Lothian NHS Board

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Date 08/12/2025
Your Ref
Our Ref 10796

Enquiries to Richard Mutch
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Dear

FREEDOM OF INFORMATION – MATERNITY DEATHS

I write in response to your request for information in relation to maternity deaths.

Question:
1. *How many deaths of mothers and/or babies have been recorded by obstetric, midwifery, and/or home birth services within your health board each year for the last 10 years?*

Answer:
The table below details the number of mother and/or baby deaths reported as an adverse event for the last 10 years, 01/01/2015 to 04/11/2025 (date of FOI). The table is broken down by Severity and calendar year.

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Harm to a person - death	44	14	46	35	28	37	29	29	31	38	37

Question:
2. *Of those deaths, how many have resulted in internal investigations?*

Answer:
The table below details the number of deaths that have resulted in internal investigations. The table is broken down by Type of Review and calendar year. We did not record the Type of Review (Level 1 SAE Review; Briefing Note, PMRT and CCR-Maternity/NNU) until January 2020. Prior to January 2020 all maternal deaths/intrapartum stillbirths would have been reviewed as a Case Note Review.

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Level 1 SAE Review	0	0	0	0	≤5	7	≤5	6	7	≤5	≤5
Briefing Note	0	0	0	0	0	0	0	0	0	0	≤5
PMRT	0	0	0	0	11	28	24	23	24	33	30
CCR- Maternity/NNU	0	0	0	0	≤5	≤5	≤5	0	0	0	≤5
Case Note Review	44	14	46	35	13	0	0	0	0	0	0

Question:
3. What were the outcomes of those investigations?

Answer:
The table below details the outcomes of those investigations. The table is broken down by Review Outcome and calendar year. We did not classify as outcome code until January 2020; hence no data is provided prior to this date.

	2020	2021	2022	2023	2024	2025
Outcome 1	16	20	19	17	26	6
Outcome 2	16	7	7	10	8	≤5
Outcome 3	≤5	≤5	≤5	≤5	≤5	0
Outcome 4	≤5	≤5	0	≤5	≤5	0

Outcome Codes

1	**Appropriate care** - The adverse event review concluded that the care and/or service was well planned and appropriately delivered; no care or service delivery problems were identified; and the adverse event outcome was ultimately unavoidable. However, it is likely there are still learning points (especially good practice points).
2	**Indirect system of care issues** - The adverse event review identified indirect or incidental sub-optimal care or service issues and lessons that could be learned (and good practice points). However, these were unlikely to have affected the final outcome. For example, a protocol was not strictly followed or there was a delay in accessing the case notes, but these were unlikely to have affected the final outcome.
3	**Minor system of care issues** - The adverse event review identified minor or sub-optimal care or service provision and that a different plan or delivery of care/service may have resulted in a different outcome. For example, system or management factors were identified (such as incomplete records or a delay in transferring the patient or service user), but there was uncertainty regarding their impact on the final outcome. Learning points have been identified and improvement plans developed.
4	**Major system of care issues** - The adverse event review identified that a different plan and/or delivery of care or service would, on the balance of probability, have been expected to result in a more favourable outcome. Factors were identified which negatively influenced or contributed to the adverse event outcome. For example, how the case was managed had a significant impact on the level of harm. Learning points have been identified and improvement plans developed.

Question:

4. *How much has your health board spent settling negligence claims relating to obstetric care each year for the last 10 years?*

Answer:

Financial Year	Settlement
2015/16	£1,000,000
2016/17	£61,000
2017/18	£122,500
2018/19	£1,000,000
2019/20	£3,000
2020/21	£278,300
2021/22	£4,702,190
2022/23	£418,000
2023/24	£501,500
2024/25	£60,000
Total	£8,146,490
Incidents likely occurred in years prior - claims can take months, and in some cases years to settle.	

I hope the information provided helps with your request.

If you are unhappy with our response to your request, you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive