Monday, 7th October 2024

(10.33 am)

MS NIELD: Good morning, my Lady. I will call, please, Tamsin Mullen who can be sworn.

MS TAMSIN MULLEN (sworn)

LADY JUSTICE HALLETT: Ms Mullen, I know how distressing this is going to be for you, but please, just remember we are all here to try and help you through it and we will get you through it as quickly as we can, and although it won't be pain free, it will be as pain free as we can make it. All right?

A. Thank you.

Questions from COUNSEL TO THE INQUIRY

MS NIELD: Can you give your full name, please.

A. Tamsin Mullen.

Q. Now, Ms Mullen, you have kindly provided a witness statement to the Inquiry dated June 2024, that's INQ000485735. I think you have got a copy of that witness statement in front of you; is that right?

A. Yes.

Q. Mrs Mullen, I think it is right that you are married with three children?

A. Yes.

Q. You have a daughter who is now nine years old and twin boys aged four; is that right?

A. Yes.

Q. I think your twin boys were born in the relatively early days of the pandemic, on 13th April 2020, and they spent 31 days in the neonatal unit before being discharged home, and you are here today to give evidence about your and your husband's experiences of antenatal and maternity care at that time, as well as your experiences as parents visiting babies on that neonatal unit.

Mrs Mullen, I think it's right that you found out at eight weeks that you were pregnant with twins; is that correct?

A. Yes.

Q. And you were considered to be a high-risk pregnancy due to having experienced pre-eclampsia when you were pregnant with your first child; is that right?

A. Yes.

Q. And also I think your daughter had suffered from intrauterine growth restriction; is that correct?

A. Yes.

Q. Because of all those factors I think the pregnancy was monitored quite closely and you were having scans initially every two weeks; is that right?

A. Yes.

Q. And then I think there came a point where that changed to weekly scans because there were some concerns about

the growth of one of the babies; is that correct?

A. Yes.

Q. When you were having those scans how far away was the hospital from where you lived?

A. It was around 50 miles. It was about a 45-minute journey.

Q. So every time you had to go for a weekly scan it was a one-and-a-half-hour round trip; is that right?

A. Yes.

Q. I think initially your husband was able to come to the scan appointments with you; is that correct?

A. Yes.

Q. But then I think there came a point where that changed because of Coronavirus rules?

A. Yes.

Q. And can you remember when it was that the rules changed about your husband being able to accompany you?

A. It was shortly before the first lockdown came into effect.

Q. So in March of 2020?

A. Yes.

Q. Thank you. And so when Shayne, your husband, was no longer able to attend the scans with you, were you travelling to the hospital by yourself or was he bringing you to the hospital?

A. He was still bringing me.

Q. And so where would he be when you were going in for the scan?

A. In the car.

Q. And how did that affect you when you were going into the scans on your own?

A. I was very nervous. It was -- it was really difficult, really difficult to do that alone knowing about the high-risk part.

Q. And did you speak to your husband about how it was impacting him to have to wait in the car while you were having the scans?

A. Yes. He supports me 100 per cent in everything so having to be separated during that time that I really, really needed the support was really distressing for him to have to do.

Q. I think you have explained in your witness statement that he felt excluded and as if the healthcare system was saying that he didn't matter. Is that right?

A. Yes.

Q. Thank you. I think the babies were monitored, as you said, weekly with scans and on Friday, 10 April you were told that the babies need to be delivered by caesarean section in the next five days; is that right?

A. Yes.

Q. And I think you were booked in then for that procedure to take place the following Monday, 13th April; is that correct?
A. Yes.
Q. The twins then were 34 weeks' gestation; is that correct?
A. Yes.
Q. When it came to finding out that the babies were due to be delivered the following Monday, was Shayne with you at that point or were you on your own in the hospital when you were informed?
A. I was on my own then.
Q. And when you went to the hospital for the caesarean delivery, was your husband allowed to come in with you at that point?
A. Yes.
Q. So I think you arrived quite early in the morning for that caesarean section to take place and in fact the boys were delivered I think in the early afternoon; is that correct?
A. Yes.
Q. And was your husband able to be with you throughout that period of time when you were waiting?
A. Yes.
Q. And was he able to come into the operating theatre with

you?
A. Yes.
Q. Either when you were waiting or when you went into the operating theatre, can you recall whether you were provided with or asked to wear any kind of masks or personal protective equipment?
A. No, we can't recall any point of that at all.
Q. So it wasn't something that was discussed with you at all?
A. No.
Q. Do you remember whether the medical staff and the nursing staff were wearing anything, any PPE?
A. I can't remember about the maternity unit staff but later on the neonatal staff were, but I can't remember about the maternity staff.
Q. I think in your witness statement you recalled that your husband had decided to wear some PPE but he hadn't been asked to do so; is that right?
A. He -- yeah, he wore, like, the sort of -- the hospital gave him scrubs to wear and things, so he would wear that but mask-wise, he -- there was nothing.
Q. Thank you. I think once your twins were born they were taken very quickly to the neonatal intensive care unit. I think there was an opportunity, I think your husband had been able to cut the umbilical cords; is that right?

A. Yes.
Q. And only had a chance to take a photograph of one of the boys before they were both taken away?
A. Yes.
Q. Once the babies had been taken to the neonatal intensive care unit, was your husband able to stay with you?
A. He was able to stay with me while I was in recovery only and then he was told to leave.
Q. Do you know how long he was allowed to stay with you for?
A. About an hour.
Q. And so then he was told to leave, was that because of Coronavirus rules?
A. Yeah, yeah.
Q. So, once your husband had left you, did you have an opportunity to see the babies again?
A. I was wheeled down to the neonatal unit to see them and then -- before going to the antenatal ward.
Q. How long did you have with the babies at that point when you were wheeled down to the unit?
A. I can't recall exactly but not very long, it wasn't very long.
Q. And then you were taken down to, I think, a postnatal side room; is that right?
A. Yes, that is right.

Q. Were you on your own in that room?
A. Yes.
Q. And was Shayne allowed -- your husband allowed to come into the room with you?
A. No.
Q. And how often did you see nurses or healthcare assistants while you were in that side room on your own?
A. Every so often, just to sort of check in on me or give me medication or if I called them on the buzzer.
Q. In that first day or two, after the twins had been born, how was communication from the neonatal unit where they were being looked after? Were you given regular updates on their progress?
A. No.
Q. I think in large part because of that you were keen to be discharged as soon as possible so that you were able to see your boys and your husband and, indeed, your daughter who was at home; is that right?
A. Yes.
Q. I think in total you spent 27 hours and -- in the side room before you were discharged; is that correct?
A. Yes.
Q. Once you had been then discharged from postnatal care, I think you explain in your witness statement that you and your husband then encountered the rigid visiting

rules for the neonatal intensive care unit. I think the rules at that point were that only one parent was permitted to visit at a time; is that correct?
A. Yes.
Q. And that was not interpreted as one parent per baby, so your twins could only -- you could only see your twins one at a time; is that correct?
A. Yes.
Q. And so how were you managing the visits, then, between yourself and your husband at that period? You were travelling over, from your home, 45 minutes; how did an average day work out for the two of you?
A. Average day was leave home for the journey, get to the hospital, and we would sort of decide who would go in to the unit first, and one of us would wait in the waiting room just outside of the unit. And we spent a couple of hours like that, and then we would swap over for a couple of hours, and then go home because we had our daughter at home who we also wanted to see, so then we had to travel home after that time.
Q. I think your parents were looking after your daughter at that point; is that right?
A. Yes.
Q. And she was not at school because of the lockdown?
A. Yes.

Q. So you would go in for two hours whilst your husband waited in the waiting room. Were there other parents in the waiting room at that time?
A. There were, sometimes, yes. Yeah, and there were other people as well, coming and going. There was always people coming and going.
Q. And were parents visiting babies on the neonatal unit being asked to wear masks or any other kind of PPE at that time?
A. No.
Q. I think on a number of occasions you questioned that visiting policy as to why the two of you couldn't go in together as you had come from the same household and travelled to the hospital in the same car, and were going to travel back together. What was the response whenever you questioned those rules?
A. It was -- the nurses responded in -- that they didn't understand why either. And the matron was -- her hands were tied because the rules came from higher up, I'm not quite sure where she said, but the rules came from higher up so her hands were tied, so she couldn't do anything, to change anything, or to help that matter.
Q. So the matron didn't seem to have any discretion to vary the rules herself or to have a conversation with someone in a position of authority to see if there could be any

relaxation of the rules in your case?
A. It didn't seem so.
Q. I think in that first week after the twins had been born, when you were on the unit visiting the boys, you were informed that they had been swabbed for MRSA and the results had come back -- the initial results had come back positive; is that right?
A. Yes.
Q. So how were you informed about that?
A. I was alone on the units, holding -- sorry ...
LADY JUSTICE HALLETT: Take your time. Have a sip of water. Always helps.
A. Holding our son who was on oxygen at the time ...
(**Pause**)
A couple of people from the hospital, they were wearing black scrubs, I had never seen them before, they weren't from the unit; they had just come in and said that the provisional results for the boys were MRSA-positive, and I was sort of in a state of shock, I think. So I didn't really say much, and they just -- they just came in, told me that, and they said "We will get the final result tomorrow", and they just went, and I was just sort of there on my own, sort of thinking -- I didn't know what that meant, and I just was really panicked and it just got worse and worse and it was --

for me, MRSA is a super bug, it kills people, and I had no idea what it meant for me, whether I was allowed to leave the room or anything. So, yeah, at the time I was -- it was awful because it was just -- I had no information really, at all, apart from they had been swabbed -- I had no idea they had been swabbed, Shayne had no idea either, and we were just -- yeah, I just felt awful.
MS NIELD: I think you were able to go and speak to your husband, Shayne, in the waiting room to explain what you had just been told. And I think he went to speak to a nurse or somebody to try to find out what was happening; is that right?
A. Yes.
Q. I think it wasn't until the following day that you were able to speak to a doctor who could explain that, in fact, there were two types of MRSA, and this was a less serious type of MRSA that colonised on the skin and could be treated with soap; is that right?
A. Yes.
Q. But I think, prior to being given that reassuring information, you were very uncertain about whether you might be exposing the babies to further risk from germs or other kinds of infection if you were holding them; is that correct?

A. Yes.
Q. I think, at one point, your husband did once break the rules to come into the ward with you, to try to allay your fears about that, and so that you could be holding the babies together; is that correct?
A. Yes.
Q. I think that was when you were asked to go and swab yourselves for the MRSA virus; is that right?
A. Yes.
Q. And, when your husband came into the unit with you, on that occasion, did the nurses intervene, did anyone object to that?
A. No, not at all.
Q. After the twins had received that diagnosis of MRSA, they were then put into an isolation room effectively, they were put into a room by themselves without any other babies; is that right?
A. Yes.
Q. And you were still able to visit them?
A. Yes.
Q. At that point, was there any relaxation in the rules in terms of the two of you being able to visit at the same time?
A. No.
Q. And did you raise that again, that now, there were no

other babies in the room with them, and would it be possible for the two of you to visit together?
A. Yes, we did, yeah.
Q. And what was the response?
A. That it was the same response, hands are tied, couldn't do anything.
Q. So, with the two babies there in the room and only one parent, what would happen if both babies started crying at the same time?
A. We would have to try and decide which one to see to first, because they were in separate incubators, so it was just a matter of maybe who cried first, and it was literally as simple as that. Just, we just had to choose, and then go to one and then go to the other one, and try and settle one while the other one is screaming and -- very difficult.
Q. You have set out on this witness statement there was an occasion when you were in the room with your twins when a counsellor came into the room to ask if you wanted any support, and you explained you couldn't understand why another person was allowed into the isolation room with you when your husband and co-parent was not allowed. Did you raise that with anyone at the time?
A. I can't remember, to be honest, if we did raise that

specific point, but it was a very -- it was one thing that baffled us.
Q. At this period when you were coming in, were you coming in daily to visit the twins in hospital?
A. Yes.
Q. And your daughter was at home, 45 minutes away, being looked after by your parents. How was this impacting your daughter because you were spending quite long periods of the day away from home?
A. She was five at the time. She couldn't understand why Mummy and Daddy were able to go to the hospital without her, and why we were away for so long. It would always be a question when we came back, "When can I meet the boys? When can I come and see them with you?"
So she was -- she just couldn't understand it in her head, no matter how much we tried to explain it to her, for her, she was -- she did start to become distressed, so we sort of had to change things -- the way we did things a little bit. But yeah, she just couldn't understand.
Q. And so you had to change your routine in visiting the twins to try to accommodate your daughter's needs as well?
A. Yes.
Q. And how did that work?

A. We went up first thing in -- we would get up, drop her off at Mum and Dad's, go up to the hospital first thing in the morning, and then be back just after lunchtime to then homeschool her and be with her for the rest of the day.
Q. And was your daughter permitted to visit the babies on the unit, or --
A. No.
Q. And was that made clear to you from the early days of the boys being on the unit?
A. Yes.
Q. I think in the early time when the boys were on the unit, you were trying to express milk, or it was your intention to try to express milk for the twins; is that right?
A. Yes.
Q. And I think you made a request whether it would be possible for you to have a private place or a side room where you could express the milk in the hospital, and that wasn't made available to you. Can you explain what happened there?
A. So I asked whether one of the side rooms that weren't being used on the unit could be used by me. I wasn't going to go down to where Shayne was with the boys, just so I could express at the times I needed to. But it was

a, "No, you can't be on the unit, you can't use one of the rooms" and the suggestion was made to me to use one of the toilets, which I wasn't going to do because we all know the germs that can be found in toilets. And to take milk that's supposed to be sterile to poorly babies, tiny babies, just wasn't -- in my head was not going to happen anyway. So I wasn't given the opportunity to do that.

Q. And were you given any explanation for why you couldn't use a side room that appeared to be empty and available for use?

A. No, just it was just all down to the rules, Shayne was on the unit, so I couldn't be.

Q. In terms of communication with the hospital at the time that the boys were on the neonatal intensive care unit, were you getting regular communications or updates when you were away from the hospital? Were you getting telephone calls or updates on their progress?

A. No.

Q. And when you went into the unit in the mornings, were you given any explanations for -- or updates about how the boys had been doing overnight or were you left to check notes?

A. We were usually left to ask them how have they been, you know, what have particular things been like. Yeah, we

were left to our -- unless something particular happened overnight that they voiced to us, we would ask.

Q. I think there were occasions when you noted there had been some changes made to, for example, the feeding routines when the twins were being bottle fed, you tried to get them ready for being discharged from the unit, and you had noticed that overnight they had been fed by a nasogastric tube; is that right?

A. Yes.

Q. And is that something that you discussed and tried to find out why that had taken place?

A. We asked the nurses on the unit but they didn't know either because we were trying the bottle feeding and they all knew we were trying that. They also couldn't understand.

Q. I think you later explain that once the boys had been discharged and you were given the discharge notes, you found some other aspects of their care or, indeed, their condition that hadn't been explained to you at the time. And that in fact you found out on reading the discharge notes that one of the boys had chronic lung disease; is that right?

A. Yes.

Q. And that wasn't anything that had been brought to your attention or discussed with you while they were on the

unit?

A. No.

Q. How would you describe communications between yourselves as parents and the hospital throughout that period when the boys were on the unit?

A. During the day when we were actually on the unit, the nurses in the room with us were very good at communicating and explaining things. It was when we were not on the unit or overnight that the communication wasn't there and there were a few times where we would phone the unit and say, "How has this gone?", or "How has this been?" But other than that there wasn't any.

Q. And reflecting on your experiences during the 31 days that the twins are in the neonatal unit, how did these rules and restrictions around visiting, in particular, how did that make you feel as parents?

A. We didn't feel like we were being treated like parents. It was more like a -- we were visitors, we were visiting. It didn't -- although we were their parents it didn't feel like we were their parents because we weren't being treated like that and that was down to the rules because it was -- the restrictions were on visiting rather than on parents.

Q. And did you feel that the rules made any allowance or took into account the fact that these were twins, this

was a multiple birth?

A. No.

Q. Or, indeed, the fact that you had another child at home?

A. No.

Q. What you have said in your witness statement is that -- is this:

"We needed for the hospital to understand that we are a family and these are our children. We didn't feel that we were going to see our children, we felt we were going to see patients. We didn't feel like a mother and father to the children in the way that we should have done."

Does that sum up your feelings about that time?

A. Yes.

MS NIELD: Thank you very much, Mrs Mullen, I have no more questions for you.

