IN THE UK COVID-19 INQUIRY
MODULE 3

OPENING STATEMENT ON BEHALF OF 13 PREGNANCY, PARENTING AND BABY ORGANISATIONS

A. INTRODUCTION AND SUMMARY

1. This opening statement is made on behalf of 13 Pregnancy, Baby and Parent Organisations ('**the PBPOs**'). The PBPOs[1] bring together organisations working in early pregnancy, pregnancy, maternity, antenatal, neonatal and postnatal care. They work with policymakers, service providers and perhaps most importantly, the families, women and pregnant people who directly experienced that care during the Covid-19 pandemic.

2. One message from the PBPOs' experiences is clear: the reactive healthcare response to Covid-19 failed to properly value the care of women, pregnant people and newborn babies, and failed the women, pregnant people, and babies who were supposed to be at the heart of that care.

3. These failures have left many women and pregnant people traumatised. They led to partners and fathers being wrongly excluded from the first hours, days, and weeks with their children. They resulted in unbearable choices, such as the parents of neonatal twins who had to choose which parent could visit, and divide the one hour of allocated visiting time between both children;[2] the mother who had to call her partner after emergency surgery to explain that both their babies had died and, due to poor phone signal, had to decide what to do with the embryos' remains alone,[3] or those who simply lost the ability to choose how, when, where, and with whom they would deliver their babies.

4. These failures were not merely missed opportunities to provide preferable or ideal care. As the Royal College of Obstetricians and Gynaecologists ('**RCOG**') has identified, some women received maternity services which were inadequate.[4] Devastatingly, some pregnant women died in potentially avoidable circumstances. MBRRACE-UK's[5] surveillance study

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1 The PBPOs are (1) Aching Arms, (2) Baby Lifeline, (3) Bliss, (4) The Ectopic Pregnancy Trust, (5) Group B Strep Support, (6) ICP Support, (7) The Lullaby Trust, (8) The Miscarriage Association, (9) National Childbirth Trust, (10) Pelvic Partnership, (11) Pregnancy Sickness Support, (12) Tommy's and (13), Twins Trust. The PBPOs refer the Inquiry to their witness statement filed for this Module which introduces the organisations in more detail (Witness Statement of Jenny Ward on behalf of 13 Pregnancy, Baby and Parent Organisations, dated (11 Jan 2024), "**PBPO Statement**", [INQ000408656], §§6-37).

2 PBPO Statement, §139 [INQ000408656_0042].

3 PBPO Statement, §164 [INQ000408656_0049].

4 Witness Statement of Dr Edward Morris on behalf of the RCOG (21 Sep 2023), §113 [INQ000470853_0041].

5 'Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK'.

(2019 – 2021) on maternal deaths and morbidity[6] found that Covid-19 was the leading cause of maternal death in the UK, disproportionately affected Black and Asian ethnic minority women, and found that improvements in care may have made a difference for 76 per cent of those maternal deaths from Covid-19.[7] These were failures to ensure adequate care was given to pregnant women and people; amplified by an already under-resourced system in which women and minorities' voices were routinely dismissed.

5. These failures were also not merely a result of an inevitable struggle to respond to a novel virus. MBRRACE-UK's surveillance study found that clear guidance from RCOG and Royal College of Midwives (**'RCM'**) on the treatment of Covid-19 in pregnancy was either not known about or not applied.[8] As the PBPOs emphasise throughout this opening statement, these errors appear to have been the result of structural failures to pay attention to, prioritise, and provide sufficient resources to, the safety of pregnant women and people and their babies, and to ensure that overstretched healthcare staff provided adequate care.[9]

6. The failures were not quickly identified, nor remedied. Following the first period of lockdown, and the failings which should have been obvious by that stage, too little was done to ensure that pregnant women and people, new mothers, and babies – particularly those admitted to neonatal care immediately after birth – were adequately considered. Visiting restrictions continued to affect pregnant women and people for prolonged periods including when public restrictions had eased and even while the public were being encouraged to "*Eat out to Help out*" [see §29 below]; as did restrictions on parents being able to spend time with their sick newborn babies in neonatal intensive care.

7. Babies, parents, and families ought to be specifically considered, prioritised, and protected in a pandemic. The PBPOs hope to assist the Inquiry in making meaningful recommendations which will stop the identified failures repeating themselves in any future public health emergency. The PBPOs also wish to share with the Inquiry the direct experiences of women, pregnant people, fathers and partners, and babies during the pandemic. One reason the PBPOs are participating in the Inquiry is to prevent repetition of those experiences. It is all the more important that their stories are at the forefront of the Inquiry's work in Module 3.

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6 MBRRACE-UK, 'Maternal, Newborn and Infant Clinical Outcome Review Programme, Saving Lives, Improving Mother's Care - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-21' (October 2023) "**MBRRACE-UK 2019-21 Report**" [INQ000399403].

