1 **Monday, 7th October 2024**
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 HALLETT:** Ms Mullen, I know how distressing this is
7 going to be for you, but please, just remember we are
8 all here to try and help you through it and we will get
9 you through it as quickly as we can, and although it
10 won't be pain free, it will be as pain free as we can
11 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 **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

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?

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.

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

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?

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.

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

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.

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

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 HALLETT:** Take your time. Have a sip of water. Always
12 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 --

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?

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

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

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?

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

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

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

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

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 HALLETT:** Thank you very much indeed, Ms Mullen.
18 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 HALLETT:** And how is your daughter coping with two
22 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,

1 very, very good.
2 **LADY HALLETT:** You have obviously got your hands full, so
3 thank you very much for coming along to help us.
4 **A.** Thank you.
5 **(The witness withdrew)**
6 **MS HANDS:** My Lady, may I call Ms Jenny Ward. She will
7 affirm.
8 **MS JENNY WARD (affirmed)**
9 **Questions from COUNSEL TO THE INQUIRY**
10 **MS HANDS:** Good morning, Ms Ward, you should have your
11 statement in front of you and that is INQ000408656.
12 Ms Ward, you are here today as Chief Executive of
13 the Lullaby Trust and also Chair of the Pregnancy and
14 Baby Charities Network; is that right?
15 **A.** Yes, that is.
16 **Q.** And your evidence today is on behalf of the 13 Pregnancy
17 Baby and Parent Organisations; is that correct?
18 **A.** Yes, that is correct.
19 **Q.** And if you don't mind, I will refer to them as the PBPOs
20 from hereon in.
21 You have set out the members of the PBPOs in full
22 in your statement but can you give us an example of some
23 of the organisations within that group?
24 **A.** Yes. Absolutely. So of the 13, just to reiterate,
25 although we tend to talk about maternity and neonatal,

1 we cover a wide range of that whole period and it can be
2 divided into early pregnancy, antenatal, postnatal, and
3 neonatal. So we have a number of organisations such as
4 The Ectopic Pregnancy Trust and the Miscarriage
5 Association that cover early pregnancy, and then those
6 of us like The Lullaby Trust, like Tommy's, who cover
7 the period of birth and post natal and then neonatal is
8 covered, again, by Tommy's and by Bliss.
9 So there is a wide range of organisations.
10 **Q.** Thank you.
11 And it is right that there is representation
12 across the UK?
13 **A.** Yes, that is correct.
14 **Q.** We are going to go, essentially, through the impact of
15 the pandemic on maternity services for pregnant women
16 throughout the maternity journey, starting with
17 antenatal services.
18 The guidance at the start of the pandemic was for
19 antenatal services to be maintained with a minimum of
20 six face-to-face antenatal consultations with video and
21 remote consultations as an alternative.
22 Now, in your experience, was that guidance
23 followed throughout the pandemic?
24 **A.** I think there was a mixed experience there. And when we
25 look at some of those organisations that deal with early

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

1 healthcare professionals had with an increased use of
2 online and remote access to maternity services. You
3 have set out some there but were there some -- could you
4 perhaps provide us with some of the positives and
5 negatives of the increased use of those online options?
6 **A.** Yes, absolutely. They weren't all negative. So there
7 are some good examples of practice of appointments being
8 far more accessible by being online, and that's good.
9 Some of the parts that might be -- and also, for
10 example, if you had pregnancy sickness, the thought that
11 you had to go face to face somewhere was practically
12 very difficult to do. So it was good that there was
13 an online option.
14 Some of the negative parts of that, as I said,
15 there are specific tests and specific concerns that
16 people would raise face to face that maybe they felt
17 they wouldn't on an online appointment and also there
18 were some people who simply didn't have the ability
19 there to use an online system and to contact their
20 health professional. So where we talk about the
21 inequalities that are there, digital poverty definitely
22 meant that those who were less able to access that were
23 more negatively impacted.
24 **Q.** I think you have given some examples in your statement
25 of pregnant women delaying access to care and

