

Monday, 7th October 2024

1
2 (10.33 am)
3 **MS NIELD:** Good morning, my Lady. I will call, please,
4 Tamsin Mullen who can be sworn.
5 **MS TAMSIN MULLEN (sworn)**
6 **LADY JUSTICE HALLETT:** Ms Mullen, I know how distressing
7 this is going to be for you, but please, just remember
8 we are all here to try and help you through it and we
9 will get you through it as quickly as we can, and
10 although it won't be pain free, it will be as pain free
11 as we can make it. All right?
12 **A.** Thank you.
13 **Questions from COUNSEL TO THE INQUIRY**
14 **MS NIELD:** Can you give your full name, please.
15 **A.** Tamsin Mullen.
16 **Q.** Now, Ms Mullen, you have kindly provided a witness
17 statement to the Inquiry dated June 2024, that's
18 INQ000485735. I think you have got a copy of that
19 witness statement in front of you; is that right?
20 **A.** Yes.
21 **Q.** Mrs Mullen, I think it is right that you are married
22 with three children?
23 **A.** Yes.
24 **Q.** You have a daughter who is now nine years old and twin
25 boys aged four; is that right?

1

1 the growth of one of the babies; is that correct?
2 **A.** Yes.
3 **Q.** When you were having those scans how far away was the
4 hospital from where you lived?
5 **A.** It was around 50 miles. It was about a 45-minute
6 journey.
7 **Q.** So every time you had to go for a weekly scan it was
8 a one-and-a-half-hour round trip; is that right?
9 **A.** Yes.
10 **Q.** I think initially your husband was able to come to the
11 scan appointments with you; is that correct?
12 **A.** Yes.
13 **Q.** But then I think there came a point where that changed
14 because of Coronavirus rules?
15 **A.** Yes.
16 **Q.** And can you remember when it was that the rules changed
17 about your husband being able to accompany you?
18 **A.** It was shortly before the first lockdown came into
19 effect.
20 **Q.** So in March of 2020?
21 **A.** Yes.
22 **Q.** Thank you. And so when Shayne, your husband, was no
23 longer able to attend the scans with you, were you
24 travelling to the hospital by yourself or was he
25 bringing you to the hospital?

3

1 **A.** Yes.
2 **Q.** I think your twin boys were born in the relatively early
3 days of the pandemic, on 13th April 2020, and they spent
4 31 days in the neonatal unit before being discharged
5 home, and you are here today to give evidence about your
6 and your husband's experiences of antenatal and
7 maternity care at that time, as well as your experiences
8 as parents visiting babies on that neonatal unit.
9 Mrs Mullen, I think it's right that you found out
10 at eight weeks that you were pregnant with twins; is
11 that correct?
12 **A.** Yes.
13 **Q.** And you were considered to be a high-risk pregnancy due
14 to having experienced pre-eclampsia when you were
15 pregnant with your first child; is that right?
16 **A.** Yes.
17 **Q.** And also I think your daughter had suffered from
18 intrauterine growth restriction; is that correct?
19 **A.** Yes.
20 **Q.** Because of all those factors I think the pregnancy was
21 monitored quite closely and you were having scans
22 initially every two weeks; is that right?
23 **A.** Yes.
24 **Q.** And then I think there came a point where that changed
25 to weekly scans because there were some concerns about

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1 **A.** He was still bringing me.
2 **Q.** And so where would he be when you were going in for the
3 scan?
4 **A.** In the car.
5 **Q.** And how did that affect you when you were going into the
6 scans on your own?
7 **A.** I was very nervous. It was -- it was really difficult,
8 really difficult to do that alone knowing about the
9 high-risk part.
10 **Q.** And did you speak to your husband about how it was
11 impacting him to have to wait in the car while you were
12 having the scans?
13 **A.** Yes. He supports me 100 per cent in everything so
14 having to be separated during that time that I really,
15 really needed the support was really distressing for him
16 to have to do.
17 **Q.** I think you have explained in your witness statement
18 that he felt excluded and as if the healthcare system
19 was saying that he didn't matter. Is that right?
20 **A.** Yes.
21 **Q.** Thank you. I think the babies were monitored, as you
22 said, weekly with scans and on Friday, 10 April you were
23 told that the babies need to be delivered by caesarean
24 section in the next five days; is that right?
25 **A.** Yes.

4

1 Q. And I think you were booked in then for that procedure
 2 to take place the following Monday, 13th April; is that
 3 correct?
 4 A. Yes.
 5 Q. The twins then were 34 weeks' gestation; is that
 6 correct?
 7 A. Yes.
 8 Q. When it came to finding out that the babies were due to
 9 be delivered the following Monday, was Shayne with you
 10 at that point or were you on your own in the hospital
 11 when you were informed?
 12 A. I was on my own then.
 13 Q. And when you went to the hospital for the caesarean
 14 delivery, was your husband allowed to come in with you
 15 at that point?
 16 A. Yes.
 17 Q. So I think you arrived quite early in the morning for
 18 that caesarean section to take place and in fact the
 19 boys were delivered I think in the early afternoon; is
 20 that correct?
 21 A. Yes.
 22 Q. And was your husband able to be with you throughout that
 23 period of time when you were waiting?
 24 A. Yes.
 25 Q. And was he able to come into the operating theatre with

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

7

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

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

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

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

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

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

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- 1 A. Yes.
- 2 Q. I think, at one point, your husband did once break the
3 rules to come into the ward with you, to try to allay
4 your fears about that, and so that you could be holding
5 the babies together; is that correct?
- 6 A. Yes.
- 7 Q. I think that was when you were asked to go and swab
8 yourselves for the MRSA virus; is that right?
- 9 A. Yes.
- 10 Q. And, when your husband came into the unit with you, on
11 that occasion, did the nurses intervene, did anyone
12 object to that?
- 13 A. No, not at all.
- 14 Q. After the twins had received that diagnosis of MRSA,
15 they were then put into an isolation room effectively,
16 they were put into a room by themselves without any
17 other babies; is that right?
- 18 A. Yes.
- 19 Q. And you were still able to visit them?
- 20 A. Yes.
- 21 Q. At that point, was there any relaxation in the rules in
22 terms of the two of you being able to visit at the same
23 time?
- 24 A. No.
- 25 Q. And did you raise that again, that now, there were no

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

15

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

14

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

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

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

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

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

19 **A.** No.

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

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

17

1 unit?

2 **A.** No.

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

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

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

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

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

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

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

9 **A.** Yes.

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

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

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

23 **A.** Yes.

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

18

1 was a multiple birth?

2 **A.** No.

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

4 **A.** No.

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

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

13 Does that sum up your feelings about that time?

14 **A.** Yes.

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

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

19 How are your daughter and the boys doing?

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

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

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

20

1 very, very good.
 2 **LADY JUSTICE HALLETT:** You have obviously got your hands
 3 full, so thank you very much for coming along to help
 4 us.

5 **A.** Thank you.

6 **(The witness withdrew)**

7 **MS HANDS:** My Lady, may I call Ms Jenny Ward. She will
 8 affirm.

9 **MS JENNY WARD (affirmed)**

10 **Questions from COUNSEL TO THE INQUIRY**

11 **MS HANDS:** Good morning, Ms Ward, you should have your
 12 statement in front of you and that is INQ000408656.

13 Ms Ward, you are here today as Chief Executive of
 14 the Lullaby Trust and also Chair of the Pregnancy and
 15 Baby Charities Network; is that right?

16 **A.** Yes, that is.

17 **Q.** And your evidence today is on behalf of the 13 Pregnancy
 18 Baby and Parent Organisations; is that correct?

19 **A.** Yes, that is correct.

20 **Q.** And if you don't mind, I will refer to them as the PBPOs
 21 from hereon in.

22 You have set out the members of the PBPOs in full
 23 in your statement but can you give us an example of some
 24 of the organisations within that group?

25 **A.** Yes. Absolutely. So of the 13, just to reiterate,
 21

1 look at some of those organisations that deal with early
 2 pregnancy, and there is reference to that there, there
 3 were families who, where they had concerns about their
 4 pregnancy, they weren't able to access the face-to-face
 5 or even an online appointment that they needed to. So
 6 I think it was very much a mixed picture.

7 **Q.** And can you just set out for us some examples of the
 8 potential impact and risks of those appointments or
 9 services being missed in the early stages?