7 MBRRACE-UK 2019-21 Report, pp i, vi, 60 [INQ000399403_0005, 0010, 0078].

8 MBRRACE-UK 2019-21 Report, pp 54 [INQ000399403_0072].

9 One telling example of the relative prioritisation given to visiting issues for pregnant women and people that in May 2020, the question of whether to allow visitors for hospital in-patients was raised in an email discussion between Department of Health and Social Care staff, No 10, the Chief Medical Officer, and the Chief Scientific Adviser alongside the issue of zoos and visitor farms, other outdoor venues and (at least one other health issue) dentistry [INQ000069482_0003].

B. RESTRICTIONS ON ACCESS TO SERVICES FOR PREGNANCY AND BABY-RELATED CARE

8. The PBPOs welcome the Inquiry's commitment to exploring antenatal and postnatal care, the quality of maternity care and services, and the treatment for complications in pregnancy, as set out in the Issues List. The PBPOs reiterate that despite the colloquial use of "maternity" as a catch-all for the care of pregnant women and people, healthcare treatment surrounding pregnancy extends more widely. The PBPOs urge the Inquiry to give attention to the distinct impacts of the healthcare response to Covid-19 on early pregnancy (such as ectopic pregnancy or miscarriage and who are cared for in specialist early pregnancy units or outside of hospitals); antenatal care (care given during pregnancy); neonatal care (the care of babies immediately after birth, for example if born early or sick and admitted to hospital); and post-natal care (at a minimum, up to 6 weeks' post-birth care). Each of these was affected by Covid-19.

9. Similarly, it is important to note that although some CPs, and the Inquiry, have used the umbrella term of 'pregnant women' the experiences of pregnant women during the relevant period were shared by all pregnant people. References to pregnant women (in the Inquiry and where used in this statement) must be understood inclusively to include pregnant people.

Quantifying the impacts of access to services

10. The PBPOs note there is limited NHS-wide information about the extent to which maternity, early pregnancy, ante, post and neonatal services were affected due to Covid-19 (directly or indirectly) despite significant concerns being raised by women and families about their experiences from the outset of "lockdown". No doubt this is a result of varied provision of services nationally, but the PBPOs also note the apparently limited quantitative data collected throughout the pandemic.

11. Between late April to May 2020,[10] NHS England began requesting maternity service 'SitReps' (situation reports) of high-level data from each Trust providing intrapartum maternity services. However, these by definition did not address neonatal or early pregnancy care, despite those being equally fundamental services.[11] In Scotland, an initial request for information was not made to Boards until June 2020 but a deliberate decision was also made not to repeat this request, primarily for resourcing reasons.[12] The result, as the Director General of Health and Social Care Caroline Lamb frankly acknowledges, is that "*there is no systematically collected national data covering the delivery of maternity services* [in

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[10] See Witness Statement of Dame Ruth May, Chief Nursing Officer for England (17 May 2024), §324 [INQ000479043_0070] but cf: Witness Statement of Sir Stephen Powis for NHS England (31 May 2024), §1129 [INQ000485652_0300].

[11] Neonatal care reporting questions were only added on 9 June 2021, see 'Maternity transformation programme COVID-19 response and recovery SitRep summary slides' (7 Oct 2021) [INQ000421197_0010].

[12] Witness statement of Caroline Lamb on behalf of the Director General for Health and Social Care (18 June 2024), §§93-94 [INQ000485984_0031].

Scotland]".[13] This prevents systematic analysis of gaps in services. The Inquiry may consider that this lack of information reflects a wider lack of resourcing and attention to maternity-related issues.

Impacts of inability to access services in hospitals and clinics and choice of birth

12. The findings of MBRRACE-UK (see above at §4) are important. They conclude that improvements in care may have made a difference for 76 per cent of pregnant women and birthing people who died from Covid-19. That is an indictment of systemic failures in the provision of care to pregnant women and people during this period. In particular, the MBRRACE report found there were difficulties communicating new guidelines to frontline staff, who were overstretched before the pandemic and then overwhelmed by the proliferation of new information.[14] The study also found that Covid-19 added to existing pressure in the system and resulted in surgeries being delayed or performed without supervision by more senior staff.[15] The PBPOs echo the comments of RCOG and the RCM:[16] healthcare workers were not given the support and resourcing they needed to ensure pregnant women and birthing people received adequate treatment and care.

13. As well as failures to convey information about appropriate treatments, the PBPOs agree with the findings of MBRRACE-UK that Covid-19 caused a skewing of priorities: "*all other risk factors became secondary to the possibility of [Covid-19] infection*".[17] This was true both in the provision of individual care and at a systemic level. It is reflected in the initial redeployment of maternity staff,[18] despite purported recognition by NHS England that maternity and neonatal services were "*required 24 hours a day, 7 days a week, on demand*";[19] and a commitment to completely ringfence maternity staff in at least Northern Ireland, Wales and Scotland by 7 April 2020.[20] In Northern Ireland, a system for reconfiguring critical capacity care that was intended to protect children and maternity services resulted in the removal of inpatient maternity services altogether at one hospital and reduced services at another and was reached without apparent input of midwifery staff.[21] In this regard, the