1 telephone -- they are examples of telephoning triage.
2 So if we can go to INQ000408656, page 11.
3 If we look at question 1 and question 2. Is it
4 right this is feedback from various organisations within
5 the 13 PBPOs that you have included within your
6 statement, and we are going to a few of those throughout
7 the morning?
8 A. Yes, absolutely. Of the 13 organisations we all work
9 closely with the people that we support. So they come
10 and talk to us and we have gone and asked them what
11 could be improved. So these are those people who work
12 closely with us directly coming with those comments.
13 Q. So the first comment there is:
14 "It was really only because I was worried about
15 Covid in the hospitals that I didn't go to A&E."
16 And then the second:
17 "A day passed and I started feeling dizzy and the
18 pain had got worse, reluctant to go to A&E in the
19 current pandemic. I new (sic) something was not right."
20 Then the third one there relates to problems
21 getting an appointment with a doctor. They said:
22 "My severe pain went from ... possible
23 appendicitis to pelvic inflammatory disease. This was
24 by telephone consultations, then 3 weeks after the pain
25 had started I was finally told I had an ectopic

1 pregnancy and my tube had completely ruptured."
2 So the reasons that we see there, are they the
3 same or similar to the experiences that PBPOs heard
4 during the pandemic as to why women weren't accessing
5 healthcare or delayed doing so?
6 A. They give a really good representation of the messages
7 that we got which was: people pulling back, thinking,
8 well, I have been told to stay at home. We have also
9 been told that healthcare -- places like hospitals are
10 overwhelmed. We are also worried about Covid. We have
11 been told that in pregnancy we are particularly
12 vulnerable. And as I said, some of these conditions,
13 the initial symptoms are not necessarily things that
14 make you feel you absolutely need to go to A&E directly.
15 So yes, people held back and yes, there were
16 difficult situations as a result of that.
17 Q. And on the topic of telephone triage, in your statement
18 you have referred to guidance from the Royal College of
19 Obstetricians and Gynaecologists regarding telephone
20 triage services when a woman makes a complaint or raises
21 a concern.
22 And essentially there was rationalisation of
23 services to look at what scans or services were needed
24 either without delay or whether there could be a safe
25 delay.

1 Obviously we see some of that in the third
2 quotation here around a telephone consultation. Were
3 PBPOs aware of cases where pregnant women who had
4 concerns about their unborn baby and were feeling
5 unwell, they were given "Stay at Home" advice where they
6 may, in non-pandemic times, have been asked to attend
7 a face-to-face appointment or assessment?
8 A. Yes. I think there's a mixed picture there and
9 actually, there is some good examples where having that
10 telephone triage was helpful, it was helpful to families
11 to give them some reassurance, it was helpful to health
12 professionals who, as we heard in this particular area,
13 were already over stretched. So they could really look
14 and decide who it was that they -- where they had to
15 make a choice.
16 So yes, there are some benefits to that but yes,
17 we did hear that there were also negatives.
18 Q. And did you hear about those continuing throughout the
19 pandemic?
20 A. In terms of having triage?
21 Q. Yes. Those concerns that you have just mentioned, did
22 they continue or did you find that they kind of went in
23 waves?
24 A. My understanding is that they continued throughout.
25 Q. Thank you. In your statement you have referred to

1 a finding by Tommy's midwives who saw a 40% increase in
2 email inquiries between March and August 2020 for help
3 and support, they say, from a trusted source, which they
4 believe was a consequence of women being discouraged
5 from visiting hospital or antenatal services unless
6 absolutely necessary. And you have said in your
7 statement that Tommy's considers that women were being
8 encouraged to miscarry at home.
9 Was help and support available other than from the
10 charitable organisations?
11 A. I think, again, that was a -- that was a mixed picture.
12 So, usually, if a woman is worried about miscarriage,
13 they could contact a health professional, and they could
14 then get checked, and they would -- if that was
15 confirmed that's the case, they would be given options
16 on what to do.
17 In this circumstance, in this period, certainly of
18 the early pandemic, it appears that women were
19 encouraged to take what we would call a managed wait,
20 which is basically stay at home and let nature take its
21 course. That has a huge impact on families.
22 Q. I want to stay on the topic of miscarriage and building
23 on what you have just said. If we could go to another
24 example from your statement, so INQ000408656, and it is
25 number 8. Question 8 in the blue box. This is another