LADY JUSTICE HALLETT: Thank you very much indeed, Ms Mullen. I hope it wasn't too distressing for you.

How are your daughter and the boys doing?

A. Really well, thank you. They are really good.

LADY JUSTICE HALLETT: And how is your daughter coping with two horrors of four-year-olds?

A. Really well, actually. She has her moments but she is quite motherly to them. She can be very protective which I can very much understand, bless her, so yeah,

very, very good.
LADY JUSTICE HALLETT: You have obviously got your hands full, so thank you very much for coming along to help us.
A. Thank you.
(The witness withdrew)
MS HANDS: My Lady, may I call Ms Jenny Ward. She will affirm.
MS JENNY WARD (affirmed)
Questions from COUNSEL TO THE INQUIRY
MS HANDS: Good morning, Ms Ward, you should have your statement in front of you and that is INQ000408656.
Ms Ward, you are here today as Chief Executive of the Lullaby Trust and also Chair of the Pregnancy and Baby Charities Network; is that right?
A. Yes, that is.
Q. And your evidence today is on behalf of the 13 Pregnancy Baby and Parent Organisations; is that correct?
A. Yes, that is correct.
Q. And if you don't mind, I will refer to them as the PBPOs from hereon in.
You have set out the members of the PBPOs in full in your statement but can you give us an example of some of the organisations within that group?
A. Yes. Absolutely. So of the 13, just to reiterate,

although we tend to talk about maternity and neonatal, we cover a wide range of that whole period and it can be divided into early pregnancy, antenatal, postnatal, and neonatal. So we have a number of organisations such as The Ectopic Pregnancy Trust and the Miscarriage Association that cover early pregnancy, and then those of us like The Lullaby Trust, like Tommy's, who cover the period of birth and post natal and then neonatal is covered, again, by Tommy's and by Bliss.
So there is a wide range of organisations.
Q. Thank you.
And it is right that there is representation across the UK?
A. Yes, that is correct.
Q. We are going to go, essentially, through the impact of the pandemic on maternity services for pregnant women throughout the maternity journey, starting with antenatal services.
The guidance at the start of the pandemic was for antenatal services to be maintained with a minimum of six face-to-face antenatal consultations with video and remote consultations as an alternative.
Now, in your experience, was that guidance followed throughout the pandemic?
A. I think there was a mixed experience there. And when we

look at some of those organisations that deal with early pregnancy, and there is reference to that there, there were families who, where they had concerns about their pregnancy, they weren't able to access the face-to-face or even an online appointment that they needed to. So I think it was very much a mixed picture.
Q. And can you just set out for us some examples of the potential impact and risks of those appointments or services being missed in the early stages?
A. Yes, absolutely. There are some conditions in pregnancy that can only be picked up by being seen face to face and having specific tests for that. So not being able to access that or families being concerned about going somewhere face to face, would have had an impact potentially on their health, of not being able to do that, and there is of course the other side of families being particularly worried because in those early weeks we were all told to stay at home.
So having a concern and as organisations, and as healthcare professionals, we would encourage people to go and seek support if they are worried, in that period I think it was harder to get that support and it was also more likely that people would shy away from going out proactively.
Q. And I think you have given quite a few examples, in your

statement, of experiences that parents and also healthcare professionals had with an increased use of online and remote access to maternity services. You have set out some there but were there some -- could you perhaps provide us with some of the positives and negatives of the increased use of those online options?
A. Yes, absolutely. They weren't all negative. So there are some good examples of practice of appointments being far more accessible by being online, and that's good. Some of the parts that might be -- and also, for example, if you had pregnancy sickness, the thought that you had to go face to face somewhere was practically very difficult to do. So it was good that there was an online option.
Some of the negative parts of that, as I said, there are specific tests and specific concerns that people would raise face to face that maybe they felt they wouldn't on an online appointment and also there were some people who simply didn't have the ability there to use an online system and to contact their health professional. So where we talk about the inequalities that are there, digital poverty definitely meant that those who were less able to access that were more negatively impacted.
Q. I think you have given some examples in your statement

of pregnant women delaying access to care and telephone -- they are examples of telephoning triage.

So if we can go to INQ000408656, page 11.

If we look at question 1 and question 2. Is it right this is feedback from various organisations within the 13 PBPOs that you have included within your statement, and we are going to a few of those throughout the morning?

A. Yes, absolutely. Of the 13 organisations we all work closely with the people that we support. So they come and talk to us and we have gone and asked them what could be improved. So these are those people who work closely with us directly coming with those comments.

Q. So the first comment there is:

"It was really only because I was worried about Covid in the hospitals that I didn't go to A&E."

And then the second:

"A day passed and I started feeling dizzy and the pain had got worse, reluctant to go to A&E in the current pandemic. I new (sic) something was not right."

Then the third one there relates to problems getting an appointment with a doctor. They said:

"My severe pain went from ... possible appendicitis to pelvic inflammatory disease. This was by telephone consultations, then 3 weeks after the pain

had started I was finally told I had an ectopic pregnancy and my tube had completely ruptured."

So the reasons that we see there, are they the same or similar to the experiences that PBPOs heard during the pandemic as to why women weren't accessing healthcare or delayed doing so?

A. They give a really good representation of the messages that we got which was: people pulling back, thinking, well, I have been told to stay at home. We have also been told that healthcare -- places like hospitals are overwhelmed. We are also worried about Covid. We have been told that in pregnancy we are particularly vulnerable. And as I said, some of these conditions, the initial symptoms are not necessarily things that make you feel you absolutely need to go to A&E directly.

So yes, people held back and yes, there were difficult situations as a result of that.

Q. And on the topic of telephone triage, in your statement you have referred to guidance from the Royal College of Obstetricians and Gynaecologists regarding telephone triage services when a woman makes a complaint or raises a concern.

And essentially there was rationalisation of services to look at what scans or services were needed either without delay or whether there could be a safe

delay.

Obviously we see some of that in the third quotation here around a telephone consultation. Were PBPOs aware of cases where pregnant women who had concerns about their unborn baby and were feeling unwell, they were given "Stay at Home" advice where they may, in non-pandemic times, have been asked to attend a face-to-face appointment or assessment?

A. Yes. I think there's a mixed picture there and actually, there is some good examples where having that telephone triage was helpful, it was helpful to families to give them some reassurance, it was helpful to health professionals who, as we heard in this particular area, were already over stretched. So they could really look and decide who it was that they -- where they had to make a choice.

So yes, there are some benefits to that but yes, we did hear that there were also negatives.

Q. And did you hear about those continuing throughout the pandemic?

A. In terms of having triage?

Q. Yes. Those concerns that you have just mentioned, did they continue or did you find that they kind of went in waves?

A. My understanding is that they continued throughout.

Q. Thank you. In your statement you have referred to a finding by Tommy's midwives who saw a 40% increase in email inquiries between March and August 2020 for help and support, they say, from a trusted source, which they believe was a consequence of women being discouraged from visiting hospital or antenatal services unless absolutely necessary. And you have said in your statement that Tommy's considers that women were being encouraged to miscarry at home.

Was help and support available other than from the charitable organisations?

A. I think, again, that was a -- that was a mixed picture. So, usually, if a woman is worried about miscarriage, they could contact a health professional, and they could then get checked, and they would -- if that was confirmed that's the case, they would be given options on what to do.

In this circumstance, in this period, certainly of the early pandemic, it appears that women were encouraged to take what we would call a managed wait, which is basically stay at home and let nature take its course. That has a huge impact on families.

Q. I want to stay on the topic of miscarriage and building on what you have just said. If we could go to another example from your statement, so INQ000408656, and it is

number 8. Question 8 in the blue box. This is another experience that a woman had during the pandemic where she said:

"I had a really drawn-out experience in which I had to go to multiple GP surgeries and hospitals to confirm my miscarriage as appointments were so scarce. I was ... dismissed by the doctor in A&E as being dramatic regarding spotting in my 8th week of pregnancy. [And] from there, it took almost 3 weeks to diagnose a missed miscarriage, and a further week for my treatment to be booked. As it was, I miscarried naturally on the day of my appointment, at home, where I was scared and in pain. I rang the hospital and they simply told me to take paracetamol. I still have flashbacks and nightmares regarding this, even following the birth of my healthy child."

Is that an example of what you have just given of a managed miscarriage?

A. Yes, it is.

Q. And the Miscarriage Association carried out a survey during the first wave -- sorry, during the first and second wave of the pandemic, of women that were affected by pregnancy loss, and found most were able to access health professional care but 10% were unable to be seen in person. And again, is that the impact of the use of

more remote and virtual consultations that --

A. Yes, yes, it is. And I would also say it feels, from that quote and from the examples from the Miscarriage Association, as if miscarriage was downplayed like it is something that it happens. So -- you know, that -- that's just -- kind of "That's what happens, keep on with it" and it wasn't prioritised.

Q. Also in your statement, if we could go to page 18, please, and Q11 and 12.

This relates to surgery for miscarriage, so the in-hospital care and access to treatment. So the first, number 11, is:

"I was left in pain for hours with no pain relief. Unable to have surgery due to covid 19. My miscarriage was manually removed. This has had a big impact on how I have been feeling over the last 3 years."

Then in the second one, she said:

"[I] ended up waiting 3 days in hospital for surgery 4 weeks after finding out I had a missed miscarriage. [And] I was told surgery was not an option originally due to covid and ended up with an infection."

Were PBPOs aware of the impact of Covid on access to in-hospital treatment for miscarriage, for example, surgery that we have seen here, keyhole surgery, during the pandemic?

A. Yes. Yes, and we fight hard to make sure that families, and have over the years, get a choice in the treatment, particularly when it relates to a miscarriage or the loss of a pregnancy or a baby. So it was particularly distressing for us to hear that that was taken away from families, and as these say, it has an impact on them for a very long time.

Q. Moving on then to birth and to labour, can you briefly summarise the birthing options available to a woman outside of the pandemic?

A. Yes. Usually you would have the choice to either give birth in a hospital setting, consultant-led, in a midwifery-led centre or in a birthing centre which is -- comes separate from a hospital, or at home, which would have maternity staff there. We would have midwives and they usually specialise in home births, so those are the options.

Q. And you have described in your statement how the choice of birth setting is, in normal situations, a key part of maternity policy, to enable women autonomy and control over safe birthing event; is that right?

A. Yes, that is correct.

Q. And we will come onto specific examples, but overall, did that happen during the pandemic?

A. No. Those choices were decreased immediately the

pandemic started.

Q. And in your statement you have set out some findings from a survey that the Royal College of Midwives undertook -- sorry, a survey, yes, that they undertook in regard to closures. And we are going to come onto address that in more detail with the Royal College.

But you have set out in your statement some of the impact of those closures that we can see from pregnant women that have provided those quotations, so if we can go to INQ000408656 page 25, please.

At the top and one Respondent said that:

"In my birth plan I had requested a water birth and an active birth. This was not possible, but again, no midwife explained why I couldn't do this or even appeared to acknowledge my birth plan."

Then at page 33, number 30. Here somebody said:

"Due to midwife shortages my baby was delivered at the side of the road ... The ambulance crew told us we were the second couple they had been to that night who had delivered en-route to the hospital."

Dealing first with the first example we looked at, was there a lack of information or explanation as to why options were limited during the pandemic?

A. Yes. I think that's true. I think families certainly felt that their choice wasn't there and they didn't

fully understand why, but at that time we all understood the pressures that were under the health system, and I think a lot of families just kind of accepted, okay, that would have been my choice but unfortunately it is not there, and we have been told we are all in this together and I kind of need to accept that.

Q. And could you explain briefly what free births are, and whether PBPOs saw any increase in free births and what the risks of them are as well?

A. Yes. My understanding of the free birth is somebody who gives birth without any medical care there. We did hear of them being more likely to happen during this period for several reasons; firstly, that, as I said, the teams that would normally support families to have home birth in their own setting had been re-deployed elsewhere, and that wasn't something that was offered, but also families who felt that going into a hospital was a risk for them and their baby, felt that they -- their choice to mitigate that risk was to give birth at home even if that meant they were on their own.

Q. And dealing with that second quotation around staff shortages, again, is that something that PBPOs heard impacted on the care and the services that were available to pregnant women during the pandemic when it came to birthing options?

A. Yes, yes, absolutely.

Q. We touched briefly on pain relief and pain management with the water birth there. You have set out at paragraph 81 of your statement findings from a survey of 1200 people who had given birth from August 2021 to July 2022.

And that showed that 39% had to wait over 30 minutes for pain relief during labour. And 35% had reported delays in staff noticing or acting on signs they had, or might have had, a serious health problem.

There was guidance from the Royal College of Midwives on access to water births, but was it PBPO's experience that there were delays or suspensions of pain relief, for example, water births or epidurals during the pandemic?

A. I think this -- this survey seemed to suggest that yes, that was so. Those figures are higher than the ones that were found pre-pandemic. And that is exactly the result that we would expect to have heard from what we heard about staff shortages, and what was going on in the units. And as we said, if the other options for places to give birth had been closed and weren't available, you would expect that those consultant-led units were even busier at a time when they had even greater staff shortages than they did prior to the

pandemic.

Q. Moving on to maternal mortality and inequalities. At paragraphs 45 to 49 of your statement, you have summarised the findings from two reports by MBRRACE, and they found that improvements in care may have made a difference for 7 in 10 women who died with Covid-19 whilst pregnant or in the immediate post-pregnancy period and they later updated that to 7.6 in 10 women.

What were PBPO's views on the findings?

A. I think -- well they are devastating aren't they? That there could have been a different outcome. We know that there are lots of inquiries going on into maternity safety, in terms of inequalities, that they have been there for a long time, and in this period we knew that the groups that were at risk prior to the pandemic were even more at risk now. And this is the upshot, and unfortunately those groups were even more impacted. So, yeah, devastated. Lots of things that we would like to change, and that we are all working hard and engaging with to try and change these figures -- those are not figures any of us want to see.

Q. I think in your statement you have set out some steps that could and should have been taken during the pandemic to address pregnant women's fears and concerns about accessing medical support and the practical

barriers to doing so. Could you summarise some of those practical steps that could have been taken and should have been taken?

A. Yes, I think there was a very strong "Stay at Home" messaging and very strong messaging around pregnancy being a vulnerable group, and I think that actually going out to those people and saying "But your care -- that doesn't count for your care", should have been a very strong message. One of the themes we have come out with is the engagement of us as 13 organisations, and as a wider network there are 31 organisations -- 31 charities who are in the Pregnancy and Baby Charities Network, so not within this group, we all work directly with families. We are all used to getting messages out there. We are trusted organisations to them, and we could have worked on that much more clearer and made sure that families weren't staying at home when they really needed to get out.

Q. You have also summarised the findings from another report from MBRRACE which found that there remains an almost fourfold difference in maternity mortality rates amongst women from black ethnic background, and twofold difference from women from Asian ethnic backgrounds compared to white women, and that women from the most deprived areas have twice as high mortality

rates as those in least deprived areas.

Again, what were PBPO's views on those findings and the experiences that they heard? Did they mirror those findings?

A. Yes. I would say, as I mention, we all know that they are high-risk groups. They are groups that we all target, and there are specific groups who are led by people within those communities. So if you have heard of an organisation called Five X More, they exist because of that inequality.

So I think yes, we are shocked, but sadly not surprised that those inequalities remain. I would certainly hope that they should have been a high risk group from the very beginning that everybody tried to focus on; unfortunately, as it transpired, they were also a high risk group for Covid. So you had the two challenges, really, coming together here, and I think with -- we would have hoped the communications around that would have recognised that in a bit more detail than possibly they did.

Q. There was guidance from the Royal College of Midwives, and NHS England also announced additional support for pregnant ethnic minority women. Does PBPOs have any views as to whether that additional support and advice was in fact effective?

A. I think, looking at the guidance, and I know you have heard from other professionals as well that there was a lot of guidance that came out, it was continually updated. Trying to stay on top of that and to translate it into practice on the ground when they are completely over stretched is really difficult for professionals to do. So, from our perspective, it may have been recognised there but the communications to people on the ground weren't as effective as they could have been.

Q. Moving on to the topic of visiting restrictions, first of all, in antenatal settings. There was, as we have heard in this inquiry, a suspension on hospital visiting from the end of March 2020. And one of the -- there wasn't a permitted exception for women to be accompanied at a scan or early pregnancy appointment.

We have got some examples in your statement of the impact that had, so if we could have one of those up, please. INQ000408656. It is number 62. Thank you.