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[13] Witness statement of Caroline Lamb on behalf of the Director General for Health and Social Care (18 June 2024), §§95 [INQ000485984_0032].
[14] MBRRACE-UK 2019-2021 Report, p 53-54 [INQ000399403_0071, 0072]
[15] Ibid, p 45 [INQ000399403_0063].
[16] Witness Statement of Dr Edward Morris, see e.g. §89, §93 [INQ000470853_0034]; Witness Statement of Gil Walton for the Royal College of Midwives (17 November 2023), at e.g. §64 [INQ000347411_0023].
[17] MBRRACE-UK 2019-2021 Report, p 46 [INQ000399403_0064].
[18] Witness Statement of Dr Edward Morris, §§89 – 93 [INQ000470853_0034].
[19] Witness statement of Sir Stephen Powis, §1135 [INQ000485652_0301]; see also Witness Statement of Judith Paget (Wales) at §527 [INQ000486014_0185]. The World Health Organisation and International Confederation of Midwives issued guidance which confirmed that pregnancy and birth were "essential" health services which should not be redeployed [INQ000339579].
[20] See email chain between RCM staff members regarding the redeployment of midwives outside of maternity (7 April 2020) [INQ000339579].
[21] Email from Karen Murray to Charlotte McArdle (Department of Health Northern Ireland) and HSC colleagues, regarding Paediatric Surge Plan (8 April 2020) [INQ000360955].

PBPOs invite the Inquiry to find that the lack of attention and prioritisation of maternity and related services was indicative of structural failures to recognise the importance of continued care for women, pregnant people and children.

Staff shortages

14. Staff shortages had a major impact on the provision of services and notably on the choices pregnant women and people could make about where and how to give birth. As early as 23rd March 2020, the Chief Nursing Officer (**'CNO'**) for England was informed that London Ambulance Services had advised that it could no longer guarantee that ambulances would be available to attend to homebirths or a woman giving birth in a standalone birth centre if an obstetric emergency occurred.[22] She was also informed that epidurals might not be available if anaesthetists were required to attend to Covid-19 patients, and about the potential closure of midwifery led units and standalone birthing units, as NHS Trusts began to rationalise and centralise care. By 2 April 2020, many of those closures had been implemented. Decisions, it appears, were taken at a local, clinical level and without NHS England oversight.[23]

15. Due to the limited data, it is to some extent impossible to quantify how many women and pregnant people were impacted by the restrictions on the availability of birth settings (as the CNO for Scotland has recognised).[24] However, the impacts were clearly widespread. In April 2020, 57% of homebirth services were closed in England.[25] The choice and control over birth settings is part of good clinical care and encouraging autonomy and control toward a safe birthing event,[26] and restrictions on birth settings had a seriously detrimental impact on pregnant women and people.

16. More broadly, in late November 2020, 24 NHS Trusts across England were reporting that Covid-19 was impacting on the maintenance of safe staffing levels in maternity services.[27] This did not improve in the second wave of the pandemic. Indeed, it had deteriorated by 6 October 2021, when 66 trusts were reporting that Covid-19 was impacting on the maintenance of safe staffing levels.[28]

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[22] Witness Statement of Dame Ruth May, Chief Nursing Officer for England (17 May 2024), §319, [INQ000479043_0068], citing the 'Risks and concern document' sent from Jacqueline Dunkley-Bent, Chief Midwifery and National Maternity Safety Champion and colleague to Ruth May, CNO (23 March 2020) [INQ000421159].

[23] Witness Statement of Dame Ruth May, CNO for England (17 May 2024), §321, [INQ000479043_0070].

[24] Witness Statement of Fiona McQueen, former CNO for Scotland (17 June 2024), §166 [INQ000474225_0050].

[25] Witness Statement of Dame Ruth May, §326 [INQ000479043_0071].

[26] Aydin et al, 'Giving birth in a pandemic: women's birth experiences in England during COVID-19' BMC Pregnancy and Childbirth (10 April 2022), p 9 [INQ000308968_009].

[27] Department of Health and Social Care, 'Weekly Maternity SitRep - 07.12.2020, reporting on COVID-19 related maternity headlines and statistics' (7 Dec 2020). [INQ000409877_0002].

[28] Department of Health and Social Care, 'Weekly Maternity SitREP, reporting COVID-19 related maternity headlines and statistics' (6 Oct 2021) [INQ000409885_0003].

Limitations on access to care

17. There were also limitations on access to care, especially face-to-face care, for miscarriages and ectopic pregnancies. In respect of ectopic pregnancy, access to non-surgical treatments, and to laparoscopic surgery, was reduced due to Covid-19 related restrictions, in the latter case requiring women to have more invasive procedures.[29] NHS England confirm that the approach during the Covid-19 pandemic was only to consider surgical management if no other management option was feasible.[30] Much like visiting guidance, even once medical guidance indicated services could be resumed with proper infection prevention and control ('**IPC**') measures,[31] it took time for different hospitals to reinstate provision.

