

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

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Module Name – Quality Assurance and Service Improvements

Module Code – LCHS7006

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Introduction

- The given presentation is dedicated to examining the ways in which systemic governance, non-compliance with policies, and absence of leadership culture at the Shrewsbury and Telford NHS Trust influenced the quality of maternity care through systems-based models and policy analysis.
- The **Ockenden Report (2022)** exposed systemic failures in maternity care at Shrewsbury and Telford NHS Trust between the 1970s–2019.
- Hundreds of avoidable deaths and life-changing injuries occurred due to **governance breakdowns and poor clinical oversight** (BBC, 2022).
- This presentation applies systems-based models to identify **root causes**, analyse **policy failures**, and assess their **impact on quality, efficiency, and equity**.

The Ockenden report findings



- Examined almost **1,600 cases** spanning **20 years**
- **201 deaths** where concerns over care found
- **131 stillbirths** and **70 neonatal deaths** affected
- Also **29 cases** where babies suffered severe **brain injuries**
- And **65 incidents** of **cerebral palsy**

Sources: (Ockenden Report, 2022)

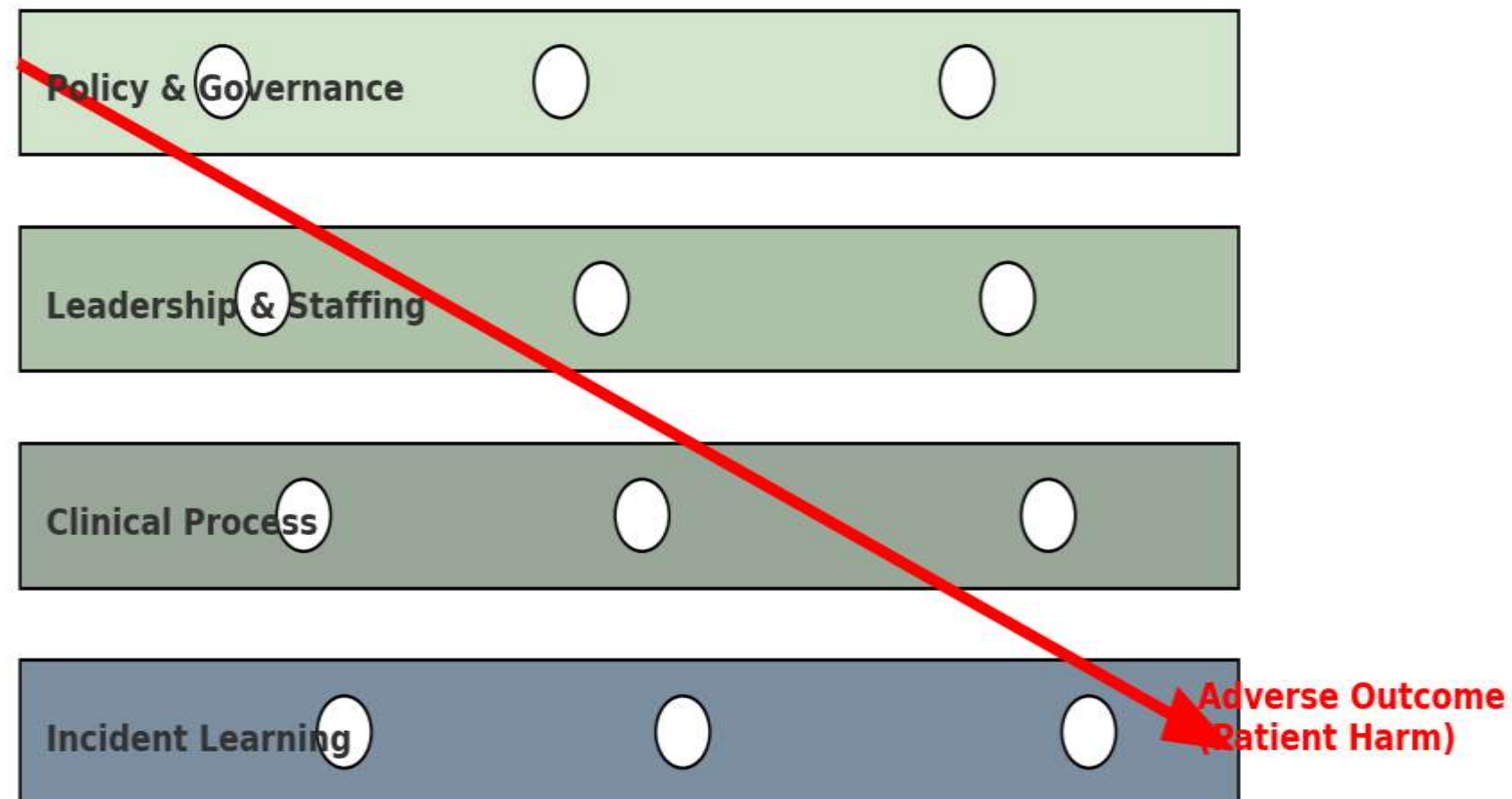
Background and Context

- ❑ The scandal is the **largest maternity care failure in NHS history**, highlighting decades of unsafe practices (Dobson, 2022).
- ❑ Families' concerns were ignored, and incident reports were inadequately investigated (Dixon-Woods, 2024).
- ❑ It illustrates systemic deficiencies in **leadership, governance, and learning culture** (Lethbridge, 2022).



Sources: (Dobson, 2022)

Systems-Based Model – Swiss Cheese Model



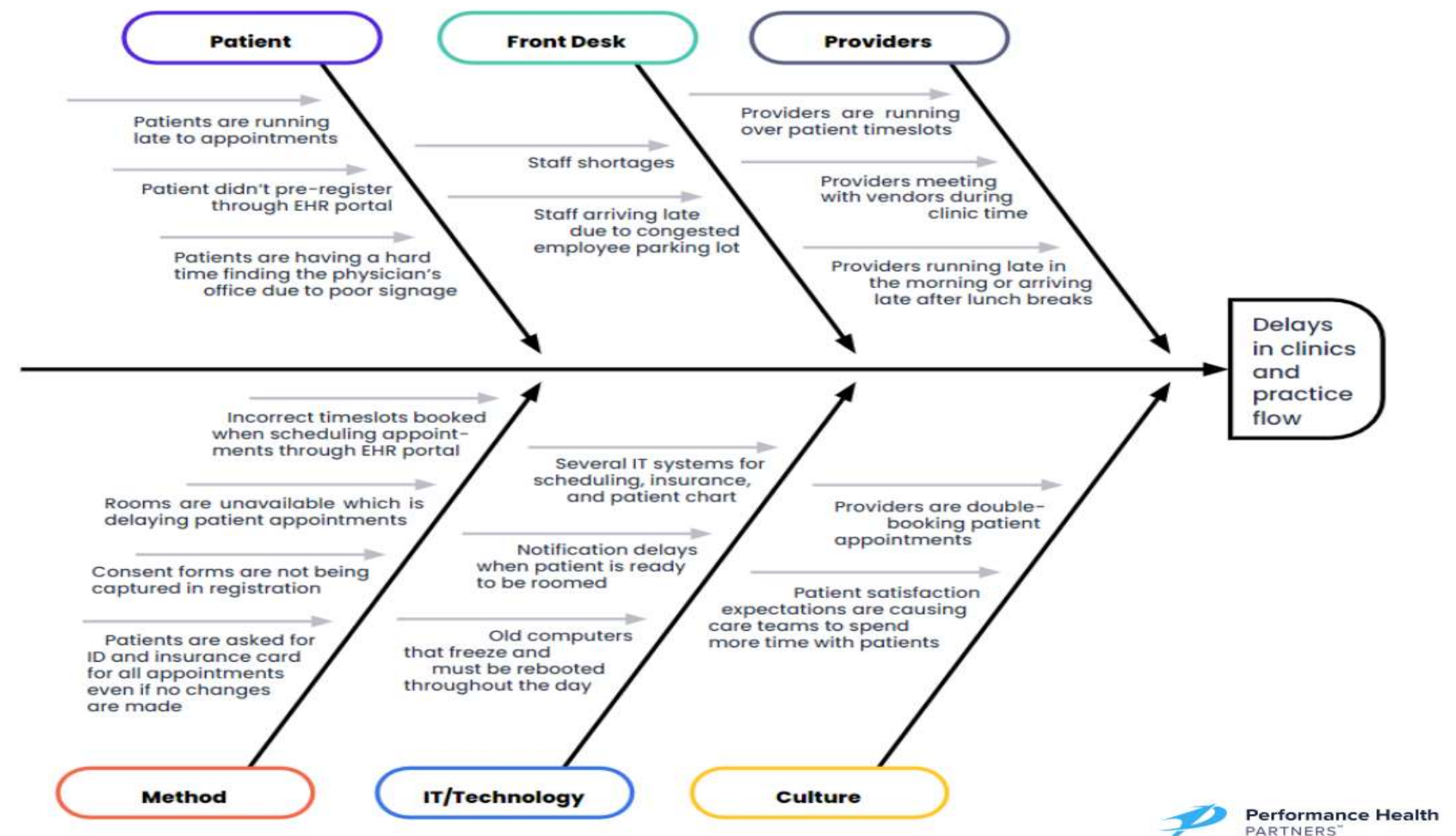
- ❑ The **Swiss Cheese Model (Reason, 2000)** visualises how multiple system gaps align to cause harm.
- ❑ *Latent conditions*: inadequate staffing, outdated monitoring, policy non-compliance.
- ❑ *Active failures*: misdiagnosis, failure to escalate fetal distress.
- ❑ *Defences*: poor incident learning and lack of safety audits.
- ❑ Each layer of safety failed simultaneously (McDonagh Hull et al., 2025).