This responder said:

"I had a routine scan which my husband couldn't attend but the reason it affects me now still is because I later lost my baby, she was born at 20 weeks but I had a missed 2nd trimester miscarriage as she passed at 16 weeks. My husband never got to see her alive as he wasn't at that first scan."

Of course, all of those that were impacted during the pandemic will have been impacted in different ways, but you have said that in PBPO's experience, the restrictions had a particularly negative impact on those receiving bad news; is that right?

A. Yes, that is.

Q. Again, the Miscarriage Association survey found that 77% could not take anyone with them to an in-hospital appointment during the early stages of the pandemic and 25% -- sorry, under 25% were able to make a call or video during that appointment.

A. Yes.

Q. And is that reflective of the impact and the experiences that PBPO heard from its members of the restrictions on attendance at antenatal scans during the pandemic?

A. Yes, that is correct.

Q. In your statement you have set out the changes -- some of the changes to the approach in the guidance in the summer of 2020.

I think you have said that Scotland were the first to define the circumstances in which maternity and neonatal services could reduce the level of restrictions and then Northern Ireland followed shortly.

Just dealing with those two first. What was the response of the PBPOs to those changes in the guidance

and did that lead to some more consistency in the implementation of the guidance in the units?

A. I think for us as UK organisations trying to stay on top of guidance that was changing quite -- across the board, changing fairly frequently in some areas, was tricky. To know that that was different depending on what country -- which part of the UK you were in, was particularly hard.

So families picked that up. They knew, well, I know somebody who is in here and they are allowed to do that, why am I not? And we didn't have the answers for them to be able to say that.

Usually we would hope that we could reassure families and say, you should be allowed your partner at this point, and we simply couldn't do that. These were, of course, still guidance and the practical set up of units meant that it had to be guidance, we accept that, and they needed to know the arrangements within their own unit and what they could facilitate. But we just saw a lot of discrepancy. It was -- as I said, it was guidance, it wasn't something that came into -- it was actually practically there for quite a long time and after that, of course, we faced future waves of Covid and that meant that we saw units pulling back again and going back to the more restrictive policies.

Q. Yes, I was going to come onto guidance that followed later in September 2020 from NHS England, where they developed a visiting framework encouraging local risk assessments and providing for birth partners, visitors in labour and birth settings, and that included the antenatal and postnatal wards and scans and that they should be deemed essential visitors at that stage.

Then, there's further guidance from NHS England in December 2020, so right at the beginning of the second wave, which set out that women should be supported by another person throughout the pregnancy journey. And including at scans when it was important to the woman.

So did PBPOs have any views on the timing of that guidance and, again, whether in fact it did lead to any changes on the ground?

A. That's a long time to come out from the first lockdown, that we saw in March, to December and even then it was guidance and it still refers to birth partners as "visitors" and those coming into the scan partners as "visitors" and we strongly belief that's not the case.

So yes, it was too long in coming out, too long in being implemented locally and for the staff on the ground to be supported to understand how they could allow people to come in. But, essentially, yes, it still referred to birthing partners and neonatal parents

as "visitors" and that is not a line that we think has been helpful to families, it has been hugely damaging.

Q. Then, finally, just dealing with Wales which, again, you addressed in your statement. It is right that they didn't update their guidance to reflect birthing partners and supporters at appointments as essential visitors until May 2022; is that right?

A. Yes, that is correct.

Q. Moving on to birthing partners during labour. So this was one of the exceptions to the restrictions on visitors to hospital from the early part of the pandemic in the guidance.

In Wales there was a difference in that the woman in labour should be permitted a birthing partner from their household. Did PBPOs receive any feedback on the difference in that Welsh guidance that you are aware of?

A. I'm not aware of specific differences in Wales that we were fed back.

Q. And to your knowledge, was that guidance, with that exception, implemented across the UK?

A. No. We continued to hear stories going into 2021 where there were differences between different hospitals and units on birthing partners and when and if they were allowed in.

Q. Again, reflective of the changes we discussed in

relation to antenatal services, there were also changes to the visiting guidance for labour and birth throughout summer --

A. Yes.

Q. -- of 2020, wasn't there?

A. Yes.

Q. In respect of visiting guidance, did the PBPOs hear concerns about women only being allowed a birthing partner during active labour and any inconsistencies in the interpretation of active labour?

A. Yes, absolutely. Having a birthing partner there and what you define as active labour is something that is open to debate and we understand as well that, as I said, units were very stretched. So if you were in a labour ward, for most women who are in labour are in there, are in a private room by themselves. So if they are not allowed their birthing partner in until they are deemed to be at a certain point of labour, they are on their own in that room and that's frightening. So, actually, to sit there and think, well, I have to be at a certain stage in order for -- to get support is particularly tricky.

I also want to make the point that that impacts on the staff who are on that unit as well. They don't have somebody else to support women to advocate for them, to

say, she doesn't look right or she seems to be in extreme pain, all the things that birthing partners have discussed and are ready to do. So it actually had an even greater impact on staff of not being able to have them there until they were deemed to be in active labour.

Q. Were you aware of reports indicating that some women felt obliged to undergo vaginal examinations to prove they were in inactive labour so that partners could enter the room?

A. We have seen those reports, yes. And although I could couldn't tell you how often that happened, I think from understanding how women felt during that period, if they felt, as I said, alone and scared and in a room where they are largely by themselves and they don't want to bother the staff that are really busy, I think it is completely understandable if they felt that that examination might be the access for them to get more help that they -- even without a medical reason being needed for that, I think we can understand why some people may have consented to that.

LADY JUSTICE HALLETT: I'm not following this line of argument. Wouldn't you, if you were in labour be subject to vaginal examinations anyway to check how far along you were?

A. Yes, I think in this respect it wasn't for medical reason they were checking, it was purely so they could decide whether the partner was allowed in or not.

MS HANDS: Taking all of that into account then, is it your view that active labour should have been and in future should be defined in guidance?

A. I think that would be helpful for staff there. I would say we did get some really good feedback from families who had staff who were aware of how difficult it was to be on their own, sometimes said, "I'm going to let them in" or in some instances letting them in in the fire escape so that they weren't subject to the usual entrance into the unit. So I think, yeah, there was an understanding of how difficult that was to be by themselves until that point.

Q. And dealing then with visiting guidance for postnatal wards, it is right, isn't it, that again this was quite varied across the UK not only in the guidance but also implementation actually on the ground.

In your statement there are examples as to the impact of those restrictions.

So if we could turn, please, to INQ000408656, page 41. Thank you.

So two examples here. The first being that:

"Not being able to be on the ward together was so

hard and definitely had an impact on our ability to gel as a family (as this was our first baby) -- I felt bad for my husband for every moment I was on the ward and not him. It had a major impact on breastfeeding which in turn had an impact on my baby's care and length of stay in hospital."

Then secondly:

"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."

Again, is that reflective of some of the experiences from PBPO members of the restrictions on attendance at postnatal wards?

A. Yes, it is. And just to reiterate there, that where they were classed as visitors, and as I said, that's not a term that we think should have been in place, actually most of the impact was on partners and most of those were dads.

MS HANDS: Thank you.

My Lady, my next topic is still on visiting restrictions but neonatal units, so it may be just a moment to take our mid-morning break.

LADY JUSTICE HALLETT: Very well.

I hope you were warned, Ms Ward, you probably know anyway from following our proceedings. 11.55 am.

(11.40 am)

(A short break)

(11.55 am)

LADY JUSTICE HALLETT: Ms Hands.

MS HANDS: Thank you.

Ms Ward, just one more question before I move on to neonatal units. You have said a few times this morning that it is the view of PBPOs that parents should not be considered visitors in the guidance. Can you just say why that is.

A. In relation to neonatal units?

Q. Units that aren't neonatal units. We will come on to neonatal.

A. So in terms of birthing partners, are you specifically asking?

Q. Yes, and in antenatal units as well.

A. Because the care appears to be around the person who is receiving the medical care, so in most instances it will be a pregnant woman, we very much reiterate that this is an impact on both partners there. So where there is -- also the partner is the dad, that decisions -- bad news or even update news, any kind of news directly impacts them as well. And that's why they should be a part of

that.

So just, for example, to think about if you were to have a scan in early pregnancy and as a woman you are there on your own, you are given bad news as a result of that, you may then be given treatment options or options that could impact your future fertility and certainly have an impact on how you are going to manage the difficult news that you have had and we have heard stories of women having to do that by themselves or then having to go out and explain that to their partner who has been waiting in a car, which is incredibly difficult.

Q. Is it also right that in terms of during labour and birth, and also in postnatal awards as well, they can provide a caring role?

A. Absolutely. There is multiple elements to why it is important they are there. It is caring both for the mother, for the baby, being the support, the advocacy and trying to understand the advice that they had. So if you are given medical advice from somebody in a difficult period or in a traumatic period, it is very difficult to take that in and the role of your partner there is often to have a bit more understanding of that and to ask questions that maybe you wouldn't be able to.

Q. Thank you.

So moving on then to neonatal units. So one of the exceptions in the national restrictions on visiting was for one parent to visit a child. We heard this morning impact evidence of restrictions on neonatal units.

Is that reflective of the experiences that PBPO members had?

A. Yes, it is.

Q. And in your statement you have described attempts by PBPOs and the Royal Colleges during the summer of 2020 for there to be unrestricted parent access to neonatal units but that they were met with resistance.

Can you explain what that resistance was and who that was from?

A. Just to reiterate that's from -- mainly that advice comes from Bliss who are the neonatal charity and they worked closely with BAPM who are the British Association for Perinatal Medicine and RCPCH, Royal College of Paediatrics and Child Health, and they were all very supportive of those restrictions being relaxed in that setting.

I believe that the resistance to that was around opening up again infection risks for Covid. I don't think it took into account the impact that those organisations were very strongly putting across that

that was having, both on the parents and also on the babies themselves who didn't -- who for a lot of the time were in a unit not being cared for in the way that they would usually be. So just to state in case people aren't aware, that usually parents have 24/7 unrestricted access to a baby in a neonatal unit.

The other thing that they do with that unrestricted access and quite often, if they are able to, parents will spend as much time as they can with their babies, they are a very integral part of their care and they are encouraged to be. So they will be, for example, where possible, changing the baby's nappy and supporting staff in that. So they would -- if you are looking at your individual baby you are much more likely to be able to say, they look a bit different here, they seem to be a bit more uncomfortable, they are a bit more fractious, and then staff can step in.

So the impact on staff of not having parents there was also going to be an increased workload.

LADY JUSTICE HALLETT: Who would have been the on high for a neonatal unit to impose what seemed to have been rigid visiting restrictions?

A. I believe it was that guidance that you have referred to and then individual hospitals or trusts would have to make that decision. We certainly heard hospitals that

were, from a birthing partner perspective, close geographically but had very different policies. So the consistency didn't appear to be there. And there were certainly families in neonatal settings, depending on the care that your baby needed, you may well end up with that baby having care between units and then for families changing from one unit to another and seeing a difference in the access that they had was also difficult.

MS HANDS: Thank you. As far as you were aware, what were some of the barriers to implementing more relaxed restrictions on visiting in neonatal units?

A. I think the space that -- the physical space that they had was probably a concern. So if your baby is in a separate room compared to in one room where there may be up to eight cots and staff looking after those, you could see that eight families potentially coming and going would be a concern. I think it is one that could be mitigated and it could be considered how you reduce that, and lots of different things that we could take into account here as time went on, whether that's PPE, whether that's testing. But as Tamsin said this morning when her -- even when they are in a private room it seemed like at some stages that wasn't anything that was taken into account and any changes that were made.

In a unit typically as well you would have not just the room that the babies are in, but you would have a feeding -- expressing room, you would have a kitchen and other areas where families are supported, as I said, because they are there 24/7, they have additional support to allow them to be there. That also gave them the ability to cross over with other families and our experience is that those additional rooms were closed as infection risks.

Q. You have referred in your statement to the situation in Wales and you have said that Bliss met with the Welsh Government in the summer and autumn of 2021 because the guidance was that one parent could be present at a time.

What was the intention of those meetings and if and when did that lead to any changes in the guidance?

A. I think I would refer -- that's Bliss, so I wasn't a part of those meetings, but my understanding is that they were certainly hoping that those restrictions would be reduced, given that there's guidance in place. I think it took longer than that to actually see that and to hear from families that a more ideal situation was taking place.

Q. I think you have said in your statement that it wasn't until May 2022 that in fact those changes were made. And then in England and Scotland and Northern Ireland in

fact, it was in April 2022 that the guidance was for unrestricted visiting in neonatal units.

A. Yes, it was much later than we all might have presumed that the Covid period had an impact. It was actually several years on.

Q. And in general what were the issues of parents being considered visitors on neonatal units and, again, do you think they should have been?

A. No, we don't think they should have been. I would say in those early few months then yes, when we were trying to understand how the pandemic and how infection worked and knowing that babies are particularly vulnerable, it was a huge concern for everybody. So caution in those early months is completely understandable.

The impact that that had on families and babies is significant and you have obviously had an impact witness who has given you an idea of an individual family of the impact that that had. As I said, that also had an impact on babies themselves. Those early few weeks you get to know your baby. You get to see -- they change very rapidly and one of the worries that families with a baby in a neonatal unit have with separation, even in normal times, is: will I still be able to recognise my baby? They may have masks on them, they may have breathing equipment. If you are only able to

see them for one or two hours a day that is exacerbating the trauma that neonatal parents go through anyway.

Q. Thank you. There were some initiatives that were introduced to try and promote contact where it couldn't be in person, for example video calls in England, and in Scotland there was funding for taxi fares for parents to be able to travel to the hospital where they may be travelling more often than they would have otherwise done and perhaps further. Do you have any feedback on those initiatives and whether they were successful and whether there could be recommendations for further initiatives in the future?

A. My understanding is that we certainly did support those and it recognised the difficult situation that families were in. So just -- Tamsin was talking about that it was a one-and-a-half-hour round trip, I believe. That's not uncommon for families to have to go through and obviously in this period where you have got other children, it is very difficult and, again, we wouldn't want the access and the support that parents have to be negatively impacted for any financial reason.

I think we would certainly need to look at studies and actually have an evidence base for how we best support families to have the maximum access to their baby that they can and if that involves more funding

then absolutely we would support that.

Q. In terms of those initiatives and the guidance in general, was there any consultation with the PBPOs during the development of that guidance or any feedback sought in terms of the implementation and the impact it was having throughout the pandemic?

A. I do not believe so but I'm aware that there was much impact -- much feedback from Bliss and from other organisations to try and get that guidance changed.

Q. In relation to access to PPE and Covid-19 testing to facilitate visiting, it is not until the end of 2020 that in some of the UK the national guidance included use of LFTs to facilitate visiting. Were you aware of any issues related to access to suitable PPE or Covid testing for pregnant women and their partners or family members to attend to visit them in hospital?

A. We haven't done a study to look into the actual impact of that. However, there have certainly been concerns about whether the difficulties in accessing both of those things meant that the visitor restrictions were not relaxed as quickly as they might have been if that was more readily available.

Q. And does the PBPO have any views as to whether increased use of PPE and Covid-19 testing in future should be available in order to facilitate visiting?

A. Yes, it absolutely should. The one impact that I would think about is how you use PPE. So if you are -- and I know you have already had another impact witness whose baby was sadly at end-of-life care and she reiterated they still had to use PPE even knowing that. So I think actually understanding where that fits in and -- having more specific guidance to allow that because that shouldn't have been the case. It is a tragic situation there.

Q. Were PBPO made aware of communication issues with the use of PPE?

A. Yes, absolutely. And specifically in groups that we would class as vulnerable. So people who were maybe -- had difficulties with particular access, whether that's speaking another language or having issues with hearing, they found that particularly difficult.

So there is a National Bereavement Care Pathway that covers all types of pregnancy and baby loss and that very much reiterates across those that -- and it is accepted by just about every Trust in the country, that communication is absolutely key and understanding how somebody is comprehending the news that you are giving them is very much -- being able to see them very much aids you to know, as a professional, whether you need to give them more support in that messaging.

Q. Were you aware of any training for healthcare professionals to facilitate that kind of communication when using PPE?
A. I'm not aware of any, no.
Q. Thank you. You have touched upon, in your statement, support for healthcare workers in implementing the guidance and whether there was any support available. Could you just explain that a little bit more and what the PBPO's experience of that was?
A. Which guidance are you referring to?
Q. It is at paragraph 47 of your statement.
A. I think in general this is around guidance to try and encourage people to come into units and hospitals. I think in general we -- certainly some of my colleagues in the other organisations -- heard from health professionals who were asking them to help to work out what the guidance meant and how they could implement it.