18. A Miscarriage Association study found that only 58 per cent of respondents who experienced pregnancy loss from 1 April 2020 and 4 July 2021 were given a choice of treatment for their loss (e.g. between medical or surgical management), with 40 per cent saying they ultimately did not receive their preferred management method.[32] One woman[33] was told that she had miscarried but that surgical removal of pregnancy tissue was only available once per week and was booked out. She either had to wait or go through medical management at home without medical supervision. She had no access to childcare. She began bleeding onto the bathroom floor. She called the ward for help and was told to stay at home and to keep the "*product of miscarriage*" in the fridge for two days before she was allowed to attend a clinic. In the end, the medical treatment failed and she had to wait a further week to then be admitted for follow-up surgery. It is perhaps not surprising that she reports that her experience was emotionally scarring. There are many other similar accounts. The PBPOs submit that the Inquiry must focus on the experiences of the pregnant women and people who were unable to access necessary services. Their stories are deeply distressing, but they are central to the Inquiry's work.

19. In August 2020, the APPG on Baby Loss called on NHS England and the Department of Health and Social Care to swiftly reinstate treatment options for pregnancy loss in all NHS Trusts. It is regrettable that NHS England's corporate witness statement summarises this report but says nothing about any response or action taken on this recommendation.[34]

Post-natal and bereavement support

20. One of the major impacts of Covid-19 was the limited ability to provide face-to-face care, particularly in the community including once people were discharged home. There was reduced access to midwives and health visitors, alongside an absence of direct family

[29] PBPO Statement, §§68-70 [INQ000408656_0021].
[30] Witness Statement of Sir Stephen Powis, §1180 [INQ000485652_0320]
[31] PBPO Statement, §§67-72 [INQ000408656_0020].
[32] PBPO Statement, §58 [INQ000408656_0017]
[33] PBPO Statement, §59 [INQ000408656_0017].
[34] Witness Statement of Sir Stephen Powis, §§1183-1184 [INQ000485652_0322].

support.[35] This left many new mothers and families isolated. It further impacted bereavement care and support including through lack of access to specialist bereavement trained midwives, many of whom seem to have been redeployed to address pressures elsewhere in the system.[36] Again, the PBPOs submit these are not merely matters of preferential care or care ancillary to healthcare treatment. Post-natal support and bereavement care require qualified support from specialist healthcare providers.

21. It is understandable that some face-to-face support would need to be restricted during the pandemic. However, without either face-to-face support from specialists, or from friends and family, women and their partners could not access effective bereavement care. Given that baby loss did not stop due to Covid-19, the result was that parents went without support. Some hospitals continued to apply rigid policies to bereaved families, meaning some parents were unable to take photographs of their deceased children or to spend time sitting and holding their child in the hospital.[37] Beyond a lack of flexibility, the PBPOs suggest this reflected a lack of adaptation of bereavement care standards over the course of the pandemic. The Inquiry should treat bereavement and post-natal support as a crucial form of pregnancy-related healthcare provision, as should the NHS and all healthcare providers in the future.

Restrictions on pregnant women and people's willingness to engage with services

22. The PBPOs have submitted evidence which shows that women and pregnant people expressed consistent fear of Covid-19, and that this discouraged some who ought to have sought early pregnancy or maternity care.[38] Healthcare Safety Investigation Branch ("**HSIB**") national learning reports into maternal deaths found that the broad "*safety netting*" advice caused delays in seeking healthcare and that pregnant women and people put off going to hospital due to concerns about their health or the risk of exposing their unborn baby to COVID-19 and the requirement to attend hospital alone.[39] Other evidence indicates that more women decided to "*freebirth*", i.e. give birth without healthcare support, due to fears of going into hospital and the lack of maternity services.[40]

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35 See, in addition the PBPO Statement at §§86, 91-92, 110-113, 185, Witness Statement of Alison Morton, CEO of the Institute for Health Visiting (7 April 2024) [INQ000411557].

36 PBPO Statement at §185 [INQ000408656_0055]; see also Baby Lifeline, 'Mind the Gap' (November 2021), [INQ000399402_0050].

37 Thomson et al, 'Companionship for women/birthing people using antenatal and intrapartum care in England during COVID-19: a mixed-methods analysis of national and organisational responses and perspectives' (British Medical Journal Open, 1 December 2021) [INQ000236184_0008].

38 PBPO Statement, §§40-44 [INQ000408656_0017].

39 Healthcare Safety Investigation Branch [HSIB], 'Maternal death: learning from maternal death investigations during the first wave of the COVID-19 pandemic' (February 2021) [INQ000216631]; Witness Statement provided by Dr Rosie Benneyworth on behalf of HSIB (20 Nov 2023), §1.63 [INQ000347443_0017].

40 See e.g. research by Kings College London: Greenfield et al 'Between a rock and a hard place: considering 'freebirth' during Covid-19' (2021) [INQ000216632]; concerns were still being raised in Northern Ireland about increases in freebirthing in September 2021, see Chair's brief, Swansea Bay UHB IQPD meeting, regarding Unpublished waiting time performance position (15 November 2021) [INQ000412564].

23. The PBPOs submit that this was at least partially due to failures in the communication and clarity about the relevant risks in pregnancy and the need for pregnant women and people to continue seeking healthcare. The Inquiry must look at how information was communicated during the course of the pandemic and how this contributed to confusion and misunderstanding in how pregnant women should engage and seek care.