1 experience that a woman had during the pandemic where
2 she said:
3 "I had a really drawn-out experience in which
4 I had to go to multiple GP surgeries and hospitals to
5 confirm my miscarriage as appointments were so scarce.
6 I was ... dismissed by the doctor in A&E as being
7 dramatic regarding spotting in my 8th week of pregnancy.
8 [And] from there, it took almost 3 weeks to diagnose
9 a missed miscarriage, and a further week for my
10 treatment to be booked. As it was, I miscarried
11 naturally on the day of my appointment, at home, where
12 I was scared and in pain. I rang the hospital and they
13 simply told me to take paracetamol. I still have
14 flashbacks and nightmares regarding this, even following
15 the birth of my healthy child."
16 Is that an example of what you have just given of
17 a managed miscarriage?
18 **A.** Yes, it is.
19 **Q.** And the Miscarriage Association carried out a survey
20 during the first wave -- sorry, during the first and
21 second wave of the pandemic, of women that were affected
22 by pregnancy loss, and found most were able to access
23 health professional care but 10% were unable to be seen
24 in person. And again, is that the impact of the use of
25 more remote and virtual consultations that --

1 **A.** Yes, yes, it is. And I would also say it feels, from
2 that quote and from the examples from the Miscarriage
3 Association, as if miscarriage was downplayed like it is
4 something that it happens. So -- you know, that --
5 that's just -- kind of "That's what happens, keep on
6 with it" and it wasn't prioritised.
7 **Q.** Also in your statement, if we could go to page 18,
8 please, and Q11 and 12.
9 This relates to surgery for miscarriage, so the
10 in-hospital care and access to treatment. So the first,
11 number 11, is:
12 "I was left in pain for hours with no pain relief.
13 Unable to have surgery due to covid 19. My miscarriage
14 was manually removed. This has had a big impact on how
15 I have been feeling over the last 3 years."
16 Then in the second one, she said:
17 "[I] ended up waiting 3 days in hospital for
18 surgery 4 weeks after finding out I had a missed
19 miscarriage. [And] I was told surgery was not an option
20 originally due to covid and ended up with an infection."
21 Were PBPOs aware of the impact of Covid on access
22 to in-hospital treatment for miscarriage, for example,
23 surgery that we have seen here, keyhole surgery, during
24 the pandemic?
25 **A.** Yes. Yes, and we fight hard to make sure that families,

1 and have over the years, get a choice in the treatment,
2 particularly when it relates to a miscarriage or the
3 loss of a pregnancy or a baby. So it was particularly
4 distressing for us to hear that that was taken away from
5 families, and as these say, it has an impact on them for
6 a very long time.
7 **Q.** Moving on then to birth and to labour, can you briefly
8 summarise the birthing options available to a woman
9 outside of the pandemic?
10 **A.** Yes. Usually you would have the choice to either give
11 birth in a hospital setting, consultant-led, in
12 a midwifery-led centre or in a birthing centre which is
13 -- comes separate from a hospital, or at home, which
14 would have maternity staff there. We would have
15 midwives and they usually specialise in home births, so
16 those are the options.
17 **Q.** And you have described in your statement how the choice
18 of birth setting is, in normal situations, a key part of
19 maternity policy, to enable women autonomy and control
20 over safe birthing event; is that right?
21 **A.** Yes, that is correct.
22 **Q.** And we will come onto specific examples, but overall,
23 did that happen during the pandemic?
24 **A.** No. Those choices were decreased immediately the
25 pandemic started.