I think in this particular time it feels like training was not something that was prioritised. So we certainly found professionals who felt there was a lot of guidance coming out and they were trying to work through how they did that.

So certainly one of the things that we reiterate is giving support to professionals in understanding what the guidance is and why it is in place.

Q. Thank you. Moving on to a different topic and that is the categorisation of pregnant women as "clinically vulnerable".

Now, you have not addressed this in your statement but I wanted to ask you whether PBPOs were aware of any issues or concerns about that decision to include pregnant women in the CV category and also whether there was sufficient information available particularly early on and advice about what that meant in practice?
A. Most of us support families directly. So getting that message that you are clinically vulnerable is very difficult for people to get and at the stage that was announced in March 2020, none of us really understood enough about Covid. So trying to support people who in general were extremely worried by that and, again, as I said, we were all told to stay at home and adding in that you were also vulnerable to Covid, meant there were people who had appointments, sometimes they were moved to a digital means and sometimes they were told you still need to come in for a scan, and that was a huge worry for people as well.

So I think that that had a significant impact on that group and the support that they sought and their willingness to go into hospital and other settings as well -- GP surgeries as well -- most of those were

closed off, so going in and saying, right, you have got a midwife appointment, we want to check your blood pressure; people were having to weigh up for themselves whether they felt that was a risk they were willing to take, which is a difficult position to be in.

I think you referred earlier to Tommy's who had an increased number of calls. I would say that most of us as charities kept our methods of contact, our support help lines, emails, etc, open and we all saw big increases and they were people who were isolated and scared and worried and wanting to talk to somebody about this.
Q. Thank you. That brings me on to my next topic, actually, in regard to and the impact on mental health. What impact did PBPOs see on the mental health of pregnant women both during the antenatal and postnatal period?
A. I think it is very clear that we saw people who were extremely worried. So this is -- this period of antenatal and postnatal is a period where particularly maternal mental health is a particular focus and the professionals who would support, identify and be able to give some advice to people weren't as readily available. You add into that, as well, that your usual support mechanisms are taken away -- and we all had an increased

general level of anxiety, it was a very difficult period. So these were times when, yes, we were worried about the families that we supported.

From The Lullaby Trust we give out -- the majority of the advice we give out is about safer sleep for babies. We found our calls were much longer and they had a wide range of topics because they were people who just wanted to talk to somebody, and we are not medically trained so we can't give that advice but, actually, what they were looking for was somebody to listen to them.

So I think all the things together, all those elements made it really tricky for families in this period and I know there is research that shows that maternal mental health was impacted by that.
Q. And there was a move to providing antenatal classes and education online. Is that something that was effective and, again, were there any access issues that you were aware of?
A. Yes. So one of our 13 organisations is NCT, the National Childbirth Trust. They are known for giving antenatal classes. Prior to the Covid pandemic they were all face to face. They then had to move those and moved as many as they could online and they had a good coverage of that. Although the satisfaction rate from

that was still high, it was less than the face-to-face ones. My understanding is that most of the classes they run today are back to being face to face.

I would, again, reiterate that there are access issues particularly with digital poverty that we would be very concerned about. But actually the support networks were gone. So having a call where you have maybe eight people joining there, you can't have a chat with them in the same way as you would while you are having -- while you are getting a cup of tea and those are the things that really impacted on people's mental health and their confidence in parenting.

Q. I want to ask you some questions about health visiting. Again, this isn't addressed in your statement, but I believe you have received the statement that we have received from the Institute of Health Visiting.

For context, from 28 March 2020, the NHS England guidance was that health visitors should be considered for redeployment to the frontline, and essentially that the health visiting should be stopped and provided only as a partial service offering antenatal contact and new baby visits only, and face to face only if there was a compelling need and with PPE. The Institute of Health Visiting described this as a profound mistake, and that partial stopping of redeployment remained in England

until 3 June 2020.

Before asking you about the impact of those decisions, can you just explain to us a little bit about the importance of health visiting services throughout the pregnancy journey?

A. Yes, of course. A health visitor is a specialist public health nurse. They work directly with families, often the most vulnerable, so a lot of their time will be spent with those families, and they could have hundreds of families that they look after individually. They will focus on those that they know to be the most vulnerable. So they often go out to those families direct in the early weeks after a baby is born and through up to, I think, when the baby is about 2 or 3, maybe, something like that. They have more regular contact.

They would also have contact through something like a baby clinic, so somebody could go in proactively and say, "Can you weigh my baby?" So they do general checks. They do general checks of the family and of the baby. But they are also there as somebody to listen to, and they do have a safeguarding role to play in that as well. So, yeah, that's what health visitors are there for.

Q. And were any of the PBPOs made aware of issues or

concerns caused by the change in service provision during the pandemic?

A. Yes. From our perspective, in The Lullaby Trust we work closely with health visitors. They are one of the key areas that safed sleep advice goes out. They also run a programme that we run, called CONI, which is Care of Next Infant. So that is more intensive health visiting who have had a baby die suddenly and unexpectedly, previously. And it was those health visitors who were trained in the CONI programme who called us immediately, that is, this is the first wave that we were aware, saying, "I'm being redeployed, there is nobody to look after my families, are you going to be there? Can I refer them to you because I'm really worried about them?"

And we were -- we did manage to stay open. Usually we would offer support through health visitors for CONI families, but in this respect, we were -- we said give them our contact details. So health visitors were the ones that contacted us, worried about the families that they were being redeployed and leaving behind.

Q. Obviously, as a charitable organisation, you wouldn't have been able to help everybody; were you aware of examples where the health visitors weren't -- were

redeployed and there wasn't anybody available to look after those families?

A. Yeah, we certainly heard from families in those situations. There are some practical elements to this programme, to health visiting, as I said, in terms of, like, weighing a baby, for example, answering questions on feeding. But when you are sitting there with somebody, families tend to open up a bit more, and in the Care of Next Infant programme where we have evaluated it in the past, the part that families always say is the most important part isn't the monitor that they are given, or the guidance, or the extra equipment; it is actually somebody to listen to them.

So I think, actually, that is a really significant thing that we may not be able to measure, but it again increases that isolation that the most vulnerable felt.

Q. And would the same level of care have been able to be provided through the use of online and remote consultations that you have just described?

A. No, not the same, and just to also reiterate that, I touched upon the safeguarding role that health visitors play, and looking at the wider family setting. So, for example, thinking about mother's maternal health but also going in, and practically they might say things like "Show me where your baby sleeps" or ask them how

they are doing, or be aware of other issues that they might, by being in the home, be able to pick up. And that's a lot more difficult to do in a call.

Q. And were you made aware of any issues with access to suitable PPE in order to carry out the visits that were deemed necessary?

A. Not in terms of PPE. What we did hear were health visitors who, when they were able again to go out and visit families, weighing babies on a doorstep; so the family having to pass the baby to the health visitor who weighed the baby outside and then handed them back again.

Q. And as far as you are aware, had health visiting services been fully reinstated by the middle of 2022?

A. No, I think that they -- their -- they -- we need more health visitors than we have already, and my understanding is that it is still not back in the place that it was prior to the pandemic.

Q. A different topic. You have addressed, in your statement at paragraph 49, the inclusion of pregnant women in medical trials and treatment programmes for Covid-19. Can you just elaborate on that, please?

A. Generally, I think it is right to say that even outside of Covid, pregnant women are not included in medical trials in the same way as other groups might be, and

that was certainly the case for Covid-19.

Q. And then the Department of Health and Social Care has told the inquiry that there was funding made available to bless Tommy's and Sands organisations within PBPOs in April 2020 to provide bereavement support and to share the Covid-19 messaging to a wide audience. Did that funding have any positive impact on those two areas?

A. Absolutely -- I can't reiterate enough the good work that the 13 organisations do. Any funding that was available in that time would have been put to good use, and -- I don't want to downplay the funding that was given, but it was given for a short period at a time when, as organisations, we were all receiving far more contacts and trying to give out messaging to people in completely new ways, whilst also being at home ourselves with those challenges.

But, for charities, we saw from March 2020 our incomes go off a cliff. So any funding was helpful, but the funding available there, yes, it didn't pick up the level of income that charities saw dropping, as I said, at the same time that our services were stretched to the -- we had more calls than we had ever had before.

Q. Was there funding provided later in the pandemic as well? You said it was short-term, but was there further funding?

A. There was some through the National Lottery; there were other trusts and organisations who did an amazing job trying to offer emergency funding, but our incomes are not back to where they were pre-pandemic. And I think that's -- across the board, that is fair to say, it has had a huge impact on all of us.

Q. And, in turn, has that had an impact on the service that can be provided?

A. Yes. Yes, it has. Yes.

Q. You have helpfully set out a number of lessons learnt and recommendations in your statement. Are there any that we have not covered that you wish to draw attention to today?

A. I think just the general issues worth reiterating of the prioritisation that we believe should have been given to this area of healthcare, and I think it goes wide; it is not -- it is visiting, it is funding, it is the impact longer-term on babies, the impact on staff, the safeguarding issues around having contact with people in a very vulnerable part of their lives, but also in terms of bereavement as well. So all those areas, we would like to see that there. I think -- I mean we have touched on it quite a bit, but the communications are really, really key, and all of us work really hard. I think all my colleagues, when we are putting together

advice, we use researchers and we use experts, and we also use the people who the advice needs to get out to. So, using us as organisations, understanding the role of charities and voluntary organisations and the direct work they do, I think, could have had a much better impact. Also supporting staff. So we did support staff as well and we certainly realised the heavy impact on them and the lack of training that many of them had.

So those are things that we would also like to reiterate. But yes, it was a very difficult period for everybody.

MS HANDS: Thank you, Ms Ward. I don't have any further questions.

My Lady, do you have any questions?

LADY JUSTICE HALLETT: No, I don't. Thank you very much indeed, Ms Ward. You are a superb advocate for the causes that you are representing. Thank you so much for your help, it has been extremely constructive and at times very interesting. Things have moved on a bit since I gave birth.

A. Thank you.

LADY JUSTICE HALLETT: Thank you.

(The witness withdrew)

MS HANDS: My Lady, I understand that this afternoon's witness will be arriving shortly. So perhaps I may

invite you to take an early lunch. I know it is quite early but she will be arriving shortly this afternoon.

LADY JUSTICE HALLETT: And obviously you would like to speak to her before --

MS HANDS: I would, if possible, my Lady.

LADY JUSTICE HALLETT: Very well. If I return at 1.30 pm?

MS HANDS: Yes, I'm grateful, my Lady.

(12.27 pm)

(The short adjournment)

(1.30 pm)

LADY JUSTICE HALLETT: Good afternoon.

MS HANDS: Good afternoon, my Lady. If I may call Gill Walton who will affirm.

MS GILL WALTON (affirmed)

Questions from COUNSEL TO THE INQUIRY

MS HANDS: Ms Walton, you should have your witness statement in front of you. That is INQ000347411.

Ms Walton, you are here today to give evidence on behalf of the Royal College of Midwives and its members; is that right?

A. That is right.

Q. You hold the role of Chief Executive and General Secretary, a role you have held since September 2017?

A. That is correct.

Q. And you also have been a midwife since 1987 and prior to

joining the College you had midwifery experience in the NHS; is that right?

A. That is right.

Q. And it is correct that the Royal College of Midwives is a trade union and professional association across the UK?

A. That is correct.

Q. And can you give us an idea of the size of the team that work within the College?

A. So the Royal College of Midwives has got 100 staff and we work across all four countries of the UK and actually also the Channel Islands as well.

Q. Thank you.

My questions today are going to focus on the role of the Royal College during the pandemic and then go through the maternity journey, as it were, with a focus on the provision of maternity care and visiting restrictions and then to look at the categorisation of pregnant women as clinically vulnerable, IPC measures, and then mental health and well-being support and the impact of Long Covid on the midwifery workforce.

Starting, then, with the role of the College in formulating and issuing guidance for the maternity sector during the pandemic, is it right that outside of the pandemic the College had a role in producing

guidance and worked with the Royal College of Obstetricians and Gynaecologists to do so?

A. We did. In fact, the guidance -- we were quite separate in terms -- before the Covid pandemic we produced guidance quite separately as two organisations. The pandemic actually brought us together to produce guidance -- and with other organisations. So it was different. It is something we started almost immediately -- well, even before lockdown, actually, we got together and said we really need to do something about providing advice and guidance.

We are quite different from the Royal College of Obstetricians and Gynaecologists and other medical Royal Colleges because we don't produce educational standards, it is just guidance and advice, and that misunderstanding is quite -- is difficult at times because we can't hold our members or the organisations they work in to account, in terms of: you must do this. It is just guidance that then is accepted by the NHS or the organisations that are members working. So we are very --

LADY JUSTICE HALLETT: So who does provide -- sorry to interrupt you -- who does provide the educational standards for midwives?

A. That is the Nursing and Midwifery Council provides

standards and proficiencies for midwifery.

MS HANDS: And in terms of the clinical guidance that was available for maternity services before the pandemic, is it right that that was produced by the maternity services themselves, so local protocols and NICE guidelines?

A. That is correct, and NHS England to some extent as well.

Q. Is it right that the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives and the Royal College of Paediatric Child Health all took the lead together, as you've mentioned, on developing guidance on managing Covid in pregnancy?

A. Yes, we did because we realised that clinicians working in services would need some help and guidance, and we -- for the Royal College of Midwives, we became very focused on that piece of work and basically stopped business as usual in order to do that. We felt it was essential to be as helpful as we possibly could be for clinicians, and hopefully for the NHS, in terms of then adopting that guidance.

Q. And were you asked to take on that role or was that a role that just naturally happened?

A. No, we weren't asked to take on that role at the beginning. We took it on as we thought it was the most useful thing that we could do as a collective team.

Q. And is it right that the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists set up a guidance cell which initially was meeting daily in order to develop the guidance?

A. Yes, so we set up the guidance cell with appropriate people on there. People who had a background maybe in research or clinical practice, expert clinical practice. They called in other people when they needed it depending on what guideline they were looking at.

I think the Covid cell was daily. I can honestly say that myself and Eddie Morris, who was the president of the RCOG at the time, spoke, if not daily, sometimes several times a day, so that we could try and be on top of the constant changing nature of the pandemic, of the Covid virus, and people's understanding of it.

So we tried really hard to make sure that the guidelines and the advice that we were given was as up to date as it possibly could be.

Q. And on that very point, it is right, isn't it, that the first published guidance on pregnancy during Covid was published on 9 March 2020 and there were a further four updates in that month to that piece of guidance?

A. That's absolutely correct. You will see with the amount of guidance that was produced both jointly and us as an organisation ourselves, we had guidance that we

constantly reviewed, updated, re-wrote, and re-published all the way through the pandemic. It became one of the biggest things we did.

The joint guidance that came from the cell, it was purple in colour, we joined our colours, actually was used all the way around the world. It was recognised as a really good resource on Covid and it was -- the access on the websites was well in the millions, which was encouraging. And I can say that we were proud of that work and we were hoping that it was going to be helpful.

Q. And is it right that there were other advisory groups that the Royal College of Midwives set up during the pandemic?

A. Yes, so we had an internal professional advisory group. So that was looking at things particularly for midwives, so the things that midwives would only be doing so, for example, home births.

We also used midwifery professors to do various bits of guidance. They -- often when we have used professors in the past on guidance it takes years. A piece of guidance or some advice can take years and years. Everybody was doing things really quickly. We knew that it may not be perfect and we had to accept that. We had to do something as quickly as we could to be as helpful as possible and then review it and change

it if it then turned out not to be right. We thought that was really important rather than spend weeks and months making sure that something is absolutely perfect.

Q. Looking to the future, do you think it would be helpful if guidance was available or had been prepared in advance so that it could be used if there were another pandemic -- obviously, as you have said, there would need to be updates and changes to it, but if that was standing there ready, do you think that would be helpful?

A. I think it would be helpful to have a framework for guidance that could be used in a future pandemic. I think the most important thing is that it is everybody who is involved in delivering maternity services, for example. So the Department of Health with their maternity team, NHS in all the countries, the colleges that are all involved in delivering maternity and neonatal care, coming together with a single version of the truth and doing as much of that as you can. Obviously you never know what particular strain of virus that you are dealing with, so it would have to be developed at the time but there's definitely something about making sure that women and families get really clear advice and the staff delivering care get really clear advice and everybody is saying the same thing.