Root Cause Analysis (RCA)

- RCA revealed repeated patterns of negligence, such as failure to monitor fetal wellbeing and delayed interventions (Ockenden, 2022).
- Leadership culture discouraged transparency, fostering **defensive behavior** (Lampard, 2023).
- Systemic neglect of staff training and absence of multidisciplinary reviews amplified risk.

Fishbone Diagram

This diagram gets its name from its fishbone-like shape, and is used to group potential root causes into different subcategories such as methods, measurements, and materials. This methodology is relatively easy to use to determine a root cause in complex processes.



Sources: (Dobson, 2022)

Policy and Governance Failures



- **Poor adherence** to *NHS Maternity Safety Strategy* and *CQC inspection standards* (Dixon-Woods, 2024).
- Absence of **external accountability** and inadequate policy implementation (Lethbridge, 2022).
- *Whistle-blowing mechanisms* were ineffective or punitive (Lampard, 2023).
- National oversight was fragmented, enabling persistent policy non-compliance.

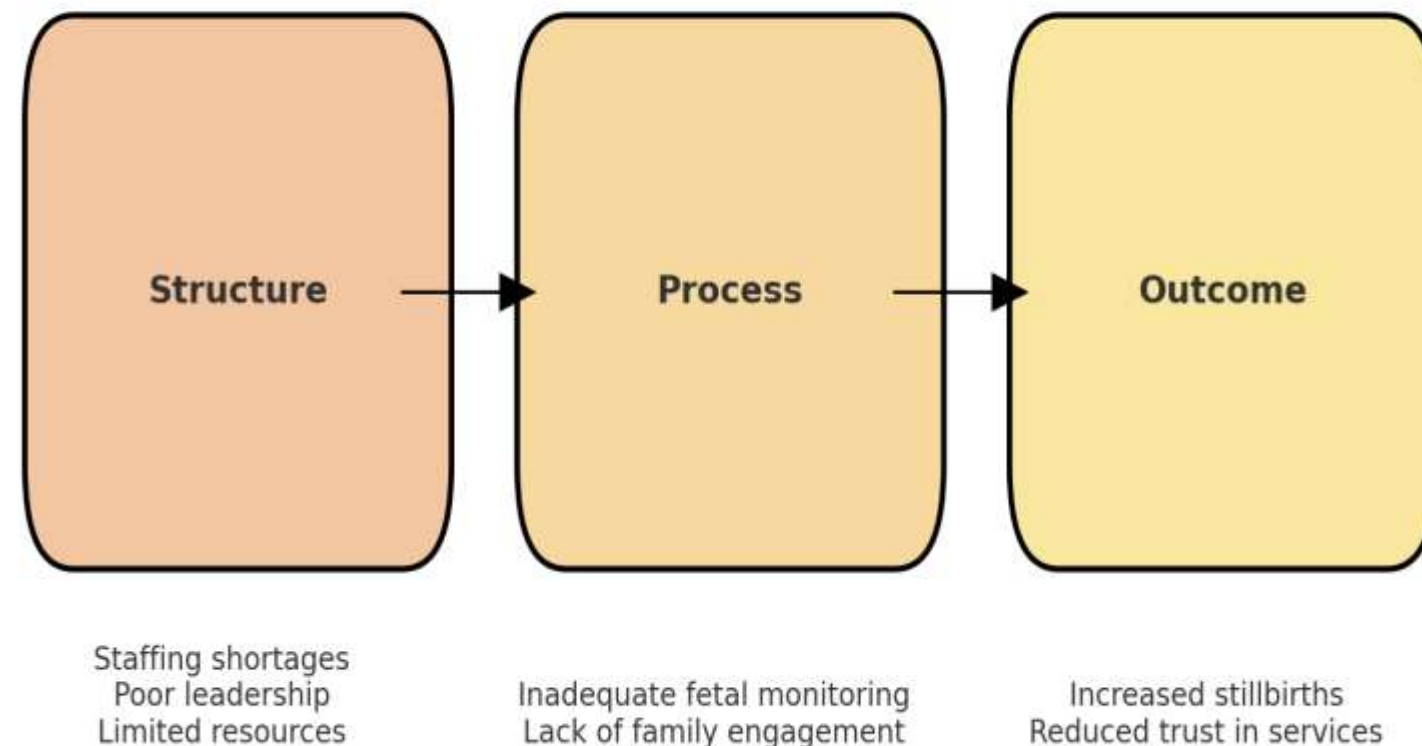
Sources: (Dixon-Woods, 2024).