1 **Q.** And in your statement you have set out some findings
2 from a survey that the Royal College of Midwives
3 undertook -- sorry, a survey, yes, that they undertook
4 in regard to closures. And we are going to come onto
5 address that in more detail with the Royal College.
6 But you have set out in your statement some of the
7 impact of those closures that we can see from pregnant
8 women that have provided those quotations, so if we can
9 go to INQ000408656 page 25, please.
10 At the top and one Respondent said that:
11 "In my birth plan I had requested a water birth
12 and an active birth. This was not possible, but again,
13 no midwife explained why I couldn't do this or even
14 appeared to acknowledge my birth plan."
15 Then at page 33, number 30. Here somebody said:
16 "Due to midwife shortages my baby was delivered at
17 the side of the road ... The ambulance crew told us we
18 were the second couple they had been to that night who
19 had delivered en-route to the hospital."
20 Dealing first with the first example we looked at,
21 was there a lack of information or explanation as to why
22 options were limited during the pandemic?
23 **A.** Yes. I think that's true. I think families certainly
24 felt that their choice wasn't there and they didn't
25 fully understand why, but at that time we all understood

1 the pressures that were under the health system, and
2 I think a lot of families just kind of accepted, okay,
3 that would have been my choice but unfortunately it is
4 not there, and we have been told we are all in this
5 together and I kind of need to accept that.
6 **Q.** And could you explain briefly what free births are, and
7 whether PBPOs saw any increase in free births and what
8 the risks of them are as well?
9 **A.** Yes. My understanding of the free birth is somebody who
10 gives birth without any medical care there. We did hear
11 of them being more likely to happen during this period
12 for several reasons; firstly, that, as I said, the teams
13 that would normally support families to have home birth
14 in their own setting had been re-deployed elsewhere, and
15 that wasn't something that was offered, but also
16 families who felt that going into a hospital was a risk
17 for them and their baby, felt that they -- their choice
18 to mitigate that risk was to give birth at home even if
19 that meant they were on their own.
20 **Q.** And dealing with that second quotation around staff
21 shortages, again, is that something that PBPOs heard
22 impacted on the care and the services that were
23 available to pregnant women during the pandemic when it
24 came to birthing options?
25 **A.** Yes, yes, absolutely.

1 **Q.** We touched briefly on pain relief and pain management
2 with the water birth there. You have set out at
3 paragraph 81 of your statement findings from a survey of
4 1200 people who had given birth from August 2021 to
5 July 2022.
6 And that showed that 39% had to wait over 30
7 minutes for pain relief during labour. And 35% had
8 reported delays in staff noticing or acting on signs
9 they had, or might have had, a serious health problem.
10 There was guidance from the Royal College of
11 Midwives on access to water births, but was it PBPO's
12 experience that there were delays or suspensions of pain
13 relief, for example, water births or epidurals during
14 the pandemic?
15 **A.** I think this -- this survey seemed to suggest that yes,
16 that was so. Those figures are higher than the ones
17 that were found pre-pandemic. And that is exactly the
18 result that we would expect to have heard from what we
19 heard about staff shortages, and what was going on in
20 the units. And as we said, if the other options for
21 places to give birth had been closed and weren't
22 available, you would expect that those consultant-led
23 units were even busier at a time when they had even
24 greater staff shortages than they did prior to the
25 pandemic.

1 **Q.** Moving on to maternal mortality and inequalities. At
2 paragraphs 45 to 49 of your statement, you have
3 summarised the findings from two reports by MBRRACE, and
4 they found that improvements in care may have made
5 a difference for 7 in 10 women who died with Covid-19
6 whilst pregnant or in the immediate post-pregnancy
7 period and they later updated that to 7.6 in 10 women.
8 What were PBPO's views on the findings?
9 **A.** I think -- well they are devastating aren't they? That
10 there could have been a different outcome. We know that
11 there are lots of inquiries going on into maternity
12 safety, in terms of inequalities, that they have been
13 there for a long time, and in this period we knew that
14 the groups that were at risk prior to the pandemic were
15 even more at risk now. And this is the upshot, and
16 unfortunately those groups were even more impacted. So,
17 yeah, devastated. Lots of things that we would like to
18 change, and that we are all working hard and engaging
19 with to try and change these figures -- those are not
20 figures any of us want to see.
21 **Q.** I think in your statement you have set out some steps
22 that could and should have been taken during the
23 pandemic to address pregnant women's fears and concerns
24 about accessing medical support and the practical
25 barriers to doing so. Could you summarise some of those