24. The CNO for Scotland acknowledges that the response to Covid-19 involved "*linear*" decisions focused on "*how to create capacity in the NHS to save lives and provide access to clinical care rather than how to prevent the virus from circulating by the use of border control, earlier lockdown, testing and tracing*".[41] She acknowledges that decision-makers did not focus on the "*aftermath*" of reducing most NHS services, nor did they consider how NHS services could be altered rather than entirely reduced. She accepts that it may have been beneficial to change restrictions so that new mothers received additional in-person support from family and friends.[42] The PBPOs hope other senior healthcare decision-makers will also frankly reflect in this Inquiry on the extent to which reactive steps to protect capacity were taken at the expense of pregnancy-related and newborn healthcare needs.

C. "VISITORS": PREVENTING PREGNANT WOMEN, PEOPLE AND BABIES FROM RECEIVING SUPPORT

25. IPC measures were a necessary part of promoting safety in healthcare settings during the pandemic. However, it is also clear that the decisions to impose restrictions on visitation and support as a primary IPC measure caused disruption and distress to pregnant women, pregnant people, babies, and their families. The PBPOs remain concerned that visiting restrictions were imposed without sufficient care and without appropriate weight being afforded to the harms caused by isolating women and birthing people and/or their babies.[43] The PBPOs submit that the Inquiry should closely scrutinise decision-makers' understanding of the IPC risks in early pregnancy, maternity and neonatal care, the proportionality of the restrictions imposed, and (centrally) the impacts of those restrictions.

Impacts of "visiting" restrictions

26. The restrictions on people entering hospital wards did not merely mean that "visitors" were excluded. It is not controversial, and was eventually recognised across the UK in various iterations of visiting guidance, that birthing partners are an essential part of the caregiving team for the pregnant woman or birthing person.[44] One study concluded that "*widespread changes to services caused unintended negative consequences including essential clinical*

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41 Witness Statement of Fiona McQueen, §208 [INQ000474225_0059]
42 Ibid.
43 PBPO Statement, §217 [INQ000408656_0064].
44 See, for example, Welsh visiting guidance (20 July 2020) [INQ000299514_0010]; English visiting guidance (14 December 2020) [INQ000330895]; Scottish visiting guidance (13 July 2020) [INQ000468048]; Northern Ireland (6 July 2020) [INQ000103666].

care being missed, confusion over advice, and distress and emotional trauma for women" and had "*exacerbated previously reported failings in hospital based postnatal care*".[45]

27. No single story can be representative, but it is important to translate findings into real-world impacts. One woman on a post-natal ward described that, without anyone to provide support, she had to rely on overworked staff, who she tried to call sparingly as they were so busy. She could not initially pick up her baby so had to rely on midwives or catering staff to pass the baby to her. No one helped her to have a shower for over 24 hours. That was the only shower she had during her five days on the ward as no one offered her further help. There was no one to watch her baby when she was more mobile and was able to take herself to the bathroom, which was painful and slow due to her injuries. She explained, "*I was extremely worried about the baby the whole time I was in there. Once home I heard babies crying every time I ran a tap in my bathroom for several days.*"[46]

During birth and antenatal screening

28. Much of the guidance, and subsequent monitoring, reported that all women and pregnant people were allowed a birth partner as support *during labour*. That consistent refrain is somewhat misleading. The policy imposed in many hospitals was that a birthing partner was only permitted during active labour. As at 16 July 2020, only 19% of units allowed partners to attend antenatal scans, and although 97% of units were allowing partners to attend births to an extent, half of these units only allowing partners once active labour "*was confirmed*".[47] It takes time to reach active labour (typically, when dilated to 4 or 6cm) and different hospitals took different approaches to defining what this meant in practice.[48] One result was that some women and pregnant people felt coerced into vaginal examinations to determine if labour was sufficiently "*established*" for partners to enter.[49] One woman reported that her partner missed the birth entirely, as he had been waiting at home because he wasn't allowed into the hospital until she was 4cm dilated.[50] These experiences caused significant distress and may have been avoidable.

29. Other women's care suffered because they had no family or support people available to help them understand what was being said to them by staff. HSIB national learning reports, which indicated a rise in stillbirths during Covid-19, identified that around 43 per cent of the birth incidents they investigated involved a mother who did not speak English as a first language

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45 Sanders et al, 'Anxious and traumatised": Users' experiences of maternity care in the UK during the COVID-19 pandemic' *Midwifery Journal* (8 June 2021), p 5 [INQ000308999_0006].

46 Ibid, p 5 [INQ000308999_0006, 0005].

47 Witness Statement of Dame Ruth May, §354 [INQ000479043_0076].

48 Sanders et al, 'Anxious and traumatised', *Midwifery Journal* (8 June 2021), p 4 [INQ000308999_0005].

49 Thomson et al, 'Companionship for women/birthing people using antenatal and intrapartum care in England during COVID-19: a mixed-methods analysis of national and organisational responses and perspectives' (British Medical Journal Open, 1 December 2021) [INQ000236184_009] and Witness statement of Shanthi Gunesekera and Janaki Mahadevan on behalf of Birthrights (14 Aug 2023), §3.3.3 [INQ000239418_0007].