10 **A.** Yes, absolutely. There are some conditions in pregnancy
 11 that can only be picked up by being seen face to face
 12 and having specific tests for that. So not being able
 13 to access that or families being concerned about going
 14 somewhere face to face, would have had an impact
 15 potentially on their health, of not being able to do
 16 that, and there is of course the other side of families
 17 being particularly worried because in those early weeks
 18 we were all told to stay at home.

19 So having a concern and as organisations, and as
 20 healthcare professionals, we would encourage people to
 21 go and seek support if they are worried, in that period
 22 I think it was harder to get that support and it was
 23 also more likely that people would shy away from going
 24 out proactively.

25 **Q.** And I think you have given quite a few examples, in your
 23

1 although we tend to talk about maternity and neonatal,
 2 we cover a wide range of that whole period and it can be
 3 divided into early pregnancy, antenatal, postnatal, and
 4 neonatal. So we have a number of organisations such as
 5 The Ectopic Pregnancy Trust and the Miscarriage
 6 Association that cover early pregnancy, and then those
 7 of us like The Lullaby Trust, like Tommy's, who cover
 8 the period of birth and post natal and then neonatal is
 9 covered, again, by Tommy's and by Bliss.

10 So there is a wide range of organisations.

11 **Q.** Thank you.

12 And it is right that there is representation
 13 across the UK?

14 **A.** Yes, that is correct.

15 **Q.** We are going to go, essentially, through the impact of
 16 the pandemic on maternity services for pregnant women
 17 throughout the maternity journey, starting with
 18 antenatal services.

19 The guidance at the start of the pandemic was for
 20 antenatal services to be maintained with a minimum of
 21 six face-to-face antenatal consultations with video and
 22 remote consultations as an alternative.

23 Now, in your experience, was that guidance
 24 followed throughout the pandemic?

25 **A.** I think there was a mixed experience there. And when we
 22

1 statement, of experiences that parents and also
 2 healthcare professionals had with an increased use of
 3 online and remote access to maternity services. You
 4 have set out some there but were there some -- could you
 5 perhaps provide us with some of the positives and
 6 negatives of the increased use of those online options?

7 **A.** Yes, absolutely. They weren't all negative. So there
 8 are some good examples of practice of appointments being
 9 far more accessible by being online, and that's good.

10 Some of the parts that might be -- and also, for
 11 example, if you had pregnancy sickness, the thought that
 12 you had to go face to face somewhere was practically
 13 very difficult to do. So it was good that there was
 14 an online option.

15 Some of the negative parts of that, as I said,
 16 there are specific tests and specific concerns that
 17 people would raise face to face that maybe they felt
 18 they wouldn't on an online appointment and also there
 19 were some people who simply didn't have the ability
 20 there to use an online system and to contact their
 21 health professional. So where we talk about the
 22 inequalities that are there, digital poverty definitely
 23 meant that those who were less able to access that were
 24 more negatively impacted.

25 **Q.** I think you have given some examples in your statement
 24

1 of pregnant women delaying access to care and
 2 telephone -- they are examples of telephoning triage.
 3 So if we can go to INQ000408656, page 11.
 4 If we look at question 1 and question 2. Is it
 5 right this is feedback from various organisations within
 6 the 13 PBPOs that you have included within your
 7 statement, and we are going to a few of those throughout
 8 the morning?

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

14 **Q.** So the first comment there is:

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

17 And then the second:

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

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

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

25

1 delay.

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

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

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

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

21 **A.** In terms of having triage?

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

25 **A.** My understanding is that they continued throughout.

27

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

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

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

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

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

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

26

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

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

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

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

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

28

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

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

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

19 **A.** Yes, it is.

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

29

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

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

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

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

22 **A.** Yes, that is correct.

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

25 **A.** No. Those choices were decreased immediately the

31

1 more remote and virtual consultations that --

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

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

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

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

17 Then in the second one, she said:

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

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

30

1 pandemic started.

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

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

11 At the top and one Respondent said that:

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

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

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

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

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

32

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

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

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

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

33

1 pandemic.

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

9 What were PBPO's views on the findings?

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

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

35

1 **A.** Yes, yes, absolutely.

2 **Q.** We touched briefly on pain relief and pain management
3 with the water birth there. You have set out at
4 paragraph 81 of your statement findings from a survey of
5 1200 people who had given birth from August 2021 to
6 July 2022.

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

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

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

34

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

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

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

36

1 rates as those in least deprived areas.

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

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

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

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

37

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

6 **A.** Yes, that is.

7 **Q.** Again, the Miscarriage Association survey found that 77%
8 could not take anyone with them to an in-hospital
9 appointment during the early stages of the pandemic and
10 25% -- sorry, under 25% were able to make a call or
11 video during that appointment.

12 **A.** Yes.

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

16 **A.** Yes, that is correct.

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

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

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

39

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

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

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

19 This responder said:

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

38

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

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

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

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

40

1 Q. Yes, I was going to come onto guidance that followed
 2 later in September 2020 from NHS England, where they
 3 developed a visiting framework encouraging local risk
 4 assessments and providing for birth partners, visitors
 5 in labour and birth settings, and that included the
 6 antenatal and postnatal wards and scans and that they
 7 should be deemed essential visitors at that stage.
 8 Then, there's further guidance from NHS England in
 9 December 2020, so right at the beginning of the second
 10 wave, which set out that women should be supported by
 11 another person throughout the pregnancy journey. And
 12 including at scans when it was important to the woman.
 13 So did PBPOs have any views on the timing of that
 14 guidance and, again, whether in fact it did lead to any
 15 changes on the ground?
 16 A. That's a long time to come out from the first lockdown,
 17 that we saw in March, to December and even then it was
 18 guidance and it still refers to birth partners as
 19 "visitors" and those coming into the scan partners as
 20 "visitors" and we strongly believe that's not the case.
 21 So yes, it was too long in coming out, too long in
 22 being implemented locally and for the staff on the
 23 ground to be supported to understand how they could
 24 allow people to come in. But, essentially, yes, it
 25 still referred to birthing partners and neonatal parents

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1 relation to antenatal services, there were also changes
 2 to the visiting guidance for labour and birth throughout
 3 summer --
 4 A. Yes.
 5 Q. -- of 2020, wasn't there?
 6 A. Yes.
 7 Q. In respect of visiting guidance, did the PBPOs hear
 8 concerns about women only being allowed a birthing
 9 partner during active labour and any inconsistencies in
 10 the interpretation of active labour?
 11 A. Yes, absolutely. Having a birthing partner there and
 12 what you define as active labour is something that is
 13 open to debate and we understand as well that, as
 14 I said, units were very stretched. So if you were in
 15 a labour ward, for most women who are in labour are in
 16 there, are in a private room by themselves. So if they
 17 are not allowed their birthing partner in until they are
 18 deemed to be at a certain point of labour, they are on
 19 their own in that room and that's frightening. So,
 20 actually, to sit there and think, well, I have to be at
 21 a certain stage in order for -- to get support is
 22 particularly tricky.
 23 I also want to make the point that that impacts on
 24 the staff who are on that unit as well. They don't have
 25 somebody else to support women to advocate for them, to

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1 as "visitors" and that is not a line that we think has
 2 been helpful to families, it has been hugely damaging.
 3 Q. Then, finally, just dealing with Wales which, again, you
 4 addressed in your statement. It is right that they
 5 didn't update their guidance to reflect birthing
 6 partners and supporters at appointments as essential
 7 visitors until May 2022; is that right?
 8 A. Yes, that is correct.
 9 Q. Moving on to birthing partners during labour. So this
 10 was one of the exceptions to the restrictions on
 11 visitors to hospital from the early part of the pandemic
 12 in the guidance.
 13 In Wales there was a difference in that the woman
 14 in labour should be permitted a birthing partner from
 15 their household. Did PBPOs receive any feedback on the
 16 difference in that Welsh guidance that you are aware of?
 17 A. I'm not aware of specific differences in Wales that we
 18 were fed back.
 19 Q. And to your knowledge, was that guidance, with that
 20 exception, implemented across the UK?
 21 A. No. We continued to hear stories going into 2021 where
 22 there were differences between different hospitals and
 23 units on birthing partners and when and if they were
 24 allowed in.
 25 Q. Again, reflective of the changes we discussed in

42

1 say, she doesn't look right or she seems to be in
 2 extreme pain, all the things that birthing partners have
 3 discussed and are ready to do. So it actually had
 4 an even greater impact on staff of not being able to
 5 have them there until they were deemed to be in active
 6 labour.
 7 Q. Were you aware of reports indicating that some women
 8 felt obliged to undergo vaginal examinations to prove
 9 they were in inactive labour so that partners could
 10 enter the room?
 11 A. We have seen those reports, yes. And although I could
 12 couldn't tell you how often that happened, I think from
 13 understanding how women felt during that period, if they
 14 felt, as I said, alone and scared and in a room where
 15 they are largely by themselves and they don't want to
 16 bother the staff that are really busy, I think it is
 17 completely understandable if they felt that that
 18 examination might be the access for them to get more
 19 help that they -- even without a medical reason being
 20 needed for that, I think we can understand why some
 21 people may have consented to that.
 22 LADY JUSTICE HALLETT: I'm not following this line of
 23 argument. Wouldn't you, if you were in labour be
 24 subject to vaginal examinations anyway to check how far
 25 along you were?