Q. And it is right, isn't it, that the College also set up a helpline in response to the pandemic? Can you provide some examples of the type of matters that they dealt with and who it was staffed by?

A. So, we had a helpline for both our members and for the public and the RCOG and we staffed it with clinicians. We wouldn't normally provide that service as the Royal College of Midwives to members of the public, that isn't actually our role, but we realised that there was a lot of confusion in terms of information and advice to women and so we decided that it was helpful for local clinicians caring for women, that if we could give some very clear advice that would be helpful to them.

We also, as part of the guidance we were producing, often had a page that was for information for women that midwives could use, so not necessarily direct to women but could be used in a conversation with women in their care. And again, we thought that was helpful and maybe clarified some confusion.

The sort of calls we often got from women were about visiting, about availability of home births, particularly when they were really frightened and just having some clarification about the impact of the virus on pregnancy was definitely something that they wanted to know.

Q. And you have said in your statement that from the outset the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists were clear that it was vital to maintain all aspects of safe maternity care and to designate it as an essential service particularly in the context of serious pre-existing staffing shortages. Can you briefly describe what the pre-existing staffing shortages going into the pandemic were?

A. There had been a shortage in midwives -- for midwives, obstetricians and other members of the maternity team over many years and we anticipated that shortage to be between 1,500 to 2,500, it is difficult to know exactly, and that gap wasn't closing. So basically we went into the pandemic with already a shortage of midwives and maternity team which was already having an impact on the quality and safety of care.

Q. And is it correct that on 7 April, following a meeting that the College had with the chief midwifery officers of the four nations, the College were provided with reassurance that in fact maternity services would be prioritised?

A. Yes. So we had brought it up as an issue because we had lots of connection with our members, particularly the Royal College of Midwives, because we are also a trade union. So we have a branch structure. We have our

Royal College of Midwives members who run branches in local services, we had loads of meetings with midwifery leaders, we were very in touch with the frontline. One of the things we were really concerned about was that maternity services weren't seen as an essential service locally and potentially nationally, and that's having a major impact on the ability to deliver safe care because, you know, the focus was really on intensive care units, respiratory areas and emergency departments. And maternity is an essential service, you can't stop it. You know, delivering that safe care is absolutely a priority for any NHS service.

So we called that meeting in April and said we really needed to be -- it needed to be a guarantee that all NHS services recognised that maternity was essential. So, for example, there were definitely issues were some midwives who were duly qualified, so there were nurses and midwives maybe then redeployed to an intensive care unit or a gynaecology unit, and then depleted that midwifery staffing even further. Anaesthetists were definitely an issue, they were also redeployed which then led to issues around being able to provide safe epidural services. So there were lots of examples that were raised with us as a huge concern and a huge anxiety amongst the staff, but also in terms of

the women as well accessing care.

Q. Thank you --

LADY JUSTICE HALLETT: Can I ask you to speak more slowly.

A. Yes, certainly.

MS HANDS: We're going to come on to look at some of those examples you've just given in more detail. If I can move on, then, to the topic of antenatal care during the pandemic. Guidance was produced by the Royal College of Obstetricians and Gynaecologists on 23 March 2020, which advised a minimum of six face-to-face antenatal consultations and three postnatal contacts, with the option for video and remote as an alternative and included guidance on how to risk assess and prioritise services in the event of staff shortages.

How did that advice differ to before the pandemic?

A. So before the pandemic, there was a minimum of ten antenatal contacts, slightly different between first-time and second-time mums. That is the very basic. If women have comorbidities or need additional care, so for example, if they had an obstetric problem they may be seen far more than that. Postnatally there is not really a minimum, but it must be a minimum of three, potentially four, and again if women in the postnatal period have particular problems and need more support, then obviously there is many more visits than

that normally.

Q. And in the college's experience, was that advice followed?

A. Actually, the -- I would say that midwives tried really hard to maintain their face-to-face contact because it -- they felt it was so important. They were anxious that they weren't doing that. There were occasions when they couldn't because they didn't have enough staff. What was reported to us was that in fact when they started to do online and telephone contacts, some women ended up with more contacts than they had previously because that wasn't a system that they had used. So, they certainly prioritised more contacts for women who were anxious, had complications, had Covid, there was definitely an increase in contact, but not necessarily face to face.

Q. The College produced guidance in July 2020 for the use of virtual consultations. Was there any guidance available before July?

A. No. I think there was some loose conversations about virtual consultations but we realised that there were different techniques being used around the country which was causing confusion, so that's why we did that guidance.

Q. And was there any analysis carried out of the impact of

that immediate roll-out of virtual antenatal and postnatal appointments to ensure that pregnant women did continue to get the level of safe care that they needed?

A. Are you referring to our survey?

Q. Yes.

A. Yes. So we did a very quick survey to -- just to make sure that midwives were using the guidance and continuing to provide as much care to women as they could in --with the backdrop of actually having a much-reduced staffing. Also there were real issues about delivering community services with a lack of PPE, not knowing whether the people you were caring for had Covid or not. So there was an anxiety amongst the staff about caring for women in a face to face setting in a community setting particularly in somebody's home. So we could see that the telephone and video contact was being used maybe more than we anticipated, because it made -- it helped the anxiety of going into the unknown and visiting people in their own home.

Q. And were you aware of there being any draw backs to that, for example, digital exclusion or access to equipment?

A. Yes, that was reported to us. So we realised that some women didn't have access to a phone or an iPad or a computer, and also for women whose first language

wasn't English. I think a lot of services picked that up as issues and tried really hard to prioritise those women for more face-to-face contacts, but that took a while to get in. But that definitely was an issue.

Q. Thank you. I want to have a look at a graph with you, and this is INQ000485652. This relates to antenatal scans in England before the pandemic but also during the relevant period as well.

We can see from this graph that there was a drop in non-routine antenatal scans and routine antenatal scans during wave one and wave two of the pandemic.

Can you briefly explain why those scans are so important and the potential impact of there being a decline?

A. So, some of the scans -- the routine scans are at 12 weeks and 20 weeks. They really are important to make sure everything is fine with the pregnancy, with the baby. There was a reduction in women accessing those scans. Some of it, I think, was because they could not take their partner or they were worried about coming into a hospital environment. So the "Stay at Home" message definitely impacted on pregnant women at that time.

I think the non-routine scans, that is checking for babies who may not be growing properly, babies that

may not be moving properly, they did reduce, and some of that wasn't because women weren't coming for the scans; my understanding from our members was that some of the women hadn't reported that they had a concern, and there was definitely some confusion around accessing maternity services because the message was "Stay at Home". Our message was very much "Maternity services are open"; I certainly went out in the media myself and said that many times because we were really worried that women would be frightened, they would stay at home, and that something might then happen to them or their baby because they weren't accessing appropriate care, and I think that might be what that graph is telling us.

Q. Thank you. And there was a guidance from the Royal College of Obstetricians and Gynaecologists on telephone triage in relation to the non-routine antenatal scans, so if there were concerns -- if a woman had concerns and whether a scan or consultation was needed straightaway, or there could be a safe delay. Was the College of Midwives aware of any training or guidance for that move to telephone triage that was published?

A. I'm not really aware of any local training. Obviously we had our guidance, and because it was guidance and not necessarily enforced, it would be up to NHS England and local organisations to adopt that guidance locally and

put in the training for it. So I can't answer in terms of what happens in every single organisation. My hope would be that if something was going to be done differently, like telephone triage that there would be training for the staff that were going to be doing that.

Q. And you have touched on the "Stay at Home" messaging but in the college's experience, was there an impact caused by the reduced access to primary care, so GP services as well?

A. Yes, I think the "Stay at Home" message impacted women accessing primary care, midwifery care, and coming into hospital. I think there was a lot of anxiety around particularly when women were classed as vulnerable, and that absolutely impacted on access to appropriate maternity care.

Q. I want to ask you some questions about the visiting guidance in antenatal settings. We have heard quite a lot of evidence about this already, but the Royal College did issue a briefing in July 2020 on the re-introduction of visitors to maternity units across the UK. You have summarised that paragraph 35 of your statement, can you just explain what that briefing included?

A. So, after the first lockdown, where access to NHS services was -- there was almost a blanket ban on

visitors and we definitely were part of the advice to at least let partners in during labour for women. That was absolutely important. The issue about opening up, so the visiting opening up and absolutely I -- you know it was such a stressful time for women and families, for the staff who were looking after them, staff didn't want to tell people they couldn't have their partners with them during their whole maternity experience because that isn't what midwives do. But they were working in difficult environments, tiny spaces, really difficult to socially -- to have a socially distanced care. There was a shortage of PPE still. And so, bringing more people into inappropriate environments was really difficult for lots of services, and midwives were really worried about the impact on increasing infection for the staff but for the women and families and the babies that were in the services.

So opening up the visiting was a really difficult thing for people to do. They really wanted to do it, but the practicalities of doing it was a different story.

I think the other thing that happened at the time, we have some really great maternity services round the country that are very new, have single rooms where women and their partners can stay practically the whole stay

in the maternity service. Those services did really well in terms of being able to open up, but those services that didn't have those sorts of environments really struggled. So, for example, in antenatal clinics there were some that were co-located with gynaecology services or gynaecology cancer services, and then there were also pregnant women with their partners. It was very difficult to create a safe environment for opening up a maternity service to what was happening before.

Q. So if I could just bring you back to the question of this briefing in July. What led to the College producing guidance on reintroducing visiting at that point in time?

A. We just wanted to make sure that it could be managed appropriately. We would have hoped that NHS England would put out very clear guidelines for opening up that could be then localised but that wasn't happening which --

Q. We are going to come onto that in a moment --

A. Okay.

Q. -- that specific example that I think you are talking about. So at that point in time in July, it is right, isn't it, that the guidance across the UK was quite varied as to whether services were opening up visiting or not?

A. Yes. And also they were localised, there were different lockdowns in different parts of the country. I think that caused huge confusion. And social media didn't help. I think it was -- on social media there were different stories from different parts of the country and then people jumped on that bandwagon and created some more confusion. Social media didn't help the: what should we do? What's the important thing for the NHS to do? How do you keep staff, and women and babies safe and how do you do this in a clear logical way?

And while that was being sorted, of course the infection rate started to go up again. So some services hadn't even managed to open up hardly at all before we knew that there was an increase in infection rates.

Q. You have spoken there to the inconsistencies and variation across services, so not just across the UK, but across services as well, as to whether the guidance was in fact implemented or followed. What impact did that have not only on pregnant women but on healthcare workers in those settings as well?

A. I think it made people very anxious because at the time I think NHS England were praising those services that were opening up, and some could, and then being quite critical and putting targets on services that couldn't open up and giving them deadlines to open up and I think

that caused a huge anxiety and we had lots of meetings with midwifery leaders who expressed how difficult it was to keep thinking about the safety of women and families and their staff in quite often poor environments that they were working in and they could not see how they could completely open up services safely.

Q. Who would be responsible in a hospital or maternity unit for implementing the guidance actually on the ground, do you know?

A. So, in the maternity service itself it would be the director or head of midwifery who would really know their service. But the infection control teams in a Trust would absolutely have a view on that and I think sometimes -- I remember some of the heads of midwifery, directors of midwifery saying to us that there was a change in policy and the infection control departments were putting in processes for opening up. But actually the midwives themselves were saying: but actually, I'm not sure this is going to work, we have got a very small, for example, four-bedded postnatal ward where the beds are really close together, there is four mums, there is four babies, and then we have mum and dad and maybe grandma as well. That is a huge infection risk and not being able to distance.

So there were lots of pressures and I know from speaking to our members at around that time, their anxiety levels were huge. They could see that the country seemed to be opening up but infection rates were starting to pick up again and they were thinking of ways of preventing harm. So it created a huge anxiety for the staff and for the women.

Q. And a lot of the guidance around this time in July 2020, in the summer, moved to local risk assessments and a local approach. Was there support, I suppose, and advice on how to undertake those kind of local risk assessments in the context of Covid-19?

A. From the NHS I think some of that advice was quite limited. Because we are also a trade union our health and safety activists in those services were helpful and we provided them with some support and guidance for that. So I think we were quite lucky in that because we are a trade union we could also provide support and guidance to people locally.

But I think this was a bit of a theme. There was slow information coming into services for local services then to do the right thing.

Q. And was there enough information about the rationale for the changes to the guidance for healthcare workers who were implementing it but also for pregnant women as well

who were --

A. I think, as I have said before, I think it was very confused.

Q. And did the College take any view on parents being designated as "visitors" in maternity settings?

A. Actually, they shouldn't be visitors. Our view was that they are equal partners, parents of the baby. But we absolutely recognise the difficulty in having additional people in some areas within some hospitals and the risk that potentially that caused. It was horrible. It was horrible for those parents. It was awful for the staff because they didn't want to do it either. Midwives absolutely see parents as both parents of the baby, even though the mother is the one having the baby, and I think it caused a lot of stress for them.

I think the guidance created some friction sometimes between the staff and the parents because of course they wanted to be there and it was right but actually there was still a risk and that caused some really difficult moments, I think, in maternity services. And on social media.

Q. And does the College see that there would be any merit in having, for example, a national framework for visiting perhaps with an element specific for maternity settings to ensure that there was consistency,

predictability, but also that support as well for those that are having to deliver the news, that there would be restrictions?

A. Yes, and I think that would be a recommendation going forward, a single truth but with a framework that has to be -- it has to come from NHS England, not from the colleges, that give people a framework in which to assess their services and localise them if necessary but the most important thing that that is then transcribed into really clear communication to the local population, so everybody is clear what that service is doing, and why, for that reassurance.

I think -- I mentioned social media before because I think social media created some confusion itself because different services talked about what they were doing and how unfair it was that the service down the road wasn't doing it and it didn't help the anxiety between groups of parents and staff and it made people angry, it made parents angry which I absolutely understand.

Q. You have said in your statement that the extent of the guidance that the Royal College of Midwives provided was an indictment of the lack of guidance and leadership provided by central government and NHS England, and we are going to come on to look at a specific example of

that in a moment, but was that also the case across Scotland, Wales and Northern Ireland?

A. Scotland, Wales and Northern Ireland, it was different because they are such small countries and I can talk from the Royal College of Midwives' perspective. The midwives in the government and the senior midwives in the NHS in those countries and the RCM all knew each other and they had worked really closely together in the past and they provided -- they sat down and worked it out together probably more than England. Different countries did things at different times and I can't remember what all of those things were but they did visiting restriction, they lifted visiting restrictions at different times, they had different rules and that caused a confusion. But I do think the way the other countries managed it was clearer for both the public and the staff working in the services.

Q. So if we were to look forward to having some form of national framework, would you support that being across the UK?

A. Yes, definitely because different countries would look at each other and say, well, in Scotland visiting has been lifted, that's not fair for England and that then creates that anxiety amongst women and staff.

Q. Moving on, then, to specific examples where the Royal

College of Midwives and the Royal College of Obstetricians and Gynaecologists took action in response to guidance and visiting guidance specifically in England.

If we could please go to INQ000280503.

At the bottom -- this is an email, sorry, from Mr Morris from the Royal College of Obstetricians and Gynaecologists sending to NHS England, with you cc'd in, on 10th July 2020. So, again, around this time that we are talking about, the changes in guidance.

In that last paragraph there on page 1 he said that:

"While we understand restrictions on visitors remain in place in some Trusts in England to ensure compliance with social distancing measures and prevent the spread of Coronavirus, we think it's vitally important that NHSE/I urgently produce a framework or set of principles to enable Trusts to take a consistent approach to the approach to the relaxing of out-patient and in-patient visiting restrictions on maternity units. There needs to be a reasonable balance between continuing to protect women and staff from in-hospital transmission and enabling vital support at appointments, during induction of labour and from visitors on postnatal wards."

If we go up we can see the response that in fact comes from NHS England the following day and that is the second paragraph:

"You will no doubt appreciate that we cannot address this issue within maternity in isolation, notwithstanding the particular need women have for support during maternity appointments, and we are operating within a fixed set of parameters, including in particular the decision that there will be no relaxation of the 2m social distancing rule in hospitals in England."

What was the College's response to that response?

A. If I remember correctly we wanted NHS England to not have a blanket approach for all NHS services and have maternity as a separate consideration. But bearing in mind that there would still have to be consideration about keeping everybody safe. But I think the key issue about these emails was about the lack of response. It was taking a long time to sort out a growing concerning issue around visiting and the inconsistencies and how unhappy women and families were and the staff were about not having clear guidance.