Cultural and Leadership Issues

- ❖ A “**non-listening and defensive culture**” permeated management (BBC, 2022).
- ❖ Clinicians were silenced when raising safety concerns (Dobson, 2022).
- ❖ Lack of compassionate leadership and ethical accountability (Chambers & Taylor, 2021)
- ❖ Aligns with NHS findings of **toxic blame culture** reducing quality assurance effectiveness.

Donabedian Model Application

Donabedian Model Applied to Shrewsbury & Telford Maternity Scandal

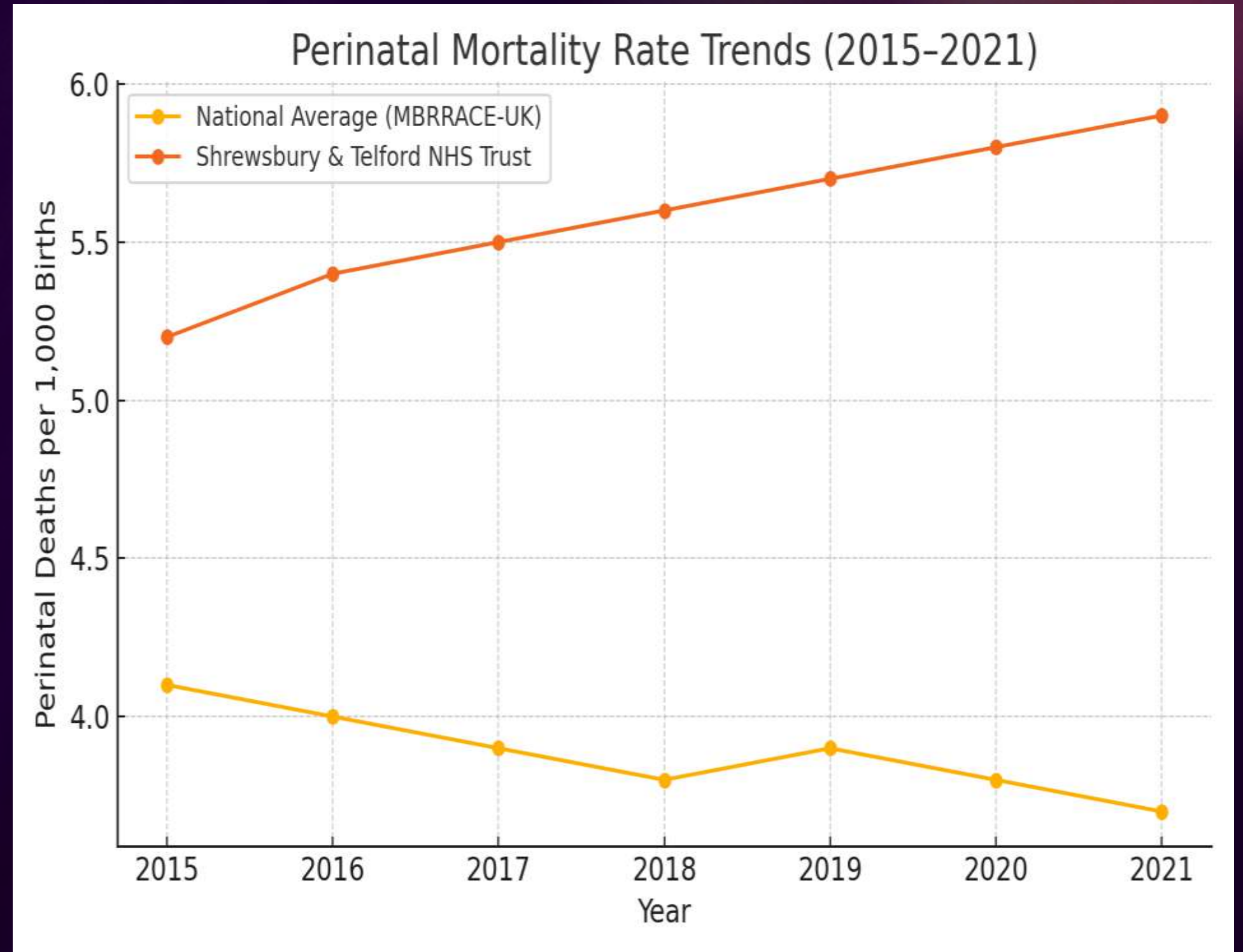


Sources: (McDonagh Hull, 2025).

- **Structure:** Staffing shortages, insufficient leadership training, poor resource allocation.
- **Process:** Ineffective fetal monitoring, lack of family engagement.
- **Outcome:** Increased perinatal mortality and stillbirths (McDonagh Hull, 2025).
- Demonstrates that poor structure and process directly impaired **care outcomes** (Adams et al., 2023).

Data and Trends

- *MBRRACE-UK (2015–2021)* found consistent red flags across maternity units (McDonagh Hull et al., 2025).
- Higher-than-average perinatal mortality rates at Shrewsbury and Telford reflect **persistent QA failures**.
- National comparison shows poor learning from adverse incidents (Dixon-Woods, 2024).



Sources: (McDonagh Hull et al., 2025)

Impact on Service Quality

Aspect	Impact
Quality	Preventable maternal and neonatal deaths (BBC, 2022).
Efficiency	High legal costs and duplicated investigations (Lethbridge, 2022).
Equity	Families denied justice and clear communication (Dobson, 2022).
Trust	Loss of public confidence in NHS maternity services.

Open Disclosure and Learning

- Failure to implement **open disclosure** worsened family trauma (Adams et al., 2023).