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1 A. Yes, I think in this respect it wasn't for medical
 2 reason they were checking, it was purely so they could
 3 decide whether the partner was allowed in or not.
 4 **MS HANDS:** Taking all of that into account then, is it your
 5 view that active labour should have been and in future
 6 should be defined in guidance?
 7 A. I think that would be helpful for staff there. I would
 8 say we did get some really good feedback from families
 9 who had staff who were aware of how difficult it was to
 10 be on their own, sometimes said, "I'm going to let them
 11 in" or in some instances letting them in in the fire
 12 escape so that they weren't subject to the usual
 13 entrance into the unit. So I think, yeah, there was
 14 an understanding of how difficult that was to be by
 15 themselves until that point.
 16 Q. And dealing then with visiting guidance for postnatal
 17 wards, it is right, isn't it, that again this was quite
 18 varied across the UK not only in the guidance but also
 19 implementation actually on the ground.
 20 In your statement there are examples as to the
 21 impact of those restrictions.
 22 So if we could turn, please, to INQ000408656,
 23 page 41. Thank you.
 24 So two examples here. The first being that:
 25 "Not being able to be on the ward together was so
 45

1 I hope you were warned, Ms Ward, you probably know
 2 anyway from following our proceedings. 11.55 am.
 3 (11.40 am)
 4 (A short break)
 5 (11.55 am)
 6 **LADY JUSTICE HALLETT:** Ms Hands.
 7 **MS HANDS:** Thank you.
 8 Ms Ward, just one more question before I move on
 9 to neonatal units. You have said a few times this
 10 morning that it is the view of PBPOs that parents should
 11 not be considered visitors in the guidance. Can you
 12 just say why that is.
 13 A. In relation to neonatal units?
 14 Q. Units that aren't neonatal units. We will come on to
 15 neonatal.
 16 A. So in terms of birthing partners, are you specifically
 17 asking?
 18 Q. Yes, and in antenatal units as well.
 19 A. Because the care appears to be around the person who is
 20 receiving the medical care, so in most instances it will
 21 be a pregnant woman, we very much reiterate that this is
 22 an impact on both partners there. So where there is --
 23 also the partner is the dad, that decisions -- bad news
 24 or even update news, any kind of news directly impacts
 25 them as well. And that's why they should be a part of
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1 hard and definitely had an impact on our ability to gel
 2 as a family (as this was our first baby) -- I felt bad
 3 for my husband for every moment I was on the ward and
 4 not him. It had a major impact on breastfeeding which
 5 in turn had an impact on my baby's care and length of
 6 stay in hospital."
 7 Then secondly:
 8 "I felt like I wasn't her mum. Like someone else
 9 was raising my baby. Like me and her dad weren't
 10 important enough to be there. All of the 'firsts' I
 11 should have been able to do with my baby were taken away
 12 from me."
 13 Again, is that reflective of some of the
 14 experiences from PBPO members of the restrictions on
 15 attendance at postnatal wards?
 16 A. Yes, it is. And just to reiterate there, that where
 17 they were classed as visitors, and as I said, that's not
 18 a term that we think should have been in place, actually
 19 most of the impact was on partners and most of those
 20 were dads.
 21 **MS HANDS:** Thank you.
 22 My Lady, my next topic is still on visiting
 23 restrictions but neonatal units, so it may be just
 24 a moment to take our mid-morning break.
 25 **LADY JUSTICE HALLETT:** Very well.
 46

1 that.
 2 So just, for example, to think about if you were
 3 to have a scan in early pregnancy and as a woman you are
 4 there on your own, you are given bad news as a result of
 5 that, you may then be given treatment options or options
 6 that could impact your future fertility and certainly
 7 have an impact on how you are going to manage the
 8 difficult news that you have had and we have heard
 9 stories of women having to do that by themselves or then
 10 having to go out and explain that to their partner who
 11 has been waiting in a car, which is incredibly
 12 difficult.
 13 Q. Is it also right that in terms of during labour and
 14 birth, and also in postnatal awards as well, they can
 15 provide a caring role?
 16 A. Absolutely. There is multiple elements to why it is
 17 important they are there. It is caring both for the
 18 mother, for the baby, being the support, the advocacy
 19 and trying to understand the advice that they had. So
 20 if you are given medical advice from somebody in
 21 a difficult period or in a traumatic period, it is very
 22 difficult to take that in and the role of your partner
 23 there is often to have a bit more understanding of that
 24 and to ask questions that maybe you wouldn't be able to.
 25 Q. Thank you.
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1 So moving on then to neonatal units. So one of
2 the exceptions in the national restrictions on visiting
3 was for one parent to visit a child. We heard this
4 morning impact evidence of restrictions on neonatal
5 units.

6 Is that reflective of the experiences that PBPO
7 members had?

8 **A.** Yes, it is.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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- 1 fact, it was in April 2022 that the guidance was for
2 unrestricted visiting in neonatal units.
- 3 **A.** Yes, it was much later than we all might have presumed
4 that the Covid period had an impact. It was actually
5 several years on.
- 6 **Q.** And in general what were the issues of parents being
7 considered visitors on neonatal units and, again, do you
8 think they should have been?
- 9 **A.** No, we don't think they should have been. I would say
10 in those early few months then yes, when we were trying
11 to understand how the pandemic and how infection worked
12 and knowing that babies are particularly vulnerable, it
13 was a huge concern for everybody. So caution in those
14 early months is completely understandable.

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

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- 1 then absolutely we would support that.
- 2 **Q.** In terms of those initiatives and the guidance in
3 general, was there any consultation with the PBPOs
4 during the development of that guidance or any feedback
5 sought in terms of the implementation and the impact it
6 was having throughout the pandemic?
- 7 **A.** I do not believe so but I'm aware that there was much
8 impact -- much feedback from Bliss and from other
9 organisations to try and get that guidance changed.
- 10 **Q.** In relation to access to PPE and Covid-19 testing to
11 facilitate visiting, it is not until the end of 2020
12 that in some of the UK the national guidance included
13 use of LFTs to facilitate visiting. Were you aware of
14 any issues related to access to suitable PPE or Covid
15 testing for pregnant women and their partners or family
16 members to attend to visit them in hospital?
- 17 **A.** We haven't done a study to look into the actual impact
18 of that. However, there have certainly been concerns
19 about whether the difficulties in accessing both of
20 those things meant that the visitor restrictions were
21 not relaxed as quickly as they might have been if that
22 was more readily available.
- 23 **Q.** And does the PBPO have any views as to whether increased
24 use of PPE and Covid-19 testing in future should be
25 available in order to facilitate visiting?

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- 1 see them for one or two hours a day that is exacerbating
2 the trauma that neonatal parents go through anyway.
- 3 **Q.** Thank you. There were some initiatives that were
4 introduced to try and promote contact where it couldn't
5 be in person, for example video calls in England, and in
6 Scotland there was funding for taxi fares for parents to
7 be able to travel to the hospital where they may be
8 travelling more often than they would have otherwise
9 done and perhaps further. Do you have any feedback on
10 those initiatives and whether they were successful and
11 whether there could be recommendations for further
12 initiatives in the future?

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

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

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

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

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

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

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1 **Q.** Were you aware of any training for healthcare
2 professionals to facilitate that kind of communication
3 when using PPE?
4 **A.** I'm not aware of any, no.
5 **Q.** Thank you. You have touched upon, in your statement,
6 support for healthcare workers in implementing the
7 guidance and whether there was any support available.
8 Could you just explain that a little bit more and what
9 the PBPO's experience of that was?
10 **A.** Which guidance are you referring to?
11 **Q.** It is at paragraph 47 of your statement.
12 **A.** I think in general this is around guidance to try and
13 encourage people to come into units and hospitals.
14 I think in general we -- certainly some of my colleagues
15 in the other organisations -- heard from health
16 professionals who were asking them to help to work out
17 what the guidance meant and how they could implement it.
18 I think in this particular time it feels like
19 training was not something that was prioritised. So we
20 certainly found professionals who felt there was a lot
21 of guidance coming out and they were trying to work
22 through how they did that.
23 So certainly one of the things that we reiterate
24 is giving support to professionals in understanding what
25 the guidance is and why it is in place.

