinatal mortality data published in the MBRRACE report (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries), which identifies Leeds Teaching Hospitals NHS Trust as an outlier.	Information
2. The review team has been established, led by an independent Consultant Neonatologist.	Information
3. Women, families and birthing people will be at the centre of this review; their voices, experiences and thoughts will be integral to the review.	Information
4. The final DRAFT Terms of Reference were reviewed at Perinatal Improvement Assurance Committee on 15 January 2026 and presented to Private Board for review and approval on 29 January 2026. These will be presented to Public Board in March 2026.	Assurance

<b><u>Risk Appetite Framework</u></b>			
<b>Level 1 Risk</b>	<b>Level 2 Risks</b>	<b>(Risk Appetite Scale)</b>	<b>Impact</b>
Workforce Risk			

Operational Risk			
Clinical Risk	Patient Safety & Outcomes Risk - We will provide high quality services to patients and manage risks that could limit the ability to achieve safe and effective care for our patients.	Minimal	Moving Away
Financial Risk			
External Risk	Regulatory Risk - We will comply with or exceed all regulations, retain its CQC registration and always operate within the law.	Averse	Moving Away

### 1. Summary

Leeds Teaching Hospitals NHS Trust (LTHT) has commissioned an independent external review of neonatal deaths and stillbirths as the Trust has higher than expected reported rates of perinatal mortality. A report was provided to Private Board in November 2025 setting out the proposed approach to the independent review.

The review team has been established, led by an independent Consultant Neonatologist. The initial DRAFT terms of reference (ToR) were agreed by NHS England North East Yorkshire and Humber regional team and the West Yorkshire Integrated Care Board (ICB). The final DRAFT terms of reference were reviewed at the Trust's Perinatal Improvement Assurance Committee on 15 January 2026. These were presented to Private Board for review and approval on 29 January 2026. The approved terms of reference will be received at Public Board in March 2026.

### 2. Background

The Trust has reported higher than expected rates of perinatal mortality, this is published in the annual MBRRACE-UK report. Assurance has been provided to Quality Assurance Committee and Mortality Improvement Group, setting out the process for reviewing perinatal deaths, identifying areas for improvement and sharing learning. It was agreed to commission an independent external review to understand if there were clinical practices, systems or processes that may be contributing to adverse outcomes.

In October 2025 the Secretary of State for Health and Social Care, announced that there would be an independent inquiry into maternity and neonatal services at Leeds Teaching Hospitals NHS Trust. The Chair of the inquiry and terms of reference have not been announced to date. The Board agreed to progress the independent review of perinatal deaths. This independent review will inform the Leeds Independent Inquiry, and the findings and recommendations will be made available for this, highlighting the key learning points and priorities for improvement.

### 3. Independent review – progress

The review will be led by an independent Consultant Neonatologist. The review will be focused on listening to the experience of families and learning, using a trauma informed approach. The review will be done *with* the clinical team(s) and they will be open and transparent in their engagement and communications. The review team will be supported by a designated family liaison lead, support will also be provided to families by the trust. The review team will provide feedback to families following the review.

A meeting was arranged to discuss the independent review with the review team at the LGI on 28 January 2026, providing opportunity for Clinical Service Unit leads, consultants and senior nurses to meet with them and discuss the approach to this.

The review team will provide updates on progress, and these will be shared with the Board. Reports will be provided to the Perinatal Improvement Assurance Committee who will receive assurance on behalf of the Board.

### **3. Proposal**

#### **4. Financial Implications**

The financial implications of commissioning the external review are significant. These will be overseen in conjunction with the finance team and the trust will liaise with NHS England regarding the costs.

#### **5. Risk**

The Quality Assurance Committee provides oversight of the Trust's patient safety event reporting framework. There was no material change to the risk appetite statement related to the level 2 risk categories set out on the front page of this report and the Trust continues to operate within the risk appetite for the level 1 risk category (clinical risk) set by the Board.

#### **6. Communication and Involvement**

The main focus of communications is to ensure that the women, families and birthing people involved in this review are fully supported. Those families involved in the review will be contacted directly to ensure sure that they receive information and developments about the review before it is shared publicly. Regular updates and support will also be provided to staff across the Trust.

#### **7. Improving Health Equity**

A formal equality analysis has not been undertaken. However, the TOR have been written with a clear recognition of the needs of all families and all colleagues.

#### **8. Publication Under Freedom of Information Act**

This paper is made available under the Freedom of Information Act 2000.

#### **9. Recommendation**

Trust Board is asked to:

- Receive the update and be assured on progress regarding the commissioning of the external independent review of perinatal deaths at Leeds Teaching Hospitals NHS Trust.

#### **10. Supporting Information**

None