- Strengthening disclosure improves transparency, accountability, and trust.
- International evidence suggests **structured disclosure frameworks** enhance safety learning (Adams et al., 2023).

Recommendations

- Establish national QA audits and independent maternity review boards.
- Strengthen **training in incident reporting, RCA, and open disclosure**.
- Mandate adherence to **NHS Maternity Safety Strategy** (Dixon-Woods, 2024).
- Foster a **just culture** encouraging learning over blame (Dobson, 2022).
- Align policy implementation with **patient-centred care models** (Chambers & Taylor, 2021).

Conclusion

- ❖ This case highlights the ethical and functional urgency of the inclusion of learning systems in all NHS Trust to make safety not a dream but a reality.
- ❖ The Shrewsbury and Telford maternity scandal teaches the lesson that the failure of the systemic governance, policy non-adherence, and cultural hindrance may destroy patient safety and trust (BBC, 2022; Dobson, 2022).
- ❖ The Swiss Cheese, Fishbone, and Donabedian models demonstrated that the causes of the issue might be multilayered, and their roots could be found in leadership weaknesses and in the absence of certain elements at the process level (McDonagh Hull et al., 2025; Dixon-Woods, 2024).
- ❖ The case highlights the necessity of caring leadership, open disclosure, and systems of continuous learning to allow avoiding the repetition of the situation (Adams et al., 2023; Chambers and Taylor, 2021).
- ❖ To achieve sustainable maternity care, policy accountability, staff empowerment, and patient-centred governance should be combined in all NHS Trusts (Lethbridge, 2022).

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Thank you