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1 closed off, so going in and saying, right, you have got
2 a midwife appointment, we want to check your blood
3 pressure; people were having to weigh up for themselves
4 whether they felt that was a risk they were willing to
5 take, which is a difficult position to be in.
6 I think you referred earlier to Tommy's who had
7 an increased number of calls. I would say that most of
8 us as charities kept our methods of contact, our support
9 help lines, emails, etc, open and we all saw big
10 increases and they were people who were isolated and
11 scared and worried and wanting to talk to somebody about
12 this.
13 **Q.** Thank you. That brings me on to my next topic,
14 actually, in regard to and the impact on mental health.
15 What impact did PBPOs see on the mental health of
16 pregnant women both during the antenatal and postnatal
17 period?
18 **A.** I think it is very clear that we saw people who were
19 extremely worried. So this is -- this period of
20 antenatal and postnatal is a period where particularly
21 maternal mental health is a particular focus and the
22 professionals who would support, identify and be able to
23 give some advice to people weren't as readily available.
24 You add into that, as well, that your usual support
25 mechanisms are taken away -- and we all had an increased

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1 **Q.** Thank you. Moving on to a different topic and that is
2 the categorisation of pregnant women as "clinically
3 vulnerable".
4 Now, you have not addressed this in your statement
5 but I wanted to ask you whether PBPOs were aware of any
6 issues or concerns about that decision to include
7 pregnant women in the CV category and also whether there
8 was sufficient information available particularly early
9 on and advice about what that meant in practice?
10 **A.** Most of us support families directly. So getting that
11 message that you are clinically vulnerable is very
12 difficult for people to get and at the stage that was
13 announced in March 2020, none of us really understood
14 enough about Covid. So trying to support people who in
15 general were extremely worried by that and, again, as
16 I said, we were all told to stay at home and adding in
17 that you were also vulnerable to Covid, meant there were
18 people who had appointments, sometimes they were moved
19 to a digital means and sometimes they were told you
20 still need to come in for a scan, and that was a huge
21 worry for people as well.
22 So I think that that had a significant impact on
23 that group and the support that they sought and their
24 willingness to go into hospital and other settings as
25 well -- GP surgeries as well -- most of those were

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1 general level of anxiety, it was a very difficult
2 period. So these were times when, yes, we were worried
3 about the families that we supported.
4 From The Lullaby Trust we give out -- the majority
5 of the advice we give out is about safer sleep for
6 babies. We found our calls were much longer and they
7 had a wide range of topics because they were people who
8 just wanted to talk to somebody, and we are not
9 medically trained so we can't give that advice but,
10 actually, what they were looking for was somebody to
11 listen to them.
12 So I think all the things together, all those
13 elements made it really tricky for families in this
14 period and I know there is research that shows that
15 maternal mental health was impacted by that.
16 **Q.** And there was a move to providing antenatal classes and
17 education online. Is that something that was effective
18 and, again, were there any access issues that you were
19 aware of?
20 **A.** Yes. So one of our 13 organisations is NCT, the
21 National Childbirth Trust. They are known for giving
22 antenatal classes. Prior to the Covid pandemic they
23 were all face to face. They then had to move those and
24 moved as many as they could online and they had a good
25 coverage of that. Although the satisfaction rate from

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

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

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

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

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

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

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

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

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1 until 3 June 2020.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 **A.** Yes. Yes, it has. Yes.

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

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

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1 that was certainly the case for Covid-19.

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

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

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

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

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

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

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

14 My Lady, do you have any questions?

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

21 **A.** Thank you.

22 **LADY JUSTICE HALLETT:** Thank you.

23 **(The witness withdrew)**

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

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1 invite you to take an early lunch. I know it is quite
2 early but she will be arriving shortly this afternoon.
3 **LADY JUSTICE HALLETT:** And obviously you would like to speak
4 to her before --

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

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

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

8 (12.27 pm)

9 (The short adjournment)

10 (1.30 pm)

11 **LADY JUSTICE HALLETT:** Good afternoon.

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

14 **MS GILL WALTON (affirmed)**

15 **Questions from COUNSEL TO THE INQUIRY**

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

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

21 **A.** That is right.

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

24 **A.** That is correct.

25 **Q.** And you also have been a midwife since 1987 and prior to
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1 guidance and worked with the Royal College of
2 Obstetricians and Gynaecologists to do so?
3 **A.** We did. In fact, the guidance -- we were quite separate
4 in terms -- before the Covid pandemic we produced
5 guidance quite separately as two organisations. The
6 pandemic actually brought us together to produce
7 guidance -- and with other organisations. So it was
8 different. It is something we started almost
9 immediately -- well, even before lockdown, actually, we
10 got together and said we really need to do something
11 about providing advice and guidance.

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

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

25 **A.** That is the Nursing and Midwifery Council provides
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1 joining the College you had midwifery experience in the
2 NHS; is that right?

3 **A.** That is right.

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

7 **A.** That is correct.

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

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

13 **Q.** Thank you.

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

22 Starting, then, with the role of the College in
23 formulating and issuing guidance for the maternity
24 sector during the pandemic, is it right that outside of
25 the pandemic the College had a role in producing
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1 standards and proficiencies for midwifery.

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

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

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

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

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

23 **A.** No, we weren't asked to take on that role at the
24 beginning. We took it on as we thought it was the most
25 useful thing that we could do as a collective team.
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- 1 **Q.** And is it right that the Royal College of Midwives and
2 the Royal College of Obstetricians and Gynaecologists
3 set up a guidance cell which initially was meeting daily
4 in order to develop the guidance?
- 5 **A.** Yes, so we set up the guidance cell with appropriate
6 people on there. People who had a background maybe in
7 research or clinical practice, expert clinical practice.
8 They called in other people when they needed it
9 depending on what guideline they were looking at.
- 10 I think the Covid cell was daily. I can honestly
11 say that myself and Eddie Morris, who was the president
12 of the RCOG at the time, spoke, if not daily, sometimes
13 several times a day, so that we could try and be on top
14 of the constant changing nature of the pandemic, of the
15 Covid virus, and people's understanding of it.
- 16 So we tried really hard to make sure that the
17 guidelines and the advice that we were given was as up
18 to date as it possibly could be.
- 19 **Q.** And on that very point, it is right, isn't it, that the
20 first published guidance on pregnancy during Covid was
21 published on 9 March 2020 and there were a further four
22 updates in that month to that piece of guidance?
- 23 **A.** That's absolutely correct. You will see with the amount
24 of guidance that was produced both jointly and us as
25 an organisation ourselves, we had guidance that we

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- 1 it if it then turned out not to be right. We thought
2 that was really important rather than spend weeks and
3 months making sure that something is absolutely perfect.
- 4 **Q.** Looking to the future, do you think it would be helpful
5 if guidance was available or had been prepared in
6 advance so that it could be used if there were another
7 pandemic -- obviously, as you have said, there would
8 need to be updates and changes to it, but if that was
9 standing there ready, do you think that would be
10 helpful?
- 11 **A.** I think it would be helpful to have a framework for
12 guidance that could be used in a future pandemic.
13 I think the most important thing is that it is everybody
14 who is involved in delivering maternity services, for
15 example. So the Department of Health with their
16 maternity team, NHS in all the countries, the colleges
17 that are all involved in delivering maternity and
18 neonatal care, coming together with a single version of
19 the truth and doing as much of that as you can.
20 Obviously you never know what particular strain of virus
21 that you are dealing with, so it would have to be
22 developed at the time but there's definitely something
23 about making sure that women and families get really
24 clear advice and the staff delivering care get really
25 clear advice and everybody is saying the same thing.