50 Sanders et al, 'Anxious and traumatised' *Midwifery Journal* (8 June 2021), p 4 INQ000308999_0005.

and half of those women had been unable to access an interpreter. For four women, it materially affected the care they received.[51] These findings reflect that a birth partner is there for support, not merely as a visitor, but a crucial part of safe healthcare.

30. Dame Ruth May, CNO for England acknowledges that restrictions may not have taken into account "*the full range of activities on the maternity journey where a partner could offer their support*", or the fact that, in parallel, restrictions were easing in the community.[52] This is an understatement. It is notable that women were being denied support in the hours after giving birth and parents were being denied access to their sick babies in neonatal care, at a time when people could meet in groups of up to 30 and when, at the start of August, the Eat Out to Help Out scheme launched.[53]

31. The Inquiry may also find it surprising that these restrictions were being imposed on support partners when the vast majority of them shared the same risks of exposure as their pregnant partner. Pregnant women had been classified as 'clinically vulnerable' and encouraged to stringently minimise social contact; logically, many of their partners were following the same guidance. It is not clear why support partners were treated as a significant additional risk. The Inquiry should examine the clinical justifications for, and the proportionality of, the restrictions placed on allowing pregnant women and people a support person during all forms of care.

Other pregnancy-related and bereavement care

32. The restrictions did not just affect women giving birth. Women and pregnant people who required treatment for ectopic pregnancies, were experiencing pregnancy sickness such as hyperemesis gravidarum, or who suffered pregnancy loss and bereavement also had to experience diagnosis, care and treatment alone, which sometimes included having to be given the devastating news that their baby had died without appropriate emotional support.

Neonatal care

33. Similarly, in the context of neonatal care, parents are not "visitors": they are primary caregivers, whose involvement in care delivery and decision-making is crucial to babies' short and long-term developmental outcomes, as well as supporting good attachment and bonding. Newborn babies admitted to neonatal care need their parents with them. They need to hear their voices, and be comforted by their touch and constant presence, just as much as healthy new babies do in their first days, weeks and months of life. However, hospitals typically treated these parents in the same way as other hospital visitors, meaning significant

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[51] HSIB, 'Intrapartum stillbirth: learning from maternity safety investigations that occurred during the COVID-19 pandemic, 1 April to 30 June 2020' (Sept 2021), §5.5.18 [INQ000176655_0079].

[52] Witness Statement of Dame Ruth May, §355 [INQ000479043_0076].

[53] BBC, 'Eat Out to Help Out: What was the impact of the scheme?' (11 December 2023), available at: https://www.bbc.co.uk/news/uk-67658106.

restrictions on the amount of time parents could be with their babies, in some cases for as little as two hours a day, and often restricted to one parent only. This cause immeasurable harm to family attachment and bonding. One mother of a child in neonatal care told Bliss, *"[I felt] Like I wasn't her mum. Like someone else was raising my baby. Like me and her dad weren't important enough to be there. All of the 'firsts' I should have been able to do with my baby were taken away from me."*[54]

34. Despite referring to neonatal parents as being partners in care not merely visitors, it is notable that NHS England's corporate witness statement continues to assert that visitor restrictions were necessary because "*the health, safety, and wellbeing of patients and staff had to remain the priority*".[55] The PBPOs remain concerned that healthcare decision-makers did not understand or properly weight the holistic health, safety and wellbeing of pregnant women, babies and their families. The absence of a support partner could, and clearly at times did, undermine the healthcare provided to pregnant women and people; as did the absence of access for parents to their babies in neonatal care.

Failure to adjust visiting rules over time or to address local variations in case rates

35. The PBPOs submit that the welfare of pregnant women and people, new mothers and vulnerable young babies ought to have been given more weight in decision-making from the outset. However, it is particularly concerning that decision-makers failed to respond once the problems with visiting restrictions became clear.

36. NHS England issued guidance limiting visitors to hospitals from 16 March 2020; on 25 March 2020 after the first lockdown began, visiting was suspended, with limited exceptions. That suspension was eventually lifted and on 6 June 2020, NHSE implemented guidance for each individual trust.[56] It is not practical for the PBPOs to outline in detail the changes in national guidance or the varied approaches taken at local levels. It will be clear to the Inquiry through examining the approaches taken by the spotlight hospitals and the experiences women and families have shared with the Inquiry that what happened, in effect, was a postcode lottery.