1 practical steps that could have been taken and should
2 have been taken?
3 **A.** Yes, I think there was a very strong "Stay at Home"
4 messaging and very strong messaging around pregnancy
5 being a vulnerable group, and I think that actually
6 going out to those people and saying "But your care --
7 that doesn't count for your care", should have been
8 a very strong message. One of the themes we have come
9 out with is the engagement of us as 13 organisations,
10 and as a wider network there are 31 organisations -- 31
11 charities who are in the Pregnancy and Baby Charities
12 Network, so not within this group, we all work directly
13 with families. We are all used to getting messages out
14 there. We are trusted organisations to them, and we
15 could have worked on that much more clearer and made
16 sure that families weren't staying at home when they
17 really needed to get out.
18 **Q.** You have also summarised the findings from another
19 report from MBRRACE which found that there remains
20 an almost fourfold difference in maternity mortality
21 rates amongst women from black ethnic background, and
22 twofold difference from women from Asian ethnic
23 backgrounds compared to white women, and that women from
24 the most deprived areas have twice as high mortality
25 rates as those in least deprived areas.

1 Again, what were PBPO's views on those findings
2 and the experiences that they heard? Did they mirror
3 those findings?
4 A. Yes. I would say, as I mention, we all know that they
5 are high-risk groups. They are groups that we all
6 target, and there are specific groups who are led by
7 people within those communities. So if you have heard
8 of an organisation called Five X More, they exist
9 because of that inequality.
10 So I think yes, we are shocked, but sadly not
11 surprised that those inequalities remain. I would
12 certainly hope that they should have been a high risk
13 group from the very beginning that everybody tried to
14 focus on; unfortunately, as it transpired, they were
15 also a high risk group for Covid. So you had the two
16 challenges, really, coming together here, and I think
17 with -- we would have hoped the communications around
18 that would have recognised that in a bit more detail
19 than possibly they did.
20 Q. There was guidance from the Royal College of Midwives,
21 and NHS England also announced additional support for
22 pregnant ethnic minority women. Does PBPOs have any
23 views as to whether that additional support and advice
24 was in fact effective?
25 A. I think, looking at the guidance, and I know you have

1 heard from other professionals as well that there was
2 a lot of guidance that came out, it was continually
3 updated. Trying to stay on top of that and to translate
4 it into practice on the ground when they are completely
5 over stretched is really difficult for professionals to
6 do. So, from our perspective, it may have been
7 recognised there but the communications to people on the
8 ground weren't as effective as they could have been.
9 Q. Moving on to the topic of visiting restrictions, first
10 of all, in antenatal settings. There was, as we have
11 heard in this inquiry, a suspension on hospital visiting
12 from the end of March 2020. And one of the -- there
13 wasn't a permitted exception for women to be accompanied
14 at a scan or early pregnancy appointment.
15 We have got some examples in your statement of the
16 impact that had, so if we could have one of those up,
17 please. INQ000408656. It is number 62. Thank you.
18 This responder said:
19 "I had a routine scan which my husband couldn't
20 attend but the reason it affects me now still is because
21 I later lost my baby, she was born at 20 weeks but I had
22 a missed 2nd trimester miscarriage as she passed at 16
23 weeks. My husband never got to see her alive as he
24 wasn't at that first scan."
25 Of course, all of those that were impacted during

1 the pandemic will have been impacted in different ways,
2 but you have said that in PBPO's experience, the
3 restrictions had a particularly negative impact on those
4 receiving bad news; is that right?
5 A. Yes, that is.
6 Q. Again, the Miscarriage Association survey found that 77%
7 could not take anyone with them to an in-hospital
8 appointment during the early stages of the pandemic and
9 25% -- sorry, under 25% were able to make a call or
10 video during that appointment.
11 A. Yes.
12 Q. And is that reflective of the impact and the experiences
13 that PBPO heard from its members of the restrictions on
14 attendance at antenatal scans during the pandemic?
15 A. Yes, that is correct.
16 Q. In your statement you have set out the changes -- some
17 of the changes to the approach in the guidance in the
18 summer of 2020.
19 I think you have said that Scotland were the first
20 to define the circumstances in which maternity and
21 neonatal services could reduce the level of restrictions
22 and then Northern Ireland followed shortly.
23 Just dealing with those two first. What was the
24 response of the PBPOs to those changes in the guidance
25 and did that lead to some more consistency in the