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- 1 constantly reviewed, updated, re-wrote, and re-published
2 all the way through the pandemic. It became one of the
3 biggest things we did.
- 4 The joint guidance that came from the cell, it was
5 purple in colour, we joined our colours, actually was
6 used all the way around the world. It was recognised as
7 a really good resource on Covid and it was -- the access
8 on the websites was well in the millions, which was
9 encouraging. And I can say that we were proud of that
10 work and we were hoping that it was going to be helpful.
- 11 **Q.** And is it right that there were other advisory groups
12 that the Royal College of Midwives set up during the
13 pandemic?
- 14 **A.** Yes, so we had an internal professional advisory group.
15 So that was looking at things particularly for midwives,
16 so the things that midwives would only be doing so, for
17 example, home births.
- 18 We also used midwifery professors to do various
19 bits of guidance. They -- often when we have used
20 professors in the past on guidance it takes years.
21 A piece of guidance or some advice can take years and
22 years. Everybody was doing things really quickly. We
23 knew that it may not be perfect and we had to accept
24 that. We had to do something as quickly as we could to
25 be as helpful as possible and then review it and change

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- 1 **Q.** And it is right, isn't it, that the College also set up
2 a helpline in response to the pandemic? Can you provide
3 some examples of the type of matters that they dealt
4 with and who it was staffed by?
- 5 **A.** So, we had a helpline for both our members and for the
6 public and the RCOG and we staffed it with clinicians.
7 We wouldn't normally provide that service as the Royal
8 College of Midwives to members of the public, that isn't
9 actually our role, but we realised that there was a lot
10 of confusion in terms of information and advice to women
11 and so we decided that it was helpful for local
12 clinicians caring for women, that if we could give some
13 very clear advice that would be helpful to them.
- 14 We also, as part of the guidance we were
15 producing, often had a page that was for information for
16 women that midwives could use, so not necessarily direct
17 to women but could be used in a conversation with women
18 in their care. And again, we thought that was helpful
19 and maybe clarified some confusion.
- 20 The sort of calls we often got from women were
21 about visiting, about availability of home births,
22 particularly when they were really frightened and just
23 having some clarification about the impact of the virus
24 on pregnancy was definitely something that they wanted
25 to know.

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- 1 **Q.** And you have said in your statement that from the outset
2 the Royal College of Midwives and the Royal College of
3 Obstetricians and Gynaecologists were clear that it was
4 vital to maintain all aspects of safe maternity care and
5 to designate it as an essential service particularly in
6 the context of serious pre-existing staffing shortages.
7 Can you briefly describe what the pre-existing staffing
8 shortages going into the pandemic were?
- 9 **A.** There had been a shortage in midwives -- for midwives,
10 obstetricians and other members of the maternity team
11 over many years and we anticipated that shortage to be
12 between 1,500 to 2,500, it is difficult to know exactly,
13 and that gap wasn't closing. So basically we went into
14 the pandemic with already a shortage of midwives and
15 maternity team which was already having an impact on the
16 quality and safety of care.
- 17 **Q.** And is it correct that on 7 April, following a meeting
18 that the College had with the chief midwifery officers
19 of the four nations, the College were provided with
20 reassurance that in fact maternity services would be
21 prioritised?
- 22 **A.** Yes. So we had brought it up as an issue because we had
23 lots of connection with our members, particularly the
24 Royal College of Midwives, because we are also a trade
25 union. So we have a branch structure. We have our

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- 1 the women as well accessing care.
- 2 **Q.** Thank you --
- 3 **LADY JUSTICE HALLETT:** Can I ask you to speak more slowly.
- 4 **A.** Yes, certainly.
- 5 **MS HANDS:** We're going to come on to look at some of those
6 examples you've just given in more detail. If I can
7 move on, then, to the topic of antenatal care during the
8 pandemic. Guidance was produced by the Royal College of
9 Obstetricians and Gynaecologists on 23 March 2020, which
10 advised a minimum of six face-to-face antenatal
11 consultations and three postnatal contacts, with the
12 option for video and remote as an alternative and
13 included guidance on how to risk assess and prioritise
14 services in the event of staff shortages.
- 15 How did that advice differ to before the pandemic?
- 16 **A.** So before the pandemic, there was a minimum of ten
17 antenatal contacts, slightly different between
18 first-time and second-time mums. That is the very
19 basic. If women have comorbidities or need additional
20 care, so for example, if they had an obstetric problem
21 they may be seen far more than that. Postnatally there
22 is not really a minimum, but it must be a minimum of
23 three, potentially four, and again if women in the
24 postnatal period have particular problems and need more
25 support, then obviously there is many more visits than

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

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

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- 1 that normally.
- 2 **Q.** And in the college's experience, was that advice
3 followed?
- 4 **A.** Actually, the -- I would say that midwives tried really
5 hard to maintain their face-to-face contact because
6 it -- they felt it was so important. They were anxious
7 that they weren't doing that. There were occasions when
8 they couldn't because they didn't have enough staff.
9 What was reported to us was that in fact when they
10 started to do online and telephone contacts, some women
11 ended up with more contacts than they had previously
12 because that wasn't a system that they had used. So,
13 they certainly prioritised more contacts for women who
14 were anxious, had complications, had Covid, there was
15 definitely an increase in contact, but not necessarily
16 face to face.
- 17 **Q.** The College produced guidance in July 2020 for the use
18 of virtual consultations. Was there any guidance
19 available before July?
- 20 **A.** No. I think there was some loose conversations about
21 virtual consultations but we realised that there were
22 different techniques being used around the country which
23 was causing confusion, so that's why we did that
24 guidance.
- 25 **Q.** And was there any analysis carried out of the impact of

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1 that immediate roll-out of virtual antenatal and
 2 postnatal appointments to ensure that pregnant women did
 3 continue to get the level of safe care that they needed?
 4 **A.** Are you referring to our survey?
 5 **Q.** Yes.
 6 **A.** Yes. So we did a very quick survey to -- just to make
 7 sure that midwives were using the guidance and
 8 continuing to provide as much care to women as they
 9 could in --with the backdrop of actually having a
 10 much-reduced staffing. Also there were real issues
 11 about delivering community services with a lack of PPE,
 12 not knowing whether the people you were caring for had
 13 Covid or not. So there was an anxiety amongst the staff
 14 about caring for women in a face to face setting in
 15 a community setting particularly in somebody's home. So
 16 we could see that the telephone and video contact was
 17 being used maybe more than we anticipated, because it
 18 made -- it helped the anxiety of going into the unknown
 19 and visiting people in their own home.
 20 **Q.** And were you aware of there being any draw backs to
 21 that, for example, digital exclusion or access to
 22 equipment?
 23 **A.** Yes, that was reported to us. So we realised that some
 24 women didn't have access to a phone or an iPad or
 25 a computer, and also for women whose first language

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1 may not be moving properly, they did reduce, and some of
 2 that wasn't because women weren't coming for the scans;
 3 my understanding from our members was that some of the
 4 women hadn't reported that they had a concern, and there
 5 was definitely some confusion around accessing maternity
 6 services because the message was "Stay at Home". Our
 7 message was very much "Maternity services are open";
 8 I certainly went out in the media myself and said that
 9 many times because we were really worried that women
 10 would be frightened, they would stay at home, and that
 11 something might then happen to them or their baby
 12 because they weren't accessing appropriate care, and
 13 I think that might be what that graph is telling us.
 14 **Q.** Thank you. And there was a guidance from the Royal
 15 College of Obstetricians and Gynaecologists on telephone
 16 triage in relation to the non-routine antenatal scans,
 17 so if there were concerns -- if a woman had concerns and
 18 whether a scan or consultation was needed straightaway,
 19 or there could be a safe delay. Was the College of
 20 Midwives aware of any training or guidance for that move
 21 to telephone triage that was published?
 22 **A.** I'm not really aware of any local training. Obviously
 23 we had our guidance, and because it was guidance and not
 24 necessarily enforced, it would be up to NHS England and
 25 local organisations to adopt that guidance locally and

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1 wasn't English. I think a lot of services picked that
 2 up as issues and tried really hard to prioritise those
 3 women for more face-to-face contacts, but that took
 4 a while to get in. But that definitely was an issue.
 5 **Q.** Thank you. I want to have a look at a graph with you,
 6 and this is INQ000485652. This relates to antenatal
 7 scans in England before the pandemic but also during the
 8 relevant period as well.
 9 We can see from this graph that there was a drop
 10 in non-routine antenatal scans and routine antenatal
 11 scans during wave one and wave two of the pandemic.
 12 Can you briefly explain why those scans are so
 13 important and the potential impact of there being
 14 a decline?
 15 **A.** So, some of the scans -- the routine scans are at 12
 16 weeks and 20 weeks. They really are important to make
 17 sure everything is fine with the pregnancy, with the
 18 baby. There was a reduction in women accessing those
 19 scans. Some of it, I think, was because they could not
 20 take their partner or they were worried about coming
 21 into a hospital environment. So the "Stay at Home"
 22 message definitely impacted on pregnant women at that
 23 time.