I think we were trying to ask very clearly that NHS England had to put in some -- a much clearer consistent framework so that everybody knew what they

should be doing because the confusion was causing more stress and particularly for women, it is a very stressful time having a baby, having a baby in a pandemic with inconsistent guidelines is even worse and staff then not being able to be really clear themselves about: this is what we are doing, this is why, this is when it will start or end. It was very unclear.

Q. And is it right that around this time both colleges had actually been working with NHS England to produce guidance but there was a delay, I think it was until 8 September, when guidance is actually issued by NHS England. Is that right?

A. That is correct, and I think it was a general, you know, looking again at recommendations, that if everybody is working together to produce guidance, how is the red tape removed in terms of getting them through various processes to get that guidance out quickly? Because I think we were working really hard and really quickly to produce guidance that was asked of us by clinicians in services and we couldn't endorse it. It was almost a gift to the NHS to say, look, we have done all this work, it needs to go out. And I think there were delays and this was absolutely one of them where if that guidance had come out even three or four weeks earlier,

then the upset, the harm, the anxiety may have been reduced just over that period of time.

Q. The guidance that was produced in September was a framework to reintroduce access for partners, visitors and supporters of pregnant women in England and focussed on local risk assessments and regular reviews, with a look towards parents being considered essential visitors.

Did the College agree with the approach towards local risk assessments at that time and did it endorse that guidance?

A. We did endorse that guidance but my memory is that we felt anxious about the local risk assessments because, again, services that could accommodate easily and safely women and their partners could have a risk assessment that would say, yes, this is fine and then others would really struggle with that. So we were anxious about it.

Q. And were you aware of any issues that Trusts had implementing that guidance?

A. My understanding was that there were concerns and they were trying to feed that back. They fed that back through us and then directly to NHS England.

There was an issue, I think, at the time, and it goes back to maternity services sometimes being the forgotten service in the NHS and where midwifery leaders

don't have a voice at the board, for example. So when there were local issues some midwifery leaders struggled to have their voices heard in terms of: we are struggling with this, we need some help, you know, we can't do this. I think there was definitely some tension there about how maternity services are structured within the NHS and it is very difficult to raise issues appropriately.

Q. Were there any changes to the guidance in response to those concerns that you have just mentioned?

A. I think so. Have I got that in my statement? You will have to refer me.

Q. I think the next changes to the guidance in fact are in December.

A. That is right. So it took until December. And I think you will find in some of the evidence lots of email exchanges and conversations -- there were lots of conversations that obviously aren't recorded.

Q. In December the guidance from NHS England was that a woman should be supported by another person throughout the pregnancy journey. So it moved away from that local risk assessment approach --

A. Yes.

Q. -- and encouraged units to change the layout and to ensure there was regular testing. Again, is it right

that the College had some concerns about increased attendance at that particular time?

A. We definitely did because the gap between September and December was too long and obviously by December the infection rates -- we had a new variant of the virus. Infection rates were increasing and so increasing the numbers of people walking into maternity services was increasing the risks for mothers, babies and staff. So we were very worried about -- staff were very worried about that. And, again, I think it is about acting quickly. It's about -- I suppose it is about predicting that. You know, absolutely right in the summer, visiting guidance started to open up by December. If there wasn't going to be an increase in infection, yes, let's start encouraging services to have partners available throughout the whole maternity journey, but we had another strain and the infection rates going up again and nervousness about: will the staff be impacted, will they get -- and in fact staff did get the infections, they were sick. In some services 40% were off sick.

So it was a really difficult time in terms of December being the time to completely open up maternity services.

There was an issue as well about testing, so

testing came in around the same time and it was so distressing for women and partners to come even into a labour ward setting and partners to be tested and were positive even though they were unwell and not able then to come into the service. Obviously women were asked to designate another person in case that happened but that caused serious anxiety, concern, some really awful behaviour as well and I absolutely understand that, but I know midwives really struggled at that time.

Q. And it is right, isn't it, that the College didn't endorse that guidance in December, but in fact issued its own ten commonsense principles which was focused on localised decision-making and risk assessments. What were the reasons, if there's any additional ones to those you have already given, to the College issuing those principles then?

A. So those principles actually came from our conversations with midwives on the ground who were saying that they still need to have -- there needs to have a -- a framework that was based on the local services that were commonsense principles that they could then communicate to women and families: so we thought, and most -- they were mostly adopted then by NHS England, but they came from clinicians, they came from midwives and maternity support workers working in clinical services and what

they thought would be most helpful in keeping everybody safe.

Q. And in the development of that guidance in December by NHS England, had the College sought to bring those principles to their attention?

A. Yes, we did. Yes.

Q. Are you aware of why they couldn't support them at that time?

A. I think it was because they were still looking at a whole-blanket NHS approach, and that they wanted to open up maternity services for parents because there was a lot of pressure from parent groups, rightly so, from the public, from the media, from politicians, from journalists. So I think NHS England -- and I can remember speaking to them -- were under huge pressure to respond to that, but actually were maybe not thinking about the total risk of keeping staff safe, and keeping women and babies safe. And it is a difficult decision to make when you are under that much pressure from external agencies. I get that. But, actually, we are a membership organisation, the staff were really important; if staff were sick or having to isolate, they can't look after women and families, and it was really important that we helped to try and get this right.

Q. And do you know if those principles were used across the

UK?
A. I think some services did use them, but again we couldn't mandate them to be used. NHS England, I think, did support some of them, so there was some leaning towards those principles being used, which was good. And certainly some of the midwifery leaders that we spoke to regularly really welcomed them and used them in their services.
Q. And you have touched upon the colleges' communications with NHS England and the like in regard to the guidance. To your knowledge, was any consideration given to consulting with patient representative groups during the development of that guidance?
A. From NHS England?
Q. Yes.
A. Yes, I think so. We also had a system in the Royal College of Midwives, we have -- with the Royal College of Obstetricians, we have something called "One Voice" where we have parent and baby charities and the colleges together, where these issues could be discussed. So we certainly discussed the things within our guidance with parent groups, and we would encourage that locally as well with maternity voices partnerships and women. So we would encourage midwifery leaders, for example, to discuss a local guidance or changes to guidance with

their local groups. That's really key.
Q. And did the College communicate with the chief nursing officers or chief midwifery officers in the four nations regarding the guidance?
A. Yes, we did, and we had lots of conversations about that. In England we did escalate some of the issues and the discrepancies we had, and the length of time, to Dame Ruth May who was the chief nurse, and she was quite helpful in terms of unblocking the way in some of those issues.
Q. You have touched upon the issue of testing to facilitate visiting in hospitals. And that that came in, certainly in England, at the end of 2020 and in Wales in middle of 2021. Could the introduction of IPC precautions, for example, testing and access to PPE earlier, could have helped to facilitate visiting?
A. Absolutely. Definitely would. I mean, if there was PPE for visitors, for partners, for the staff, testing for everybody, it would reassure people that -- of the situation, you know, who they were looking after and what the risks might be, that absolutely would have made a massive difference.

I mean, it is interesting, isn't it, that -- I'm not sure now whether the testing was available elsewhere in the NHS before it reached maternity, but I think

there was an issue there, again, maternity not being seen as a key part of NHS care, an essential service.
Q. Thank you. I want to ask you one more question regarding support during antenatal services before moving on.

If we could have on the screen, please, INQ000474233.

This is the "Every Story Matters" report that the Inquiry has received and the quotation here regarding maternity services is that:

"Going through maternity services and giving birth when the NHS was crashing around me with added layers of having sight loss was hard. All information was paper based, I couldn't see the sonogram and didn't have a partner there to explain things to me, I was full of anxiety. My sight loss wasn't accounted for, they were focussed on navigating care in covid - reading out letters to me wasn't a priority."

That is from a woman who used maternity services during the pandemic. Were you aware of there being communication issues due to the restrictions on visitors and supporters during antenatal appointments and scans, and whether there was any guidance or support available from healthcare professionals for that?
A. Yes, so we were producing guidance about prioritising

services for vulnerable women, disabled women, women from a black and Asian minority ethnic background where we know that their experiences and outcomes were different, so this lady -- would be her experience. So, absolutely, that was -- we really encouraged services to prioritise their care, which was important because their staffing was depleted. So it was really important that whatever they could provide was to people who really, really needed it and they could improve their outcomes.
Q. Thank you.

I want to move on then to birthing options and the changes during the pandemic. We heard this morning about the different birthing options outside of the pandemic being hospital, midwife-led units, whether free-standing or adjacent to a hospital, or a home birth; is that right?
A. That is correct.
Q. It is right, isn't it, that the College, along with the Royal College of Obstetricians and Gynaecologists issued guidance in April 2020 for midwife-led settings and home births in the Covid pandemic which set out a staged approach to support the continuation of home births and births in midwife-led settings, where staffing levels and ambulance capacity allowed, and then also set out a move towards centralisation of services with

restrictions and suspensions of other birthing options, with reinstatement when it was safe to do so. Is that a fair summary of that guidance?

A. Yes, it was a toolkit to be able to maintain services if staffing levels allowed, including the ambulance service, so we were hoping that was going to create some helpful decision-making, and try and create some equality amongst services, because I think at the time some services -- because their staffing levels were fine -- were able to maintain the home birth service and others wouldn't and that was creating competition, really, between services and making women feel that if they wanted a home birth, for example, they would have to change to a different hospital, and it was unsatisfactory in terms of then provision of services.

Q. If we could then -- leads me on to my next point, actually, which is some data we have received from NHS England showing the closures and suspensions in April 2020. This is at INQ000485652.

This is data taken from England in April 2020 and across 130 trusts. You should be able to see that in front of you.

A. Yes.

Q. We can see here that there was, during that month, the suspension of home birth in 60 of those trusts, so just

under 50%; a closure of -- alongside midwifery units there were eight closures, 11 free-standing units were closed, and two obstetrics service units were also closed.

The closures that we can see there, are they examples of services essentially having to centralise, as you have set out in that toolkit?

A. Yes, basically in order to deliver safe care to all women, with the depleted number of staff and access to ambulance services. The directors of midwifery used that to make sensible decisions about keeping all women safe. Midwives really support home births and it was a hard thing for them to do, but a home birth takes two midwives, and that, when you haven't got enough staff, is difficult to do where you don't have enough midwives even to provide one-to-one care to women who are may be giving birth in a local hospital.

I think it is testament to this that not every service closed their home births. They were really agile in terms of doing what they could, based on their staffing numbers and availability of ambulances at any one time, and they always tried their best to reopen parts of the service if they could. I think you know locally some services communicated that really well to the population. Other services may not have done and we

really -- we as a college really encourage good local communication with women about the status of service provision at any one time.

That was really stressful for women, and you will see in some of my evidence that there was then an increase in free births because women really wanted a home birth, there wasn't staff available so they gave birth without a health professional. Some of those women did because they were scared of going into hospital as well, but it definitely had an impact on women being able to access the service they wanted, but it was all done to keep services as safe as possible, that was always the intention, not to deprive people, women, of choice.

Q. Thank you. I'm going to look at some more data in a moment in regard to slightly later on in the pandemic but I just want to stay in this early stage.

It is right, isn't it, that the College made a plea at the end of March 2020 to ringfence maternity services by stopping the redeployment of maternity staff?

A. Yes, we did, and we made that plea quite loud because we heard from our members that staff were being redeployed, and it was having a serious impact on them being able to deliver safe maternity care. That did happen. Staff

were ringfenced although we still had people telling us that it wasn't consistent, and in fact even moving into the next wave of the pandemic, sort of December/January time, NHS England were asked again to make it absolutely clear that maternity was an essential service, and staff should not be redeployed. And that did happen.

Q. Thank you. Were you aware of services having to use healthcare assistants or senior managers or other members of staff who were redeployed into maternity settings to support service delivery?

A. I am not aware of from other services; I know some of our midwifery leaders that we met with regularly were working clinically, because they had to, but they also had leadership responsibilities in terms of managing the services and making decisions, so I think that was quite difficult for them.

Only midwives can -- you know, it's -- midwives -- nobody else can carry out the role of the midwife, that's actually illegal. So I'm not aware of others, from other parts of the unit, coming into maternity, to work clinically, because that wouldn't be possible, which is why maternity services had to be ringfenced. You can't take midwives out of maternity services to do other things because nobody else can replace them. That can't happen.

Q. Thank you. Moving on, then, into June 2020. Data from Scotland shows that of the 14 Health Boards there, only two of them at that period of time were offering the full suite of antenatal care and a survey by the Royal College of Midwives in Scotland showed that there had been significant redeployment in the maternity services in Scotland.

So were you aware of any action being taken to prevent redeployment not just in England but in Scotland, Wales and Northern Ireland as well and whether that had any impact?

A. Yes. So the directors of -- the Royal College of Midwives directors in those countries, and I believe the RCOG as well, very rapidly asked for maternity services to be ringfenced and redeployment not to happen. My understanding is that that did happen quite quickly.

Q. Thank you. In terms of the guidance from the College, after the first wave you have described that a more nuanced and localised approach was required, rather than a "one size fits all" in your statement and the College developed a set of service principles in May 2020. What was the focus of those principles during that period of time?

A. Can you just bring me to --

Q. Yes. I believe it is paragraph 32 of your statement.

A. That's about visiting again.

Q. Yes, I beg your pardon it is at 34. You have talked there about ...

A. So that was --

Q. That's all in terms of visiting?

A. It's all the -- no, that's not visiting, that's about ringfencing maternity staff. By September 2020 all the groups we set up during the first wave we knew that the infection rates were increasing, so we reconvened all our working groups but we had to reiterate the ringfencing of maternity staff and we published that as a press release so that it was out in the public domain, but also making sure that NHS leaders knew how important that was.

Q. Thank you.

If we could have a look, please, at INQ000485652.

Again, this is data from England on the closure and suspensions of home birth services, freestanding midwifery units, the alongside midwifery units, and obstetric units. This is data that was collected from May 2020 because that's the date that the maternity services were formally included in the sitrep data in England. So we can see here that there is, again, a suspension -- a number of suspensions of home birth services during the second wave.

What was the guidance from the Royal College around that time for services to continue during that second wave?

A. So in the second wave our guidance was the same. The toolkit for making sure there was safe staffing, safe transfer, ambulances, so that all women could be kept safe but to open up those services if they could, if staffing levels allowed. London had a particular issue during that time, being able to -- being able to have enough staff to provide home birth as a choice and so the choices were withdrawn and we were really supporting our members to make those commonsense decisions about making sure there was enough staff in central places in order to care for the women as safely as they could. And it did reduce choice for women. It did. And that was a consequence of the pandemic and what was happening to the staffing levels.

Q. Thank you. We can see also from this graph that from around June 2021 onwards, the closures and suspensions of services increases across almost all of the services in the options for birthing -- the birthing options in England.

What are the College's views on the reasons for this in the data?

A. I think some of it was that -- my understanding was that

staffing levels hadn't improved, people were exhausted. The mental health of the staff was poor. And they were really struggling to provide very basic services. So to start opening up more complexity of a home birth service just didn't seem possible and so it was easier to keep them shut than it was to re-open them. And I would say that was the safest thing to do. That would be our view. Keeping staff and women and families safe during this time was the most important thing even though it was difficult to give that message and it restricted women's choice it did help maintain a level of safe services.

Staffing levels at the end of the pandemic as well weren't just about current staffing levels. A lot of midwives when the pandemic started stayed, they might be retiring soon, some of them had just retired and they came back. As we went into the second wave a lot of midwives who were exhausted then left. So there was an increased staffing problem not just sickness and isolation from the pandemic.

Q. And to your knowledge, were those levels of closures pervasive across the UK or was that an England problem?

A. It was across the UK but I think England, there was a particular problem in London definitely.

Q. And ultimately did you hear reports of that impacting on

women's birthing options?
A. Yes, we did and some of the women would phone the College. They would comment on social media and I absolutely understood where they were coming from. You know, women have one opportunity in that pregnancy and birth to have a good experience and they were really disappointed, anxious, and it was a really difficult time for them and for the staff who were looking after them because they didn't want that either, but they had to make safe decisions and this is a decision they had to make which we tried to support.
Q. Thank you. Moving on to the topic of miscarriages. Were there any changes in the guidance on the management of miscarriages during the pandemic?
A. Obviously in early pregnancy miscarriage is not managed by midwives. Some women miscarry before they have even booked with a midwife. I think that the same applies to all of the maternity journey that at the beginning it was the "Stay at Home" message caused some issues and then access to services where keeping away from the NHS was part of the other story.

