

Quality Failures in Maternity Care: The Shrewsbury and Telford NHS Trust Scandal

Module: LCHS7006 Quality Assurance and Service Improvements

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SUMMARY

Shrewsbury and Telford Hospital NHS Trust (UK) Maternity Scandal

- One of the largest maternity scandals in the NHS resulting in 1,592 clinical incidents between 1970 and 2019, these included stillbirths, neonatal deaths, maternal deaths, and long-term harm.
- The final Ockenden Report (Department of Health & Social Care, 2022) found the failures at Shrewsbury & Telford were not one-off clinical errors, but results of systemic breakdowns in governance, culture, learning, oversight, and accountability.
- The concerns of families were often dismissed, and staff felt unable to speak up.



WHAT WENT WRONG?

1. Failure to recognise and act on abnormal fetal heart rate patterns.
2. Poor communication between midwives, doctors, and families.
3. Delayed or inappropriate escalation during high-risk deliveries.
4. Lack of adherence to national safety protocols (e.g. emergency C-sections).
5. Leadership and governance failures.

(Department of Health & Social Care, 2022)



Root Causes - Swiss cheese model

James Reason's "Swiss cheese" model is widely recognized in patient safety practice:

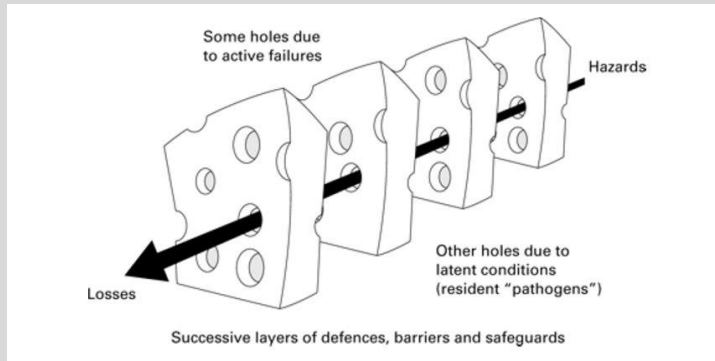


Figure 1. James Reason's Swiss cheese model. Source: Reason et al. 2001.

Layer of Defence (Slice of Cheese)	Intended Function	Hole (Weaknesses)
Clinical protocols	Ensure consistent and evidence-based maternity care which follows national guidelines	National guidelines on fetal monitoring and escalation often ignored
Staff communication	Enable accurate, timely sharing of patient information	Poor handovers, reluctance to escalate concerns and dismissive attitudes toward families
Staff Training	Maintain staff competence and oversight	Inadequate training
Incident reporting and audits	Identify, review, and learn from previous events	Reports not investigated properly and repeated patterns of harm overlooked
Leadership	Provide accountability and ensure safe systems	Defensive culture and lack of openness

When these "holes" aligned they resulted in systemic failures which led to delayed interventions, unsafe practices, and preventable maternal and neonatal deaths (Department of Health & Social Care, 2022).

BENCHMARK



Area	Metric (Current)	National Standard
Maternity Safety – Saving Babies’ Lives Care Bundle	The Ockenden Review (2022) found that 25% (1 in 4) of reviewed stillbirths had major care failings.	≥ 90% compliance with care standards
Independent Whistleblowing	62.3% of NHS staff agree they feel safe to raise concerns about unsafe clinical practice (Patient Safety Learning, 2024). The Ockenden Review (2022) found a defensive culture and lack of openness.	While there is no set benchmark by the NHS, the NHS staff survey carried every year allows this metric to be analysed. A lot of Trusts use a target of ≥ 90% (Cambridgeshire Community Services NHS Trust, 2025).

Saving Babies’ Lives Care Bundle: NHS goal to reduce stillbirths and improve outcomes for babies through evidence-based maternity care (NHS England, 2023).

Independent Whistleblowing: An employee's disclosure of wrongdoing such as criminal offences, legal breaches, miscarriages of justice, health and safety risks, environmental damage, or cover-ups of these issues (NHS England, 2024).



DISCUSSION

1. Which “holes” in the system could have been addressed earlier to prevent harm?
2. How did leadership culture at Shrewsbury and Telford Trust influence the persistence of unsafe practices?
3. What role does communication play in maternity safety?
4. How can benchmarking and transparent reporting drive quality improvement in NHS maternity services?
5. What are the limitations of the Swiss Cheese Model when applied to cases like this?

SUMMARY

Applying the Swiss Cheese model to the Shrewsbury and Telford maternity scandal shows how systemic weaknesses across multiple layers (leadership, communication, training, and governance) can align to produce devastating outcomes. This model is important in understanding the root causes of a problem (Kamoun et al., 2014). Benchmarking then allows us to monitor progress and measure performance against best practice standards, ensuring continuous improvement (Willmington et al., 2022).



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