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

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1 put in the training for it. So I can't answer in terms
 2 of what happens in every single organisation. My hope
 3 would be that if something was going to be done
 4 differently, like telephone triage that there would be
 5 training for the staff that were going to be doing that.
 6 **Q.** And you have touched on the "Stay at Home" messaging but
 7 in the college's experience, was there an impact caused
 8 by the reduced access to primary care, so GP services as
 9 well?
 10 **A.** Yes, I think the "Stay at Home" message impacted women
 11 accessing primary care, midwifery care, and coming into
 12 hospital. I think there was a lot of anxiety around
 13 particularly when women were classed as vulnerable, and
 14 that absolutely impacted on access to appropriate
 15 maternity care.
 16 **Q.** I want to ask you some questions about the visiting
 17 guidance in antenatal settings. We have heard quite
 18 a lot of evidence about this already, but the Royal
 19 College did issue a briefing in July 2020 on the
 20 re-introduction of visitors to maternity units across
 21 the UK. You have summarised that paragraph 35 of your
 22 statement, can you just explain what that briefing
 23 included?
 24 **A.** So, after the first lockdown, where access to NHS
 25 services was -- there was almost a blanket ban on

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

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

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

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

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

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

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

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

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

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

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

20 **A.** Okay.

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 who were --

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

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

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

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

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

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

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

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

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

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

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

5 If we could please go to INQ000280503.

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

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

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

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

9 **Q.** And is it right that around this time both colleges had
10 actually been working with NHS England to produce
11 guidance but there was a delay, I think it was until
12 8 September, when guidance is actually issued by
13 NHS England. Is that right?

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

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

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

12 What was the College's response to that response?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 **A.** Yes.

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

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

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

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

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

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

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

25 There was an issue as well about testing, so

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1 they thought would be most helpful in keeping everybody
 2 safe.

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

6 **A.** Yes, we did. Yes.

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

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

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

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1 UK?

2 **A.** I think some services did use them, but again we
3 couldn't mandate them to be used. NHS England, I think,
4 did support some of them, so there was some leaning
5 towards those principles being used, which was good.
6 And certainly some of the midwifery leaders that we
7 spoke to regularly really welcomed them and used them in
8 their services.

9 **Q.** And you have touched upon the colleges' communications
10 with NHS England and the like in regard to the guidance.
11 To your knowledge, was any consideration given to
12 consulting with patient representative groups during the
13 development of that guidance?

14 **A.** From NHS England?

15 **Q.** Yes.

16 **A.** Yes, I think so. We also had a system in the Royal
17 College of Midwives, we have -- with the Royal College
18 of Obstetricians, we have something called "One Voice"
19 where we have parent and baby charities and the colleges
20 together, where these issues could be discussed. So we
21 certainly discussed the things within our guidance with
22 parent groups, and we would encourage that locally as
23 well with maternity voices partnerships and women. So
24 we would encourage midwifery leaders, for example, to
25 discuss a local guidance or changes to guidance with

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1 there was an issue there, again, maternity not being
2 seen as a key part of NHS care, an essential service.

3 **Q.** Thank you. I want to ask you one more question
4 regarding support during antenatal services before
5 moving on.

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

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

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

19 That is from a woman who used maternity services
20 during the pandemic. Were you aware of there being
21 communication issues due to the restrictions on visitors
22 and supporters during antenatal appointments and scans,
23 and whether there was any guidance or support available
24 from healthcare professionals for that?

25 **A.** Yes, so we were producing guidance about prioritising

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1 their local groups. That's really key.

2 **Q.** And did the College communicate with the chief nursing
3 officers or chief midwifery officers in the four nations
4 regarding the guidance?

5 **A.** Yes, we did, and we had lots of conversations about
6 that. In England we did escalate some of the issues and
7 the discrepancies we had, and the length of time, to
8 Dame Ruth May who was the chief nurse, and she was quite
9 helpful in terms of unblocking the way in some of those
10 issues.

11 **Q.** You have touched upon the issue of testing to facilitate
12 visiting in hospitals. And that that came in, certainly
13 in England, at the end of 2020 and in Wales in middle of
14 2021. Could the introduction of IPC precautions, for
15 example, testing and access to PPE earlier, could have
16 helped to facilitate visiting?

17 **A.** Absolutely. Definitely would. I mean, if there was PPE
18 for visitors, for partners, for the staff, testing for
19 everybody, it would reassure people that -- of the
20 situation, you know, who they were looking after and
21 what the risks might be, that absolutely would have made
22 a massive difference.

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

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

10 **Q.** Thank you.

11 I want to move on then to birthing options and the
12 changes during the pandemic. We heard this morning
13 about the different birthing options outside of the
14 pandemic being hospital, midwife-led units, whether
15 free-standing or adjacent to a hospital, or a home
16 birth; is that right?

17 **A.** That is correct.

18 **Q.** It is right, isn't it, that the College, along with the
19 Royal College of Obstetricians and Gynaecologists issued
20 guidance in April 2020 for midwife-led settings and home
21 births in the Covid pandemic which set out a staged
22 approach to support the continuation of home births and
23 births in midwife-led settings, where staffing levels
24 and ambulance capacity allowed, and then also set out a
25 move towards centralisation of services with

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1 restrictions and suspensions of other birthing options,
 2 with reinstatement when it was safe to do so. Is that
 3 a fair summary of that guidance?
 4 **A.** Yes, it was a toolkit to be able to maintain services if
 5 staffing levels allowed, including the ambulance
 6 service, so we were hoping that was going to create some
 7 helpful decision-making, and try and create some
 8 equality amongst services, because I think at the time
 9 some services -- because their staffing levels were
 10 fine -- were able to maintain the home birth service and
 11 others wouldn't and that was creating competition,
 12 really, between services and making women feel that if
 13 they wanted a home birth, for example, they would have
 14 to change to a different hospital, and it was
 15 unsatisfactory in terms of then provision of services.
 16 **Q.** If we could then -- leads me on to my next point,
 17 actually, which is some data we have received from
 18 NHS England showing the closures and suspensions in
 19 April 2020. This is at INQ000485652.
 20 This is data taken from England in April 2020 and
 21 across 130 trusts. You should be able to see that in
 22 front of you.
 23 **A.** Yes.
 24 **Q.** We can see here that there was, during that month, the
 25 suspension of home birth in 60 of those trusts, so just
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1 really -- we as a college really encourage good local
 2 communication with women about the status of service
 3 provision at any one time.
 4 That was really stressful for women, and you will
 5 see in some of my evidence that there was then
 6 an increase in free births because women really wanted
 7 a home birth, there wasn't staff available so they gave
 8 birth without a health professional. Some of those
 9 women did because they were scared of going into
 10 hospital as well, but it definitely had an impact on
 11 women being able to access the service they wanted, but
 12 it was all done to keep services as safe as possible,
 13 that was always the intention, not to deprive people,
 14 women, of choice.
 15 **Q.** Thank you. I'm going to look at some more data in
 16 a moment in regard to slightly later on in the pandemic
 17 but I just want to stay in this early stage.
 18 It is right, isn't it, that the College made
 19 a plea at the end of March 2020 to ringfence maternity
 20 services by stopping the redeployment of maternity
 21 staff?
 22 **A.** Yes, we did, and we made that plea quite loud because we
 23 heard from our members that staff were being redeployed,
 24 and it was having a serious impact on them being able to
 25 deliver safe maternity care. That did happen. Staff
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1 under 50%; a closure of -- alongside midwifery units
 2 there were eight closures, 11 free-standing units were
 3 closed, and two obstetrics service units were also
 4 closed.
 5 The closures that we can see there, are they
 6 examples of services essentially having to centralise,
 7 as you have set out in that toolkit?
 8 **A.** Yes, basically in order to deliver safe care to all
 9 women, with the depleted number of staff and access to
 10 ambulance services. The directors of midwifery used
 11 that to make sensible decisions about keeping all women
 12 safe. Midwives really support home births and it was
 13 a hard thing for them to do, but a home birth takes two
 14 midwives, and that, when you haven't got enough staff,
 15 is difficult to do where you don't have enough midwives
 16 even to provide one-to-one care to women who are may be
 17 giving birth in a local hospital.
 18 I think it is testament to this that not every
 19 service closed their home births. They were really
 20 agile in terms of doing what they could, based on their
 21 staffing numbers and availability of ambulances at any
 22 one time, and they always tried their best to reopen
 23 parts of the service if they could. I think you know
 24 locally some services communicated that really well to
 25 the population. Other services may not have done and we
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1 were ringfenced although we still had people telling us
 2 that it wasn't consistent, and in fact even moving into
 3 the next wave of the pandemic, sort of December/January
 4 time, NHS England were asked again to make it absolutely
 5 clear that maternity was an essential service, and staff
 6 should not be redeployed. And that did happen.
 7 **Q.** Thank you. Were you aware of services having to use
 8 healthcare assistants or senior managers or other
 9 members of staff who were redeployed into maternity
 10 settings to support service delivery?
 11 **A.** I am not aware of from other services; I know some of
 12 our midwifery leaders that we met with regularly were
 13 working clinically, because they had to, but they also
 14 had leadership responsibilities in terms of managing the
 15 services and making decisions, so I think that was quite
 16 difficult for them.
 17 Only midwives can -- you know, it's -- midwives --
 18 nobody else can carry out the role of the midwife,
 19 that's actually illegal. So I'm not aware of others,
 20 from other parts of the unit, coming into maternity, to
 21 work clinically, because that wouldn't be possible,
 22 which is why maternity services had to be ringfenced.
 23 You can't take midwives out of maternity services to do
 24 other things because nobody else can replace them. That
 25 can't happen.
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1 **Q.** Thank you. Moving on, then, into June 2020. Data from
2 Scotland shows that of the 14 Health Boards there, only
3 two of them at that period of time were offering the
4 full suite of antenatal care and a survey by the Royal
5 College of Midwives in Scotland showed that there had
6 been significant redeployment in the maternity services
7 in Scotland.