I can't comment on gynaecology staffing issues or early pregnancy units because it is not a place where midwives normally work.
Q. Thank you. In terms of pain relief, was the College

made aware of examples of limited or delay access to pain relief including water births, birthing pools, or epidurals?
A. Certainly at the beginning of the pandemic, it was in the first wave, when we weren't quite sure about the virus transmission, there were definitely issues about whether the virus could be transmitted in water, so there was a restriction then on water birth. And I think a joint guidance with the RCOG did talk about restricting water birth particularly if we were unknown of the virus status of the women, because we weren't testing.

It changed because then it was an airborne virus, so water births started to be provided in services again and we again updated our guidance with that.

The other issues were about anaesthetics and access to epidurals. That was another reason for ringfencing staff. Anaesthetists were -- they were short of anaesthetists in ITUs so anaesthetists were redeployed away from obstetric services, so much -- not completely, but there were less staff available. So having access to epidurals and quickly was a concern to midwives who were looking after the women.
LADY JUSTICE HALLETT: Can I ask about that -- sorry to interrupt you. But it is a subject we touched on

before. But if the anaesthetists are needed in intensive care units where people are dying, can one really object to redeployment of anaesthetists away from pain relief, much as obviously somebody in labour, a woman in labour would like to have pain relief, of course, but I'm not sure there is a comparison between pain relief and people dying and needing the services of an anaesthetist.
A. Yes, my Lady, that is right apart from there's not many anaesthetists available in a maternity unit, usually there is only one, and they are needed for the emergency part of child birth, so emergency caesarean sections, epidurals when there may need to be an operative delivery, and also women who collapse. As part of an unfortunate consequence of labour, some women have a medical emergency, and most units have only one or two anaesthetists available at any one time so having no anaesthetists was a huge risk.

In terms of pain relief there are other options for pain relief and midwives obviously would talk to women and offer all of those methods of pain relief if there wasn't an anaesthetist available but we had reports from women who were traumatised by not having access to an epidural for pain relief, not necessarily for an emergency caesarean section.

So it was definitely an issue because there are not loads of anaesthetists in maternity units.
LADY JUSTICE HALLETT: And really the answer to my question is it is going far beyond the pain relief, much as the --
A. Oh, yes.
LADY JUSTICE HALLETT: -- (overspeaking) -- traumatised -- the use of the anaesthetists, for many other purposes than just the epidural for the --
A. Absolutely. Absolutely, it is.
LADY JUSTICE HALLETT: Thank you.
MS HANDS: And I just want to touch briefly on one issue around the guidance on visitors and birthing partners around active labour, and the Inquiry has heard some evidence around the definition of active labour within the guidance or the lack thereof, and the interpretation of when a woman may be in active labour and therefore allowed to have a birthing partner attend.

Did the College hear of any problems with interpreting active labour, and did it seek to raise any of those concerns?
A. Yes, and in fact it wasn't about the definition of active labour, it was much more about the environment in where women were being cared for, in that first part of the pandemic, where partners could be there in labour.

So, quite often, women who were induced or were in early labour were not on a labour ward, they are in a -- maybe in a four-bedded bay, so -- with other women. So that was more of the issue rather than definition of active labour. When women are in active labour and then require midwifery care, maybe requiring pain relief, extra monitoring, they then move to a labour ward, which was where we knew that partners could be.

So it was about the environment is the main issue, because women in early labour are quite often not on a labour ward.

Q. And did raising those issues lead to any changes in the guidance that you are aware of?

A. I'm not aware that it did, although there were lots of conversations about it, definitely.

MS HANDS: Thank you. My Lady, I'm about to move on to a new topic --

LADY JUSTICE HALLETT: If I could just ask one question before we break -- sorry to cut across you, Ms Hands -- in relation to the guidance, I appreciate the Royal College was doing its very best to issue the guidance its members it so desperately wanted, especially in a fast-moving situation. I have heard a lot about guidance whilst conducting this Inquiry. How did the College go about trying to get the balance right between

issuing the guidance that was needed, updating it when it was necessary but not doing it so often and so much that the hard-pressed midwife who is trying to implement the guidance, understand it -- I mean, there is a balance, isn't there, between issuing too much guidance and flooding the midwives with guidance and issuing the right amount? Did the College analyse?

I think at the beginning Ms Hands talked to you about four updates in March. Did the College analyse how you got that balance right?

A. We didn't analyse it, but we were told by our members that it was overwhelming, at times, the amount of guidance that was being produced, but then it was a quickly changing situation and we didn't want the guidance to be out of date that potentially might cause harm. So I do not think we had any choice. So we did try to balance it. I mean, sometimes we would hear of an issue on a Monday and produce or analyse or change our guidance so it went out on a Friday. Certainly our members told us that constantly giving them new guidance on a Friday was really difficult -- (overspeaking) -- and we did take that on board and tried really hard not to send out guidance to them on a Friday.

It is hard to get that balance right, but I think it is a risk issue not to have accurate guidance where

if the old guidance may be causing harm.

So it is one of those things you have to accept, I think.

LADY JUSTICE HALLETT: Thank you. We will break there and I shall return at 3 o'clock.

(2.45 pm)

(A short break)

(3.00 pm)

LADY JUSTICE HALLETT: Ms Hands.

MS HANDS: I'm grateful, my Lady. I have two distinct issues to deal with in terms of guidance, and then we will be moving on to the next topic.

Firstly, in relation to neonatal units, did the College have any role in developing or issuing guidance for neonatal units?

A. No, we didn't.

Q. Thank you. And then in terms of the services following the guidance that was produced by both the College of Midwives and Obstetricians and Gynaecologists, there was a review by MBRRACE during the pandemic looking at women who died with Covid-19 during that period, and found that only one in ten who died were treated in accordance with the guidance developed by the two colleges.

Did the Royal College of Midwives have evidence of that at the time and why that might be happening?

A. We didn't have evidence of that at the time. I think the guidance -- it is guidance. We had no -- we couldn't mandate the guidance. You know, NHS England would have to adopt the guidance. So the guidance to protect women, particularly black women who were more likely to have an adverse outcome and die, we were starting to be aware of that issue and therefore produced guidance, but it would need to be implemented by the NHS and by the government, not by the colleges.

Q. Thank you. Moving on then to the categorisation of pregnant women as clinically vulnerable and the guidance in that respect. It is correct isn't it that the College were not consulted on that decision or given prior notice of that decision before it was announced in March 2020?

A. That is correct, and it was probably the thing that -- by not consulting with us, that expert team, was unfortunate because had we known that women were going to be classed as vulnerable, and the conversations then went to which gestation would they need to have -- be isolating? We could have thought about mitigating some of the risks that then happened, particularly around pregnant healthcare workers. So we were surprised when that guidance came out without consultation with us, because I think by that time we had been recognised as

an expert group that can give good and quick information to the NHS and the government. So I think that was really concerning.

Q. And it is right, isn't it, that the College, along with the Royal College of Obstetricians and Gynaecologists, issued occupational health advice for employers and pregnant women during Covid-19 on 26th March 2020, which was again updated multiple times throughout the pandemic?

A. That is correct, but that wasn't really our place to do so. We had to do something to fill a gap to protect staff who were pregnant, particularly in healthcare but in other services as well that were public-facing, because with the classification of women being a vulnerable group and with then some data about some of those women then coming to harm, we felt that we needed to produce some guidance.

It was complicated producing that guidance, and I think you will find in my evidence that in the end we withdrew it and gave that responsibility completely back to the employer, to NHS England.

Q. Yes, I wanted to ask you about that, actually. Could you summarise that period in which there were communications with the government and public health bodies around the ownership of that guidance and the

outcome of that?

A. I think it was the time where it was confused that the colleges have a responsibility to provide that guidance and there was definitely an ask for us to produce it, own it and implement it, and that wasn't our role and we made that really clear.

Q. Why was it important to have it coming from the government or public health bodies?

A. Because we are not accountable for delivering services in the NHS. We are there to support our members to practice safely.

Q. And did the chief nursing officers or midwifery officers get involved in advocating for that guidance to be provided by the government or NHS England or public health bodies?

A. Yes, they did in the end, and I think it was probably one of those occasions where the senior team in NHS England got involved.

Q. And it is right, isn't it, that in fact the maternity team in the Department of Health and Social Care did take ownership of the guidance in October 2020?

A. They did. They took ownership eventually which we were pleased about.

Q. Do you know whether any action had been taken in Wales, Scotland or Northern Ireland in relation to this

guidance?

A. I'm sorry, I don't know.

We can get that information to you, though.

Q. Thank you. The first guidance that is produced by the Department of Health and Social Care was published in December 2020, and that removed the requirement that had been in the guidance from the colleges, for women that were more than 28 weeks' gestation to not work in public -- in patient-facing roles, so to move towards a more precautionary approach. Were the colleges consulted or did they advise on that guidance?

A. We weren't consulted but we didn't approve that guidance. We thought that would create an element of risk.

Q. Did you seek to raise those issues?

A. Yes, we did.

Q. What was the response?

A. I think -- so my memory is that it was quite a confused response, which is one of the reasons why we withdrew our support for that guidance and said it was the responsibility of NHS England.

Q. Did the College produce any guidance?

A. We did produce guidance. Yes, we did produce some additional guidance at that time.

Q. Can you recall what the focus was of the college's

guidance at that time?

A. The guidance was making sure that there was a local risk assessment for pregnant staff, that that was done as part of the local occupational health risk assessments, that pregnant staff who had comorbidities or more likely to be sick with Covid could then have the option not to work in a patient-facing environment, and that at 28 weeks, that, again, staff would not be in a patient-facing environment.

There was then an ongoing issue about how they would be paid if they weren't able to work, if there wasn't a suitable alternative employment for those staff. There was definitely an issue about whether they were on sick pay, whether they were on furlough, that maternity leave wouldn't be possible that early. So there was definitely some confusion about how those staff that couldn't work would be paid.

Q. And it is right, isn't it, that a year later, so in December 2021, the College issued guidance alongside the Department of Health and Social Care which moved the threshold from 28 weeks to 26 weeks' gestation. Was there a change or development in the understanding of risk in that period of time that led to that change from 28 to 26 weeks?

A. I don't recall, I'm sorry.

Q. Were you, the College, aware of any examples of issues around increased risk or misinterpretation of that guidance at the time?
A. There was some misinterpretation of that guidance. I think some of it was also about the fear that pregnant staff had, because there were some real issues about the environment they were working in, and the lack of PPE. They were classed as a vulnerable group and so working in a patient-facing environment, pregnant, even up to 28 weeks, was really concerning for staff.
Q. In April 2020, the Department of Health and Social Care withdrew the guidance from employers in regard to pregnant women in healthcare settings. Did you hear any evidence as to what impact that had?
A. It was in April 2022 that that --
Q. Yeah, sorry, did I say -- my mistake. 2022.
A. In April 2022 -- yes. The government withdrew the guidance and we did oppose that because the legal requirement to risk-assess -- the infection risk to pregnant staff, because Covid was still around, was a key issue for our pregnant members, so we did oppose that.
Q. I would like to move on to a different topic now and that's infection, prevention and control measures in maternity settings.

It is right, isn't it, that midwives expressed concerns around the PPE levels that were recommended in the PHE guidance early on, in March 2020, as to whether that provided sufficient protection in the maternity setting? And that at the end of March 2020, the College of Midwives, with the Royal College of Obstetricians and Gynaecologists produced guidance for healthcare workers in regard to use of PPE and risk assessments and did refer to the PHE guidance.

Was it the College's view that that guidance from PHE reflected the risks to healthcare professionals during labour and birth and did it provide sufficient protection?
A. No. Our view at the time was that it wasn't sufficient, that it was -- I think I have said earlier that maternity services often gets forgotten, it is not seen as an essential service, and our members told us that access to PPE was really difficult. That guidance did not protect them. By then we knew that Covid was spread through -- it was an airborne virus and what midwives told us was they were in a very small room with women in labour for many, many hours and they felt at risk just being in a normal mask and that they believed that they should be treated the same as people in respiratory wards in an ITU and be fitted properly with a FFP3 mask.

I personally had meetings also with some black midwives who were really concerned about not having access to PPE knowing that the impact of Covid on that group of staff was higher.

So there were a number of issues around PPE and availability and how maternity services were not prioritised for the right PPE for the work that they were doing.
Q. And did you raise those concerns?
A. Yes, we did.
Q. What was the response?
A. The response at the time was about availability of PPE, which was that the FFP3 masks and the fitting of them had to be prioritised for people who were in high-risk areas, so respiratory areas and known Covid patients. But that was not acceptable so we did raise that, that we wanted maternity not to be treated as a separate service, that midwives were working in a very high-risk situation with women who potentially had Covid and they were therefore at risk.

The other thing about -- just linking back to what you said before about healthcare workers who were pregnant. Maternity is largely a female workforce, and we seem to have more pregnant midwives and maternity support workers than any other group, so there was

another consideration that there were a lot of people working without appropriate PPE with the wrong guidance in maternity services and therefore the impact of that on them was considerable and we heard a lot about that.
Q. And what about PPE and, in particular, the wearing of masks for pregnant women particularly during labour? What was the College's view on that and did it change at all during the pandemic?
A. It did change. We did change that view because women really struggled to be in labour with a mask on, so the requirement to wear them -- the risk assessment about not wearing the mask was then undertaken. Midwives also found it difficult to wear a mask, to be able to communicate well with women, particularly in labour. So I think everybody struggled with it but ultimately it was about being safe.
Q. Later on, in the pandemic, in February 2021, it is right that the College signed a joint letter to Boris Johnson, copied to Matt Hancock, requesting a change in approach in the IPC guidance and advice on the use of PPE to reflect the airborne risks in healthcare settings; is that right?
A. That is correct and that letter was a joint letter with our TUC colleagues, because obviously we are also a trade union representing the safety of staff. And it

went to Boris Johnson because we were frustrated in terms of the lack of action and that attention on proper PPE guidance and access to the equipment.

Q. And in terms of maternity settings and the role of the College in particular, did that lead to any changes or further conversations?

A. Yes, it did and we had feedback from our members that things then started to improve, which was a good thing. I think there was then issues in the next wave of the pandemic but certainly at that point things did get a bit better.

Q. And it is right, isn't it, that in June 2021 the College also met with the Department of Health and Social Care and others to discuss IPC guidance further. What was discussed specifically at that meeting and, again, did that lead to any changes?

A. There were some training -- there was some changes but it was about -- quite a lot of it was about the training and the use of protective equipment because I think maternity again had been left out in terms of the training and how it could be used effectively. There was also an issue about community staff, I'm not sure if that's picked up here, because obviously midwives were working in a community setting, not just in hospitals, and PPE and the training and the use of it in the

community setting was, again, a massive issue which was brought up and I think it was around the same time.

Q. And the community setting in the maternity settings would that be around health visiting and those kind of settings?

A. No. It is community midwives who have local clinics, face-to-face clinics, but also visiting women in their own home. And they really struggled to access appropriate PPE, and they were a group that were particularly anxious because quite often they would go into a home where there were lots of people, maybe in a non-ventilated environment and they felt particularly at risk.

Q. And in terms of testing, was the College aware of any issues with maternity staff accessing testing during the pandemic?

A. Yes, when testing came in I think maternity, again, was one of those areas that wasn't at the top of the list. I can understand that but it was again our plea to make sure that maternity was seen as an essential service and therefore needed to be treated in the same way because the potential for really poor outcomes for women due to the pandemic but also the impact on staff being -- not being able to work was considerable because nobody else could look after those women other than the midwives,

and that was -- it was really important that testing -- availability of tests happened -- should have been a priority within NHS services.

Q. You spoke briefly earlier on around some of the unique issues with maternity units with what's known as cohorting of patients. Can you expand on what some of the issues were in hospitals and maternity units with cohorting of pregnant women depending on whether they had or were suspected of having Covid-19?

A. It was really difficult for some services because they didn't have the right environments to safely cohort women, Covid or no Covid. It caused considerable problems. It was also difficult before testing because unless women had Covid symptoms quite often staff didn't know whether they had Covid or not.

So, that became -- that did become -- that was difficult. I think it caused anxiety -- this is my personal view -- of the staff as well without the right PPE, then caring for women who were in an area where they were known to have Covid and it made them feel very vulnerable.