37. There was long delay in publishing national guidance. Wales, Scotland and Northern Ireland did not issue national guidance until early to mid-July 2020.[57] NHSE did not publish any guidance until December 2020.[58] The Inquiry may consider this to be surprising given the significant media outcry about the treatment of pregnant women, pregnant people and parents

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[54] PBPO Statement, §133 [INQ000408656_0041].
[55] Witness Statement of Sir Stephen Powis for NHS England (7 February 2024), §699 [INQ000412890_0182].
[56] See overview in Witness Statement of Sir Stephen Powis, §§690-691 [INQ000412890_0180].
[57] COVID-19 National Incident Response Board, 'Meeting minutes re: National guidance on the reintroduction of visitors and accompanying adults to inpatient and outpatient maternity services' (17 August 2020) [INQ000421230_0006].
[58] NHS Guidance, 'Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers' (14 December 2020), [INQ000330895].

of babies in neonatal care and the demands of frontline healthcare professionals for clear guidance they could justify.[59] When the NHSE document finally arrived (at almost the peak of the second wave), no aspect of it was mandatory. Individual trusts retained latitude to impose their own rules. It appears this was a deliberate modification to accommodate concerns raised by the RCM and RCOG and from Deputy CMO, Dame Jenny Harries.[60]

38. Visiting restrictions caused pregnant women, pregnant people and new parents significant stress and fear. This was only heightened by the inconsistent and confusing way these rules were applied across the UK, alongside the poor communication of those rules. The Inquiry should explore the reasons for the delay in providing national guidance and the failure to ensure consistency across healthcare providers.

39. It is not a sufficient answer for national level decision-makers to attribute blame to (a) local level decision-makers for restrictive rules implemented given there was no mandatory national guidance, or (b) access to sufficient or appropriate PPE, or (c) lack of testing, or (d) insufficient resourcing and training for local decision-makers and staff. Nor, however, is an answer for local decision-makers to point to staff concerns over Covid-19 as a rationale for their decisions.

40. For the reasons that follow, the Inquiry should examine why pregnant women's and newborn babies' health was not prioritised, including access to care and support, and why creative solutions reflecting a proper analysis of IPC risks could not be found.

Alternative mitigations

41. It is evident that visiting restrictions were imposed, at least in part, to protect healthcare staff from the risk of infection at work. Given the serious impact of visiting restrictions, however, it is concerning that professional bodies like the RCM felt that their ability to provide maternity services and women's access to maternity healthcare was impacted by the availability of suitable PPE.[61] Clearly, PPE shortages will have aggravated staff anxieties. The PBPOs consider that the Inquiry ought to explore whether alternative IPC measures to blanket visiting restrictions were considered and whether PPE shortages played a role in the continuation of the blanket bans amongst local NHS trusts.

42. The PBPOs note that Dame Jenny Harries (in the context of the December 2020 visitor guidance, see above at §36) cast doubt on proposed approaches to use lateral flow testing

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[59] See, by way of example, recognition of that outcry by the RCM, Witness Statement of Gil Walton, §§37-38 [INQ000347411_0015].

[60] See various emails between Private Secretary to the Chief Medical Officer and various recipients (30 Nov 2020 – 2 Dec 2020) [INQ000071972].

[61] Witness Statement of Gil Walton, §46 [INQ000347411_0018]; see e.g concerns raised about midwives caring for "*women in labouring rooms with partners present, close proximity for up to 11/12 hours per shift*," without any PPE unless there was a confirmed case of Covid-19, or a suspected/exposed risk; Witness Statement of Gerry Murphy for the Irish Congress of Trade Unions (23 Jan 2024) at §36 [INQ000409079_0013].

where social distancing was not possible.[62] The Inquiry will, no doubt, be familiar with the widespread use of lateral flow testing devices across the United Kingdom including, just a few months later in March 2021, for healthcare workers entering care homes.[63] Again, the PBPOs submit that the Inquiry should investigate whether visitor restrictions for those giving birth, meeting their babies for the first time, or caring for sick babies were proportionate and reasonably necessary for IPC.

43. Further, the CNO for Scotland has indicated that where the Scottish Government became aware of variations or restrictive practices locally, they sought explanations, and in some cases, reviewed decisions or sought alternatives.[64] Although the PBPOs are not aware of particular impacts of that approach, it is at least a welcome example of proactive oversight of local decision-making. The Inquiry is invited to explore how such reviews operated and whether other parts of the UK could have adopted a more proactive approach to assessing the need and justification for local level restrictions.

D. INEQUALITIES IN CARE OF PREGNANT WOMEN, PEOPLE, AND BABIES

44. The PBPOs are very concerned about areas of inequality which emerged in the delivery of early pregnancy, maternity care and neonatal services during the pandemic. In many instances, this was not new, but an exacerbation of patterns of inequality and exclusion previously noted in maternity, early pregnancy and neonatal services, such as the disproportionate negative impacts on Black, Asian and other ethnic minority groups.[65]

45. Areas of inequality during the main period of the Covid-19 pandemic included (a) the treatment of young babies, who experienced long periods of separation from at least one of their parents, with possible long-term impacts; (b) the treatment of people with disabilities, including in communicating without adequate support and through face masks; (c) relating to sex and gender, given the disproportionate exclusion of fathers and non-birthing parents from contact with their babies in neonatal care; (d) financial, given the greater impact on lower income families who could not seek private scans or treatment; (e) those experiencing digital poverty, who were excluded from many online and technological substitutes used in place of face-to-face care; (f) ethnicity and race, given the majority of women who died from Covid-19 in 2020 and 2021 were from ethnic minority groups and the particular communication challenges for those for who do not speak English as their first language, (g) women from migrant communities and those seeking asylum, who already find it difficult to

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62 See emails on behalf of Jenny Harries to the Private Secretary for Minister Nadine Dorries (30 Nov 2020 – 2 Dec 2020) [INQ000071972].