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

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

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

24 **A.** Can you just bring me to --

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

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

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

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

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

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

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1 **A.** That's about visiting again.

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

4 **A.** So that was --

5 **Q.** That's all in terms of visiting?

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

15 **Q.** Thank you.

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

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

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

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

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

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

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

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1 women's birthing options?
 2 **A.** Yes, we did and some of the women would phone the
 3 College. They would comment on social media and
 4 I absolutely understood where they were coming from.
 5 You know, women have one opportunity in that pregnancy
 6 and birth to have a good experience and they were really
 7 disappointed, anxious, and it was a really difficult
 8 time for them and for the staff who were looking after
 9 them because they didn't want that either, but they had
 10 to make safe decisions and this is a decision they had
 11 to make which we tried to support.
 12 **Q.** Thank you. Moving on to the topic of miscarriages.
 13 Were there any changes in the guidance on the management
 14 of miscarriages during the pandemic?
 15 **A.** Obviously in early pregnancy miscarriage is not managed
 16 by midwives. Some women miscarry before they have even
 17 booked with a midwife. I think that the same applies to
 18 all of the maternity journey that at the beginning it
 19 was the "Stay at Home" message caused some issues and
 20 then access to services where keeping away from the NHS
 21 was part of the other story.
 22 I can't comment on gynaecology staffing issues or
 23 early pregnancy units because it is not a place where
 24 midwives normally work.
 25 **Q.** Thank you. In terms of pain relief, was the College
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1 before. But if the anaesthetists are needed in
 2 intensive care units where people are dying, can one
 3 really object to redeployment of anaesthetists away from
 4 pain relief, much as obviously somebody in labour,
 5 a woman in labour would like to have pain relief, of
 6 course, but I'm not sure there is a comparison between
 7 pain relief and people dying and needing the services of
 8 an anaesthetist.
 9 **A.** Yes, my Lady, that is right apart from there's not many
 10 anaesthetists available in a maternity unit, usually
 11 there is only one, and they are needed for the emergency
 12 part of child birth, so emergency caesarean sections,
 13 epidurals when there may need to be an operative
 14 delivery, and also women who collapse. As part of
 15 an unfortunate consequence of labour, some women have
 16 a medical emergency, and most units have only one or two
 17 anaesthetists available at any one time so having no
 18 anaesthetists was a huge risk.
 19 In terms of pain relief there are other options
 20 for pain relief and midwives obviously would talk to
 21 women and offer all of those methods of pain relief if
 22 there wasn't an anaesthetist available but we had
 23 reports from women who were traumatised by not having
 24 access to an epidural for pain relief, not necessarily
 25 for an emergency caesarean section.
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1 made aware of examples of limited or delay access to
 2 pain relief including water births, birthing pools, or
 3 epidurals?
 4 **A.** Certainly at the beginning of the pandemic, it was in
 5 the first wave, when we weren't quite sure about the
 6 virus transmission, there were definitely issues about
 7 whether the virus could be transmitted in water, so
 8 there was a restriction then on water birth. And
 9 I think a joint guidance with the RCOG did talk about
 10 restricting water birth particularly if we were unknown
 11 of the virus status of the women, because we weren't
 12 testing.
 13 It changed because then it was an airborne virus,
 14 so water births started to be provided in services again
 15 and we again updated our guidance with that.
 16 The other issues were about anaesthetics and
 17 access to epidurals. That was another reason for
 18 ringfencing staff. Anaesthetists were -- they were
 19 short of anaesthetists in ITUs so anaesthetists were
 20 redeployed away from obstetric services, so much -- not
 21 completely, but there were less staff available. So
 22 having access to epidurals and quickly was a concern to
 23 midwives who were looking after the women.
 24 **LADY JUSTICE HALLETT:** Can I ask about that -- sorry to
 25 interrupt you. But it is a subject we touched on
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1 So it was definitely an issue because there are
 2 not loads of anaesthetists in maternity units.
 3 **LADY JUSTICE HALLETT:** And really the answer to my question
 4 is it is going far beyond the pain relief, much as the
 5 --
 6 **A.** Oh, yes.
 7 **LADY JUSTICE HALLETT:** -- (overspeaking) -- traumatised --
 8 the use of the anaesthetists, for many other purposes
 9 than just the epidural for the --
 10 **A.** Absolutely. Absolutely, it is.
 11 **LADY JUSTICE HALLETT:** Thank you.
 12 **MS HANDS:** And I just want to touch briefly on one issue
 13 around the guidance on visitors and birthing partners
 14 around active labour, and the Inquiry has heard some
 15 evidence around the definition of active labour within
 16 the guidance or the lack thereof, and the interpretation
 17 of when a woman may be in active labour and therefore
 18 allowed to have a birthing partner attend.
 19 Did the College hear of any problems with
 20 interpreting active labour, and did it seek to raise any
 21 of those concerns?
 22 **A.** Yes, and in fact it wasn't about the definition of
 23 active labour, it was much more about the environment in
 24 where women were being cared for, in that first part of
 25 the pandemic, where partners could be there in labour.
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1 So, quite often, women who were induced or were in early
2 labour were not on a labour ward, they are in a -- maybe
3 in a four-bedded bay, so -- with other women. So that
4 was more of the issue rather than definition of active
5 labour. When women are in active labour and then
6 require midwifery care, maybe requiring pain relief,
7 extra monitoring, they then move to a labour ward, which
8 was where we knew that partners could be.

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

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

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

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

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

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1 if the old guidance may be causing harm.

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

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

6 (2.45 pm)

7 (A short break)

8 (3.00 pm)

9 **LADY JUSTICE HALLETT:** Ms Hands.

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

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

16 **A.** No, we didn't.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 guidance?

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

3 We can get that information to you, though.

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

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

15 **Q.** Did you seek to raise those issues?

16 **A.** Yes, we did.

17 **Q.** What was the response?

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

22 **Q.** Did the College produce any guidance?

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

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

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1 outcome of that?

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

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

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

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

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

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

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

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

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1 guidance at that time?

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

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

18 **Q.** And it is right, isn't it, that a year later, so in
19 December 2021, the College issued guidance alongside the
20 Department of Health and Social Care which moved the
21 threshold from 28 weeks to 26 weeks' gestation. Was
22 there a change or development in the understanding of
23 risk in that period of time that led to that change from
24 28 to 26 weeks?

