



Wrightington, Wigan and Leigh Teaching Hospitals

NHS Foundation Trust

Trust Headquarters

Chief Nurse

Royal Albert Edward Infirmary

Wigan Lane

Wigan

WN1 2NN

T: 01942 773291

E: kevin.parker-evans@wwl.nhs.uk

Ref: FOI/2025/11233

Date Received: 13th November 2025

Response Due: 11th December 2025

Date: 11th December 2025

Dear Sir/Madam

With reference to your request for information received on 13th November 2025, I can confirm in accordance with Section 1 (1) of the Freedom of Information Act 2000 that we do hold the information you have requested. A response to each part of your request is provided below.

In your request you asked:

We are requesting the following maternity and neonatal data for the period 1 January to 31 December 2024.

Where definitions differ locally, please use those consistent with MBRRACE-UK, and exclude terminations for medical reasons (TFMR).

Where the Trust provides maternity services at more than one site please ensure that the responses are broken down by site, including whether care was Consultant led, Midwife led and whether delivery was in a Obstetrician led delivery suite, midwife led birth centre, home birth or other.

1. Births and Deaths

- **Total births** = 2,435.
- **Total stillbirths** = 7.
- **Crude stillbirth rate** = 2.87 per 1,000 births.
- **Stabilised stillbirth rate** = Not available.

- **Total live births** = 2,428.
- **Total neonatal deaths** = 3.
- **Crude neonatal death rate** = 1.23 per 1,000 births.

- **Stabilised neonatal death rate** = Not available.
- **Total perinatal deaths** = 10.
- **Crude perinatal death rate** = 4.1 per 1,000 births.
- **Stabilised perinatal death rate** = Not available.

2. Maternal Deaths

- **Total maternal deaths (as defined by MBRRACE-UK)** = 0.
- **Number of maternal deaths investigated through PMRT, PSIRF, or MNSI** = 0.
- **Number of maternal deaths referred to the Coroner** = 0.
- **Number of maternal deaths subject to Coroner investigation or inquest** = 0.
- **Number of maternal deaths where issues with care were identified** = 0.
- **Number of maternal deaths reported to MBRRACE-UK but not investigated by MNSI, with reason(s)** = 0.

3. Perinatal Mortality Review Tool (PMRT)

- **Number of PMRTs completed for 2024 cases** = 5.
- **Number of PMRTs outstanding for 2024 cases** = 0.
- **Number of PMRTs within each grading (A, B, C, D)** = please see the below.

Stillbirths and Late Fetal Losses

- Grading of care of the mother and baby up to the point that the baby was confirmed as having died:
 - A = 2
 - B = 1
 - C = 1
- Grading of care of the mother following confirmation of the death of her baby:
 - A = 3
 - B = 1

Neonatal and Post-Neonatal Deaths

- Grading of care of the mother and baby up to the point of birth of the baby:
 - B = 1
- Grading of care of the baby from birth up to the death of the baby:
 - B = 1
- Grading of care of the mother following the death of her baby:
 - A = 1
- **Whether PMRTs are linked to MBRRACE case IDs (Yes/No – if No, please explain why)**
Yes.

4. Maternity and Neonatal Safety Investigations (MNSI)

- **Number of deaths not qualifying for referral to MNSI** = 10.
- **Number of cases for each reason these deaths did not qualify (e.g. gestation, stillbirth criteria, timing, cause of death, etc.)** = no intrapartum still births, no stillbirths at term, and no neonatal deaths at term. None met MNSI criteria.
- **Number of referrals made to MNSI** = 1 (rejected as congenital anomalies).
- **Number of cases investigated by MNSI** = 0.

- **Number of MNSI investigations where recommendations were made that may have altered the outcome = N/A.**
- **Details or summary of the recommendations made to the Trust by MNSI for these 2024 cases = N/A.**
- **Confirmation whether any MNSI-investigated cases were also reported as Serious Incidents under PSIRF, and how overlap is managed = N/A.**

5. Coroner Referrals (Neonatal and Maternal Deaths)

- **Number of neonatal or maternal deaths referred to the Coroner by the hospital = 0.**
- **Number referred by parents/family/others = 0.**
- **Number of cases where the Coroner undertook a full investigation = 0.**
- **Number of inquests opened in 2024 = 0.**
- **Number of inquests completed in 2024 = 0.**
- **Number of inquests identifying issues with care = 0.**
- **Number of inquests still open related to 2024 cases = 0.**

6. Internal Investigations (PSIRF / RCA / Other)

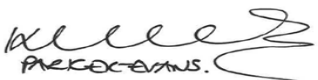
- **Number of Root Cause Analysis or PSIRF investigations undertaken relating to 2024 maternity, perinatal, or maternal deaths = 10 72-hour reviews completed, 5 of which were eligible for PMRT with no further investigations required.**
- **Number completed = 0.**
- **Outcome statistics (e.g. avoidable / potentially avoidable / no issues identified) = 1 Grade C at PMRT.**
- **Brief description or title list of any internal maternity or perinatal safety reviews conducted in 2024 not part of PMRT, PSIRF, or MNSI = None.**

7. Governance and Validation

- **Identify the primary source system used for each dataset (e.g. BadgerNet, EuroKing, etc.) MBRRACE and Euroking.**
- **Confirm whether each dataset has been validated or submitted to MBRRACE-UK, or remains provisional**
Provisional.
- **Provide the dates of Trust Board meetings in 2024 where maternity mortality data or PMRT findings were discussed**
05/06/2024, 07/08/2024 and 04/12/2024.

If you are not entirely satisfied with this response, please do not hesitate to contact the Information Governance Department via the email address provided. If we do not hear from you within 40 days, we will assume that we have been able to accommodate your request under the Freedom of Information Act 2000.

Yours sincerely,



KEVIN PARKER-EVANS

Kevin Parker-Evans MBA, FCMJ, CMgr. RN Dip HE

Chief Nursing Officer & Director of Infection Prevention and Control

PLEASE NOTE:

If you are unhappy with the service you have received in relation to your request and wish to make a complaint or request a review of our decision, you should write to: Information Governance Department, Wrightington, Wigan and Leigh NHS Foundation Trust, Suite 9, Buckingham Row, Brick Kiln Lane, Wigan, WN1 1XX.

If you are not content with the outcome of your complaint, you may apply directly to the Information Commissioner for a decision at:

The Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire, SK9 5AF

Helpline number: 0303 123 111