



MSc Public Health and Social Care in Practice

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Shrewsbury and Telford Hospital NHS Trust **(UK)-Maternity Scandal: Background**

- A review conducted at maternity services of Shrewsbury and Telford Hospital NHS trust showed that there is repeat of maternity care failures which led to preventable incidents and deaths of mothers and babies.
- The review aimed to give affected families a voice and investigate governance, policies and procedures followed by the hospital.
- Incidents led to multiple life-long injuries to mothers and babies.
- There were 1,592 clinical cases of incidents from 2000 to 2019 and 1,486 families involved, suggesting multiple care failures (Department of Health & Social Care, 2022).



Figure 1: NHS logo for The Shrewsbury and Telford Hospital NHS Trust (The Shrewsbury and Telford Hospital NHS trust, no date).

What went wrong?

-Lack or delayed referral of mothers to multidisciplinary teams: This shows lack of organisation.

-Lack of action from senior clinicians when severity increased: Shows poor leadership and lack of expertise when it was required.

-Poor staff levels: This led to available staff being overwhelmed with work, fear and stress.

-Lack of compassion: Staff were unprepared for briefings and would ignore complaints from families. In occasions they would blame the family for the issue or justify their actions.

Applying the Swiss Cheese model

Swiss Cheese model is a risk management process used to identify and assess risks. Industries can use this model to analyse systems, identify setbacks to create solutions or defences (Shabani, Jerie and Shabani, 2024). In this model cheese represents a defence barrier (Wiegmann *et al.*, 2022) and the holes represent failures from the system (Larouzee and Le Coze, 2020).

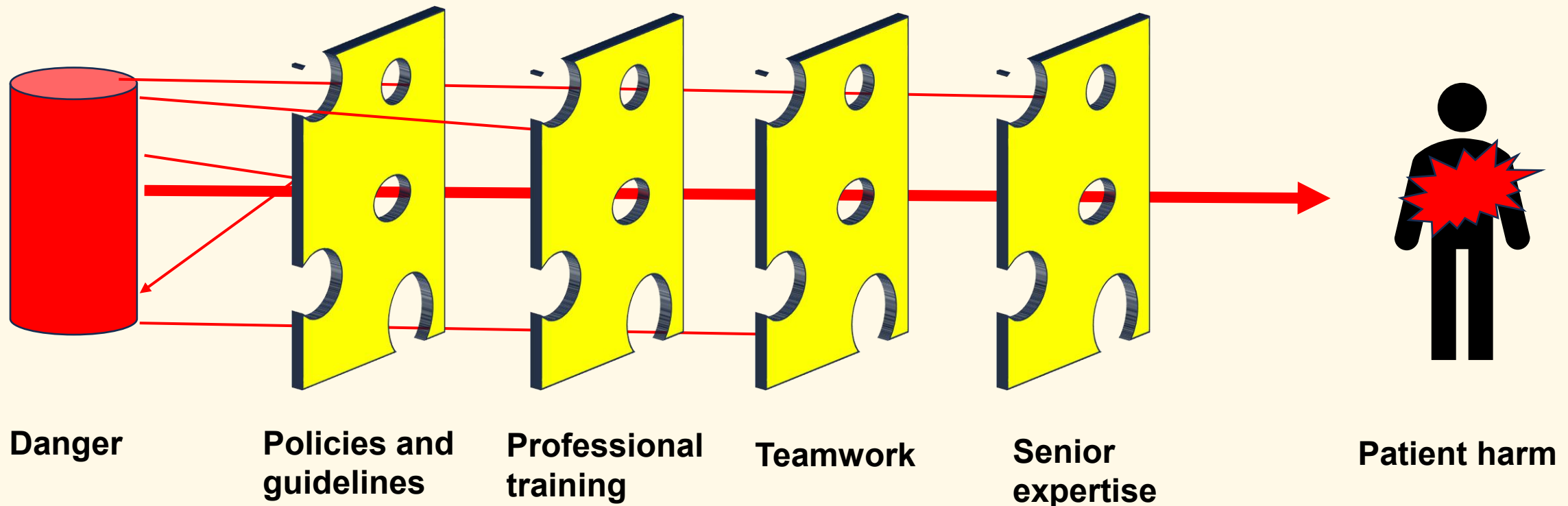


Figure 2: Swiss Cheese model. This built model was applied to Shrewsbury and Telford maternity scandal case study (Salla, 2026).

Swiss Cheese model analysis

<u>Layer of defence (slice of cheese)</u>	<u>Intended function</u>	<u>Hole (weakness)</u>
Policies and guidelines	Provide improved patient services and assist in decision making (Thoonsen <i>et al.</i> , 2024).	Since guidelines are not mandatory, most professionals did not follow leading to poor services.
Professional training	Improve decision making, patient care and confidence to respond to incidents (Heys <i>et al.</i> , 2022).	There were gaps for midwifery and medical workforce training causing delays in care and referrals.
Teamwork	Provide safe and patient centre care with minor or no errors (Harris <i>et al.</i> , 2022).	Poor relationship between midwifery and obstetric staff caused delays and errors.
Senior expertise	Prepares leaders while providing improved outcomes and additional knowledge.	Senior professionals did not fulfil their role effectively. This is poor leadership.

The holes in this model led to repeated mistakes in care and leadership causing maternal and neonatal deaths or serious life-long complications mainly due to delay in care and referring to other wards.

Benchmarking for improvement

Benchmarking is a process that is used to identify strengths and weaknesses in healthcare to find room for improvement (Willmington *et al.*, 2022).

The table below focuses on the statistics of the consequences of poor care and leadership: **neonatal** and **maternal mortality** and **brain damage** which caused lifelong impacts.

<u>Indicator</u>	<u>National standard</u>	<u>Hospital (before intervention)</u>
Neonatal mortality rate	In 1,000 deaths, 3 neonates died in 2023/24 (ONS, 2026).	77 neonatal deaths were reported between 2011-2019 (Department of Health and Social Care, 2022).
Brain injury/damage in babies after birth	5 in 1,000 babies suffers from brain injury yearly after birth (O'hare, 2017).	65 cases of brain damage were reported (Vize, 2022). This occurred due to injuries in birth process.
Maternal death rate	276 of women died in 2022-2024. This was during or after 42 days of pregnancy (Mbrace-UK, 2026).	9 maternal deaths were recorded at the hospital. These deaths were all preventable. This shows poor performance.

Component 2- structure

- This report will be focused in improving maternity services by discussing and addressing the issue of poor care and leadership.
- Analysis will occur using frameworks to identify the origin of the problems.
- Lastly, realistic recommendations will be given along with implementation strategies to ensure that all issue are addressed.

Introduction

Introducing the background of case study and the main problem.

Main body

Analysis using tools such as SWOT and Fish bone diagram to describe and explore the main problem.

Recommendations

Solutions will be suggested in this section based on the found issue.

Conclusion

A summary of all findings of the report with no additional information will be provided.

Conclusion

A review carried at Shrewsbury and Telford Hospital NHS Trust, found that poor care and leadership led to multiple preventable maternal and neonatal incidents.

Poor care and leadership were led by the following failures:

- Poor teamwork
- Lack of expertise and effectiveness
- Lack of compassion

These failures and consequences can be analysed utilising the Swiss Cheese model and a benchmarking table to understand the severity of the poor outcomes.

This case will further be explored in component 2 to understand and analyse the systems of the hospital and how they failed to protect mothers and babies.

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