Q. Thank you. Moving on to inequalities. Firstly, in the guidance for pregnant women, there is evidence of the significant disparities in maternal outcomes for ethnic minority women prior to the pandemic in a number of

reports, and in May 2020 the Royal College of Midwives issued guidance to reflect the increased risk to ethnic minority women in respect to Covid-19.

Can you briefly summarise that guidance and whether there were any challenges in communicating those risks to ethnic minority pregnant women?

A. Yes. So our guidance was to our members, so guidance, we couldn't mandate it, to prioritise women from BAME groups, to help them understand how important it was to access maternity services but also for staff to prioritise the care of those women as well, so extra visiting, I think I said earlier, extra visiting, extra support, that was really key.

Obviously, the information did come out eventually from the NHS that they were a significant group to prioritise and there was some very clear guidance about accessing -- access those women, being able to go into the communities to talk about the importance of being able to access maternity care and not to worry.

I think women were worried. They were worried when they could see that the death rates were higher for that group of women. They were anxious about going into hospital and accessing maternity care, which I think in some cases probably created a poorer outcome. So there was definitely a concerted effort by us and by everybody

to try and engage that group of women.

It also impacted on the staff because there's a significant number of staff from BAME backgrounds working in maternity services who were also really concerned about their exposure to the virus and we know that the death rate for them was higher across the NHS, than for white midwives.

Q. And the College issued guidance for employers to consider risks for --

A. We did.

Q. -- for minority staff when re-organising services as well, didn't they?

A. We did, and some of those we asked for them not to be patienting facing, particularly not patient facing with known Covid women. That, again, created problems in areas where there was a high number of BAME staff because it depleted the staff even further in terms of being able to provide face-to-face care.

Q. And -- this may be the guidance that you were just referring to, but in June 2020, NHS England announced additional support for pregnant ethnic minority women known as the "4 common sense steps".

A. Yes, that's right.

Q. Yes, and it is correct, isn't it, that the College agreed and endorsed -- (overspeaking) --

A. Absolutely --

Q. Was there any monitoring of the effectiveness of those interventions, that you are aware of?

A. I think -- we didn't but I think NHS England did and I am aware that they did check that services were implementing them so I think there was an evaluation but at the moment I am not aware of what the outcome was.

Q. I think you said in your statement that little progress had been made since the publication of the four-step action plan. So looking back, do you think there could have been further action taken at the time to try and mitigate the differences and outcome earlier on?

A. Yes, but I think it was again about having clear and focused communication about the things that were going to improve outcomes. So it would be about -- I think it did make some difference in some areas and certainly some of the staff that I spoke to were really pleased to see that guidance and that focus. But, again, it is the -- how in the pandemic was there focused communication, a single point of the truth, so that staff and women knew what was the best thing to do?

Q. I think it is right, isn't it, that there was a ministerial round table in July 2020 at which the Royal College presented findings and recommendations to address the maternity and disparities and you have said

in your statement it wasn't particularly useful and government were reluctant to engage. Why was that and what would have made the government's engagement more effective at that point?

A. I think at that time the impact of the poorer outcomes was not necessarily really understood although we had seen the data. So it was about prioritising again maternity services amongst all the other NHS services that are being delivered. So we wanted maternity services to have a higher profile. We particularly wanted those women who were more likely to have a poor outcome to have a higher profile and for there to be a focus on them and clearer support and communication for staff to deliver different services to that group of women.

Q. And in terms of risk assessments, I think a survey that the College undertook found that in September 2020, only 23% of trusts had conducted risk assessments for ethnic minority staff in patient-facing roles. Were you aware of whether that improved and, if so, when, and whether there were any additional steps that could have been taken to support that being undertaken?

A. The -- that was an improvement on where it had been before, because previous to that there was no risk assessment. So 23% was going in the right direction.

It was definitely about making sure that services saw that risk assessment as a priority. But there were lots of priorities, and it was very difficult for some of the staff to see that as the priority at that time.

During the pandemic, NHS England continued to implement some policy changes, some service delivery changes, so there was a lot going on, so, for example, midwifery continuity of care was continued to be implemented, and our view was that we had to help services and NHS England to focus on the things that were going to make a bigger difference to the outcomes for women.

LADY JUSTICE HALLETT: Please slow down.

A. Sorry.

MS HANDS: Moving on to the topic of mental health and well-being support for maternity staff, can you briefly summarise the impact on midwifery staff with the restrictions that were in place during the pandemic and any support that the College provided to its members?

A. Okay, so members told us of significant impact on their mental health. Primarily midwives, maternity support workers and the whole maternity team wanted to provide a high quality of care, safe care, choice for women as they always did. They were very anxious and stressed not being able to do that, and disappointing and

upsetting the women in their care. So that caused distress in itself.

Then, the not prioritising of maternity services, then women being classed as vulnerable and then poor access to PPE, having to make really difficult decisions about not being able to provide home births, for example, for women who really wanted them; the lack of confusion around visiting and the tension that that created between the women, the partners and the staff, all of that contributed to a much, much higher level of stress and anxiety than you would normally see in a maternity staff group.

There was support in some services for staff to access help for their mental health. We also -- we had local -- we have local field staff. So our branches are in the field, and we would -- we really encourage them to support staff in terms of accessing support locally if they were feeling very stressed and vulnerable at work.

I believe that it had an impact on staff's ability to keep going, and to keep thinking about doing their best. I think staff told us that they just about managed to get through day by day. Some staff didn't and either left the profession, left their job or went on long-term sick, and on top of that of course Covid

and Long Covid and all the other things.

So I would say that staff tried their very, very best and it had a personal toll on their health and their mental health. Which I think they are still recovering from, I don't think it is over. I think it has impacted on midwives wanting to stay in the profession.

Q. On the topic of Long Covid, are you aware of the impact it has had on the profession?

A. Yes. We have a number of members who have Long Covid and how difficult they found that, particularly when they think that they got Covid because of lack of PPE and poor environments in their workplace. And I'm certainly aware of members that are very clear that that has happened to them.

Q. Has the College provided any support to those members or signposted them to support --

A. Yes, absolutely, and we would see that as part of our role.

Q. Could you provide a couple of examples of that support?

A. So, for example, we had a member -- actually she has been on television recently talking about her Covid and Long Covid experience -- she had support in the workplace to -- and other members have had support in the workplace to negotiate working in different ways,

also to maybe have a longer period off sick, to have phased return to work, not to work in a difficult clinical environment. So there are a number of things that we have been able to do for those members.

Q. Thank you. Ms Walton, you very helpfully set out a number of key lessons to be learned in your statement. I wonder if there are any that you haven't already covered today that you wanted to pick out, to bring to our attention to ensure that maternity services are better prepared to support pregnant women in a future pandemic.

A. I think ultimately, it is that maternity services are seen as an essential service. Getting it wrong in maternity services is unacceptable. We went into the -- the service went into the pandemic in most of the countries without the right number of staff or appropriate environments. I believe that it is important that women's voices and the voices of staff who are looking after them can be heard, they are able to be heard at every level of the system, and to government. You know, this is primarily a women's service delivered by women. I think it is really important that those voices are heard, and collective voices are heard. I think my key message is that the colleges very quickly came together and had a huge

number of experts that could produce support and guidance that, if we all worked together, we could have had a single version of the truth that could be produced quickly and maybe prevented some of the inconsistencies and anxiety that then was created.

I think if we were to go into another pandemic, I think you said it earlier, what could be done before? What things would we think about in terms of, for example, prioritising provision of community services, how could that still be provided, but particularly when there is a reduced number of staff, what could be done differently to predict -- have a toolkit for predicting where staff need to be to deliver safe care?

And that could be communicated at the beginning of a pandemic and not halfway through it, so everybody knew -- the women and the staff -- what could happen if, for example, there was only half the number of staff available, what services could then safely be delivered. I think that would be really helpful.

MS HANDS: Thank you. I have no further questions, my Lady.

LADY JUSTICE HALLETT: Just before I turn to Mr Wagner who I know has some questions, at the risk of being too controversial, you have said several times that maternity services are not considered an essential service, they are not getting the priority or profile

they deserve, and you have also said, obviously, it is a service basically run by women for women.

Do you think there's anything between cause and effect, the fact that it is a service run by women for women and the lack of priority?

A. I think potentially yes, and I think, you know, women's services in the NHS don't get the right attention and maternity is part of that. I think it has been seen for a long time as women having babies. Actually, if women having babies -- if we don't get it right, it can very quickly go wrong. And the outcomes which I know you will have heard of are absolutely devastating for the families.

So I absolutely believe that getting it right at the start of life, having maternity services prioritised in the NHS, is the right thing to do, and it actually is an investment in the future health of the population.

LADY JUSTICE HALLETT: Also, and if things go wrong and a baby ends up born brain damaged, and it is because somebody in the NHS hasn't done their job properly, then that can be extraordinarily expensive to the NHS.

A. It is one of the most expensive in insurance claims, actually, in the NHS. So getting it right is so important. That's what our members want. They say that all the time.

LADY JUSTICE HALLETT: Do we have any evidence as to whether or not it is the fact that it is women's services run by women for women, to suggest that's why it doesn't get the priority it deserves, or is it just a feeling that you and I may share?

A. I think there is some evidence. There is definitely some evidence, because quite often, in an organisation, midwives don't have access to the decision-makers as often as they should, so I think there is some evidence of that and that's a short answer for probably a very complex issue.

LADY JUSTICE HALLETT: I do understand that.

Mr Wagner.

Questions from MR WAGNER

MR WAGNER: Thank you. Good afternoon. I ask questions on behalf of the 13 Pregnancy Baby and Parent Organisations. And I have no doubt that they would agree with the sentiment of that final passage of question and answer.

You have given very clear evidence this afternoon about the huge anxiety amongst staff and parents caused by inconsistent and poorly communicated guidance. And is it right that the RCM were already raising concerns about that in relation to the visiting guidance to the NHS by June 2020, and this relates to those emails that

are referred to at paragraph 38 of your statement?

A. Yes.

Q. And then, is it fair to say that over the summer of 2020, in facing that lack of guidance, the RCM, the Royal College of Obstetricians and Gynaecologists and the society of -- and College of Radiographers stepped into the breach and developed that framework agreement to support the reintroduction of visitors in maternity settings?

A. Yes, we did.

Q. And that was endorsed -- it was later -- sort of a month later endorsed and disseminated by the NHS; were they involved in the drafting, or was there a document that was presented to them for their approval?

A. They would have been involved. I'm sorry I don't know for sure, but we did communicate with NHS team regularly. Quite a lot of the guidance we produced very quickly and will have done it in consultation with the people we were working with, some of those were women and families as well, and other organisations.

It was really difficult to come up with the commonsense approach in terms of protecting women and families, in terms of the virus and the spread of the virus, and the staff who were caring for those women in very difficult environments. Sonography, I think you

mentioned, was definitely a group of staff that were really concerned of, because a lot of the sonography rooms in maternity do not have a lot of ventilation and are very, very small. So there was a huge risk there, and it was about how did we help with guidance that was going to be a commonsense approach and allow -- and encourage people to do those local risk assessments, but with some guidance from the NHS?

Q. You said in your oral evidence that we, the RCM, are not accountable for delivering services in the NHS; we are there to support our members and practice safely. So would it be fair to say that the guidance that you were producing or helping to produce was coming from that perspective?

A. Absolutely. We are a membership organisation. So we are there to, as both a trade union and a professional association, to support our members to be safe in practice and at work, but also to deliver safe care. They then deliver safe care to women and families.

So we absolutely were there to make sure we were the voice of our members, both locally, but also to the government and the NHS. That is absolutely our role.

Q. You were asked earlier by Ms Hands whether any consideration was given to consulting with patient representative groups during the development of

guidance. But I wasn't clear, and I'm sorry if I missed it, whether -- but you then said yes, it would have been, but I didn't know whether you were talking about the July guidance or the December guidance.

A. Okay, so the Covid -- the cell that was -- the Covid cell, which was the joint guideline group with the RCM and the RCOG, had patient representatives as part of that. Also we regularly talked to parent organisations, for example, the NCT, and we had a group called "One Voice" which was all of those organisations together talking about key issues.

So we absolutely had those conversations, but ultimately it was about us providing support and guidance for our members, but we would also encourage -- and I think I said this earlier -- local services to discuss guidance, changes to services, and anything that they were going to do differently with their local women's groups.

So the maternity voices partnerships, and they are different in the other countries, but with the local groups of women, that was really important and we did encourage that.

Q. In relation to the December guidance, the December 2020 guidance -- so this is moving onto the national guidance by the NHS, it is not the same structure as the previous

guidance that was developed by the trade unions with the NHS, is that fair?

A. Yes, that's right.

Q. In relation to that guidance is it right that the RCM and the RCOG raised concerns about the guidance imposing in its initial draft mandatory requirements for Trusts to facilitate women's access to support at all times during her maternity journey? And your comment was that that should be not mandatory but -- non-mandatory.

A. That is correct because at the time that guidance was finally produced the infection rates were increasing again and so there was definitely a risk to increasing the number of people who had access to maternity facilities. So there was a huge concern about then increasing infection rates amongst women, babies, the staff. Different environments, I think I said this before, lent itself really well to partners being able to have access throughout the whole labour journey because they were single rooms and it was easy to then have people cohorted in one room. It became really difficult for partners to then be in all parts of maternity services where the environments didn't facilitate appropriate social distancing.

I know that midwives found all of that really difficult. They absolutely believe that both parents

should be there, if they want to, across the whole journey of pregnancy, birth and beyond. That absolutely is key. So it is one of the things that I think midwives struggled with, being able to do what they believe was the right thing for parents but also to keep everybody safe, and that's why in December we were really concerned about the continued opening-up guidance rather than the local risk assessment.

Q. Do you accept, looking back, that one consequence of that guidance ending up giving individual Trusts that latitude rather than mandating some visitors being allowed into the room, do you agree that that would have led to continued inconsistency and unpredictability between different Trusts?

A. It did but that was -- it was going to happen because different maternity environments are not suitable for providing safe maternity care particularly in a pandemic but if it was "one size fits all", which I think NHS England wanted, that would then expose risks. The problem was, and I think I mentioned about social media, women had different experiences in different services and so those that had their partners and others with them throughout the whole experience would say: I have had the best care ever, this is what my service allows. And then other people got really disappointed and upset

because the service they accessed couldn't do that.

I'm not sure what the answer is to that other than make sure that women's services are the best, that the environment is perfect for now and for the next pandemic. Because I do believe that women and their partners should have had equal access to maternity services together but it just wasn't safe to do so in every single service across the UK.

Q. Do you also agree that if this inconsistency and confusion was going to continue, that would necessarily mean that the anxiety amongst people using the services, that you complained about -- I don't say you complained about but the RCM complained about in June 2020, would persist during the later period?

A. Because the pandemic was -- during the whole time of the pandemic more and more information and almost a trying out of different approaches was happening all the time, I think sometimes services tried something and then realised it didn't work and had to change their approach and I think -- actually I think it should be commended, some of that flexibility with always at the top of their minds keeping everybody as safe as they could.

I think right at the beginning of the pandemic, I think you are right, very clear advice when we really didn't know what we were dealing with was really

important but as more information came in, how could those local risk assessments happen but continue to be in a safe way?

I think in November/December where the whole opening-up of maternity services was actually going to create a risk, was of real concern. So it was about how could it be localised but still have some very clear principles of keeping people safe because all the environments were so different?

There was also the issue of course of home environments and midwives working in a community where, again, that caused considerable concern about exposure to the virus.

Q. Just finally on the RCM not endorsing the guidance in December 2020, in your view, did the fact that you didn't endorse the guidance impact on how widely it was disseminated and how well it was ultimately understood by the frontline professionals?

A. I'm not sure about that but I would say that we didn't endorse it because we were primarily concerned about the safety of the staff and the women and family that they were caring for and as the infection rates were growing and we were moving again into another lockdown it seemed that was moving in the wrong direction in terms of keeping everybody safe.

MR WAGNER: Thank you.

LADY JUSTICE HALLETT: Thank you, Mr Wagner.

Thank you very much indeed, Ms Walton. Really grateful to you. Sorry if we kept you here for a long stint this afternoon.

A. Okay.

LADY JUSTICE HALLETT: All I can say is that other people do get even longer stints, but I'm very grateful for your help.

A. Thank you.

(The witness withdrew)

LADY JUSTICE HALLETT: Very well. I think that completes the evidence for today, and I shall return to sit at 10 o'clock tomorrow morning.

(3.46 pm)

(The hearing adjourned until 10.00 am on Tuesday, 8 October 2024)

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