Browne Jacobson

Maternity mock inquest - film 3

This film highlights the importance of creating an open and transparent culture where staff feel able to speak up will help Trusts to identify problematic practise before significant issues arise.

21 July 2021

This film highlights the culture and power dynamics in this fictional maternity unit, which are demonstrated by tension between the midwife and doctor and the impact that this had on the care in this case.

As detailed in the Ockenden Report, Trusts must have clear standard operating pathways on when and how to escalate but there also needs to be a culture whereby staff feel able to escalate their concerns and understand that they will be listened to. This is not just about escalation from midwife to obstetrician, but also registrar to consultant. Creating an open and transparent culture where staff feel able to speak up will help Trusts to identify problematic practise before significant issues arise.

The film also emphasises the importance of organisational learning evidence at inquest to provide the Coroner with assurance so that the statutory duty to issue a Report to Prevent Future Deaths is not triggered. If an organisation can demonstrate learning from the death and evidence that action has been taken to prevent future harm in advance of an inquest this may avoid a PFD Report. However, as highlighted in the Chief Coroner's updated guidance, PFD reports are not intended as a punishment – they are a learning tool, issued for the benefit of the public.

Contact

Mark Hickson

Head of Business Development

onlineteaminbox@brownejacobson.com

+44 (0)370 270 6000

Related expertise

Clinical negligence