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

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

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- 1 I personally had meetings also with some black
2 midwives who were really concerned about not having
3 access to PPE knowing that the impact of Covid on that
4 group of staff was higher.
5 So there were a number of issues around PPE and
6 availability and how maternity services were not
7 prioritised for the right PPE for the work that they
8 were doing.
9 **Q.** And did you raise those concerns?
10 **A.** Yes, we did.
11 **Q.** What was the response?
12 **A.** The response at the time was about availability of PPE,
13 which was that the FFP3 masks and the fitting of them
14 had to be prioritised for people who were in high-risk
15 areas, so respiratory areas and known Covid patients.
16 But that was not acceptable so we did raise that, that
17 we wanted maternity not to be treated as a separate
18 service, that midwives were working in a very high-risk
19 situation with women who potentially had Covid and they
20 were therefore at risk.
21 The other thing about -- just linking back to what
22 you said before about healthcare workers who were
23 pregnant. Maternity is largely a female workforce, and
24 we seem to have more pregnant midwives and maternity
25 support workers than any other group, so there was

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- 1 It is right, isn't it, that midwives expressed
2 concerns around the PPE levels that were recommended in
3 the PHE guidance early on, in March 2020, as to whether
4 that provided sufficient protection in the maternity
5 setting? And that at the end of March 2020, the College
6 of Midwives, with the Royal College of Obstetricians and
7 Gynaecologists produced guidance for healthcare workers
8 in regard to use of PPE and risk assessments and did
9 refer to the PHE guidance.
10 Was it the College's view that that guidance from
11 PHE reflected the risks to healthcare professionals
12 during labour and birth and did it provide sufficient
13 protection?
14 **A.** No. Our view at the time was that it wasn't sufficient,
15 that it was -- I think I have said earlier that
16 maternity services often gets forgotten, it is not seen
17 as an essential service, and our members told us that
18 access to PPE was really difficult. That guidance did
19 not protect them. By then we knew that Covid was spread
20 through -- it was an airborne virus and what midwives
21 told us was they were in a very small room with women in
22 labour for many, many hours and they felt at risk just
23 being in a normal mask and that they believed that they
24 should be treated the same as people in respiratory
25 wards in an ITU and be fitted properly with a FFP3 mask.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 to try and engage that group of women.
 2 It also impacted on the staff because there's
 3 a significant number of staff from BAME backgrounds
 4 working in maternity services who were also really
 5 concerned about their exposure to the virus and we know
 6 that the death rate for them was higher across the NHS,
 7 than for white midwives.
 8 **Q.** And the College issued guidance for employers to
 9 consider risks for --
 10 **A.** We did.
 11 **Q.** -- for minority staff when re-organising services as
 12 well, didn't they?
 13 **A.** We did, and some of those we asked for them not to be
 14 patienting facing, particularly not patient facing with
 15 known Covid women. That, again, created problems in
 16 areas where there was a high number of BAME staff
 17 because it depleted the staff even further in terms of
 18 being able to provide face-to-face care.
 19 **Q.** And -- this may be the guidance that you were just
 20 referring to, but in June 2020, NHS England announced
 21 additional support for pregnant ethnic minority women
 22 known as the "4 common sense steps".
 23 **A.** Yes, that's right.
 24 **Q.** Yes, and it is correct, isn't it, that the College
 25 agreed and endorsed -- (overspeaking) --

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1 in your statement it wasn't particularly useful and
 2 government were reluctant to engage. Why was that and
 3 what would have made the government's engagement more
 4 effective at that point?
 5 **A.** I think at that time the impact of the poorer outcomes
 6 was not necessarily really understood although we had
 7 seen the data. So it was about prioritising again
 8 maternity services amongst all the other NHS services
 9 that are being delivered. So we wanted maternity
 10 services to have a higher profile. We particularly
 11 wanted those women who were more likely to have a poor
 12 outcome to have a higher profile and for there to be
 13 a focus on them and clearer support and communication
 14 for staff to deliver different services to that group of
 15 women.
 16 **Q.** And in terms of risk assessments, I think a survey that
 17 the College undertook found that in September 2020, only
 18 23% of trusts had conducted risk assessments for ethnic
 19 minority staff in patient-facing roles. Were you aware
 20 of whether that improved and, if so, when, and whether
 21 there were any additional steps that could have been
 22 taken to support that being undertaken?
 23 **A.** The -- that was an improvement on where it had been
 24 before, because previous to that there was no risk
 25 assessment. So 23% was going in the right direction.

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1 **A.** Absolutely --
 2 **Q.** Was there any monitoring of the effectiveness of those
 3 interventions, that you are aware of?
 4 **A.** I think -- we didn't but I think NHS England did and I
 5 am aware that they did check that services were
 6 implementing them so I think there was an evaluation but
 7 at the moment I am not aware of what the outcome was.
 8 **Q.** I think you said in your statement that little progress
 9 had been made since the publication of the four-step
 10 action plan. So looking back, do you think there could
 11 have been further action taken at the time to try and
 12 mitigate the differences and outcome earlier on?
 13 **A.** Yes, but I think it was again about having clear and
 14 focused communication about the things that were going
 15 to improve outcomes. So it would be about -- I think it
 16 did make some difference in some areas and certainly
 17 some of the staff that I spoke to were really pleased to
 18 see that guidance and that focus. But, again, it is
 19 the -- how in the pandemic was there focused
 20 communication, a single point of the truth, so that
 21 staff and women knew what was the best thing to do?
 22 **Q.** I think it is right, isn't it, that there was
 23 a ministerial round table in July 2020 at which the
 24 Royal College presented findings and recommendations to
 25 address the maternity and disparities and you have said

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1 It was definitely about making sure that services saw
 2 that risk assessment as a priority. But there were lots
 3 of priorities, and it was very difficult for some of the
 4 staff to see that as the priority at that time.
 5 During the pandemic, NHS England continued to
 6 implement some policy changes, some service delivery
 7 changes, so there was a lot going on, so, for example,
 8 midwifery continuity of care was continued to be
 9 implemented, and our view was that we had to help
 10 services and NHS England to focus on the things that
 11 were going to make a bigger difference to the outcomes
 12 for women.
 13 **LADY JUSTICE HALLETT:** Please slow down.
 14 **A.** Sorry.
 15 **MS HANDS:** Moving on to the topic of mental health and
 16 well-being support for maternity staff, can you briefly
 17 summarise the impact on midwifery staff with the
 18 restrictions that were in place during the pandemic and
 19 any support that the College provided to its members?
 20 **A.** Okay, so members told us of significant impact on their
 21 mental health. Primarily midwives, maternity support
 22 workers and the whole maternity team wanted to provide
 23 a high quality of care, safe care, choice for women as
 24 they always did. They were very anxious and stressed
 25 not being able to do that, and disappointing and

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

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

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

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

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

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

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

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1 and Long Covid and all the other things.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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1 are referred to at paragraph 38 of your statement?

2 **A.** Yes.

3 **Q.** And then, is it fair to say that over the summer of
4 2020, in facing that lack of guidance, the RCM, the
5 Royal College of Obstetricians and Gynaecologists and
6 the society of -- and College of Radiographers stepped
7 into the breach and developed that framework agreement
8 to support the reintroduction of visitors in maternity
9 settings?

10 **A.** Yes, we did.

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

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

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

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

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

12 **LADY JUSTICE HALLETT:** I do understand that.

13 Mr Wagner.

14 Questions from MR WAGNER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 And then other people got really disappointed and upset

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

3 **A.** Yes, that's right.

4 **Q.** In relation to that guidance is it right that the RCM
5 and the RCOG raised concerns about the guidance imposing
6 in its initial draft mandatory requirements for Trusts
7 to facilitate women's access to support at all times
8 during her maternity journey? And your comment was that
9 that should be not mandatory but -- non-mandatory.
10 **A.** That is correct because at the time that guidance was
11 finally produced the infection rates were increasing
12 again and so there was definitely a risk to increasing
13 the number of people who had access to maternity
14 facilities. So there was a huge concern about then
15 increasing infection rates amongst women, babies, the
16 staff. Different environments, I think I said this
17 before, lent itself really well to partners being able
18 to have access throughout the whole labour journey
19 because they were single rooms and it was easy to then
20 have people cohorted in one room. It became really
21 difficult for partners to then be in all parts of
22 maternity services where the environments didn't
23 facilitate appropriate social distancing.

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

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1 because the service they accessed couldn't do that.

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

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

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

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

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

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

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

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

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

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1 **MR WAGNER:** Thank you.

2 **LADY JUSTICE HALLETT:** Thank you, Mr Wagner.

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

6 **A.** Okay.

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

10 **A.** Thank you.

11 **(The witness withdrew)**

12 **LADY JUSTICE HALLETT:** Very well. I think that completes
 13 the evidence for today, and I shall return to sit at
 14 10 o'clock tomorrow morning.

15 **(3.46 pm)**

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

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