63 See e.g. NHS Guidance, 'Testing for professionals visiting care homes' (issued March 2021), available at https://www.gov.uk/government/publications/coronavirus-covid-19-lateral-flow-testing-in-adult-social-care-settings/testing-for-professionals-visiting-care-homes.

64 Witness Statement of Fiona McQueen, §171 [INQ000474225_0052]

65 PBPO Statement, §§213-214 [INQ000408656_63].

seek and access medical assistance, a situation which was exacerbated by the pandemic and (h) Gypsy/Roma/Traveller communities.

46. By way of example, the Welsh Government-commissioned Report on the impact of Covid-19 on disabled people in Wales[66] found that maternity services had been "*uneven*" across health boards in Wales and that there had been increased levels of stress, anxiety, mental health distress and baby loss amongst all women generally. In respect of disabled women in particular, the effects were more serious: disabled women had problems conveying genuine needs to be accompanied by partners or advocates during care and securing reasonable adjustments and deaf women struggled with the use of telephone appointments by health visitors. The report concluded that it would be "*necessary to assess the long-term effects on future generations of inadequate and inaccessible maternity services*". The PBPOs submit this is precisely what the Inquiry should consider: the long-term impact on future generations of the inequities in maternity and neonatal care which were further 'baked in' throughout the pandemic.

E. PPE, CARE AND CONTACT WITH BABIES, AND IMPACT ON FAMILIES

47. One women, whose baby was in the neonatal ward, said PPE made her feel cut off from her baby: "*she's 8 weeks old and I haven't kissed her yet*".[67] Another woman understood the need for safety, but "*couldn't kiss my baby or even smell him or just simply rest my cheek on his head*".[68] These are extraordinary and upsetting experiences for any parent.

48. In addition, medical professionals have recognised that masks potentially posed a barrier to healthy parent-infant relationships and to infant development. However, again, the system seems to have been slow to shift from blanket restrictive approaches. The British Association of Perinatal Medicine ('**BAPM**') recommended Trusts consider allowing asymptomatic parents to remove their masks for periods of skin-to-skin care and when providing close care due to the critical nature of parental facial recognition in early infant development and risks to family bonding and attachment.[69] The Royal College of Paediatrics and Child Health ('**RCPCH**') also called for IPC risks to be balanced against the potential harms to infant development. They noted that, given parents and their baby were one 'bubble' (linked household), there was likely to be limited extra protection in parents wearing a mask around their babies.[70] Again, safety from Covid-19 for neonates and those caring for them is

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66 'Report on the impact of COVID-19 on disabled people in Wales', commissioned by Jane Hutt, Minister for Social Justice, from the Disability Equality Forum (March 2021) [INQ000350302].
67 PBPO Statement, §126 [INQ000408656_0038].
68 PBPO Statement, §126 [INQ000408656_0038].
69 British Association of Perinatal Medicine, 'Covid-19 Pandemic, Frequently Asked Questions with Neonatal Services' (updated Jan 2022), p 18 [INQ000399378_00020]
70 Bliss Statement: Covid-19 and parental involvement on neonatal units (updated 7 January 2021), citing RCPCH, 'Guidance for Neonatal Settings' (2020) [INQ000399377_00019].

paramount, but a mother and father were not visitors or 'optional extras' - and were often not going anywhere other than to be with their babies.

49. Again, there seems to have been a failure to consider the wider health consequences of imposing blanket rules in the name of general 'public health'. The PBPOs note the recognition by the Scottish Government, as early as November 2020, that parents ought to be offered opportunities to remove face masks when it was safe to do so, to encourage bonding and skin-to-skin contact.[71] This was not widespread. Particularly as the pandemic continued across the months and years, the Inquiry should address why rules and practices were not adapted to balance the harms to infant development against relatively low gains from strict IPC measures.

F. CONCLUSION

50. Decision-makers were forced to make hard choices during the Covid-19 pandemic about the allocation of scarce healthcare resources. But pregnancy and childbirth cannot simply stop, nor can it be delayed. There were real health consequences to failing to provide adequate care to pregnant women and newborn babies. There were missed opportunities to heed the calls to ensure early pregnancy, maternity, and neonatal care was safe and adequate and that women, pregnant people, their babies and new parents were not being unnecessarily traumatised and ultimately, harmed.

51. The PBPOs have already proposed to the Inquiry lessons it considers ought to be learned from these experiences across early pregnancy, maternity, antenatal, post-natal and neonatal care.[72] The PBPOs call is, at its essence, for the Inquiry to make sure that pregnant women, new parents and infants are not overlooked in future pandemic responses and public emergencies; that inequities highlighted during the pandemic are remedied; and that the care of pregnant women, pregnant people, and newborn babies is properly resourced so that, fundamentally, they are safe.

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23rd August 2024

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[71] Scottish Government, 'Visiting in maternity and neonatal settings during Covid-19 pandemic from 2 November 2020 minimum standards' (2 November 2020) [INQ000468049_0005].
[72] PBPO Statement, §§215-244 [INQ000408656_0064ff].