1 implementation of the guidance in the units?
2 A. I think for us as UK organisations trying to stay on top
3 of guidance that was changing quite -- across the board,
4 changing fairly frequently in some areas, was tricky.
5 To know that that was different depending on what
6 country -- which part of the UK you were in, was
7 particularly hard.
8 So families picked that up. They knew, well,
9 I know somebody who is in here and they are allowed to
10 do that, why am I not? And we didn't have the answers
11 for them to be able to say that.
12 Usually we would hope that we could reassure
13 families and say, you should be allowed your partner at
14 this point, and we simply couldn't do that. These were,
15 of course, still guidance and the practical set up of
16 units meant that it had to be guidance, we accept that,
17 and they needed to know the arrangements within their
18 own unit and what they could facilitate. But we just
19 saw a lot of discrepancy. It was -- as I said, it was
20 guidance, it wasn't something that came into -- it was
21 actually practically there for quite a long time and
22 after that, of course, we faced future waves of Covid
23 and that meant that we saw units pulling back again and
24 going back to the more restrictive policies.
25 Q. Yes, I was going to come onto guidance that followed

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

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

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

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

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

1 as a family (as this was our first baby) -- I felt bad
2 for my husband for every moment I was on the ward and
3 not him. It had a major impact on breastfeeding which
4 in turn had an impact on my baby's care and length of
5 stay in hospital."
6 Then secondly:
7 "I felt like I wasn't her mum. Like someone else
8 was raising my baby. Like me and her dad weren't
9 important enough to be there. All of the 'firsts' I
10 should have been able to do with my baby were taken away
11 from me."
12 Again, is that reflective of some of the
13 experiences from PBPO members of the restrictions on
14 attendance at postnatal wards?
15 **A.** Yes, it is. And just to reiterate there, that where
16 they were classed as visitors, and as I said, that's not
17 a term that we think should have been in place, actually
18 most of the impact was on partners and most of those
19 were dads.
20 **MS HANDS:** Thank you.
21 My Lady, my next topic is still on visiting
22 restrictions but neonatal units, so it may be just
23 a moment to take our mid-morning break.
24 **LADY HALLETT:** Very well.
25 I hope you were warned, Ms Ward, you probably know

1 anyway from following our proceedings. 11.55 am.
2 **(11.40 am)**
3 **(A short break)**
4 **(11.55 am)**
5 **LADY HALLETT:** Ms Hands.
6 **MS HANDS:** Thank you.
7 Ms Ward, just one more question before I move on
8 to neonatal units. You have said a few times this
9 morning that it is the view of PBPOs that parents should
10 not be considered visitors in the guidance. Can you
11 just say why that is.
12 **A.** In relation to neonatal units?
13 **Q.** Units that aren't neonatal units. We will come on to
14 neonatal.
15 **A.** So in terms of birthing partners, are you specifically
16 asking?
17 **Q.** Yes, and in antenatal units as well.
18 **A.** Because the care appears to be around the person who is
19 receiving the medical care, so in most instances it will
20 be a pregnant woman, we very much reiterate that this is
21 an impact on both partners there. So where there is --
22 also the partner is the dad, that decisions -- bad news
23 or even update news, any kind of news directly impacts
24 them as well. And that's why they should be a part of
25 that.

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

1 the exceptions in the national restrictions on visiting
2 was for one parent to visit a child. We heard this
3 morning impact evidence of restrictions on neonatal
4 units.
5 Is that reflective of the experiences that PBPO
6 members had?
7 **A.** Yes, it is.
8 **Q.** And in your statement you have described attempts by
9 PBPOs and the Royal Colleges during the summer of 2020
10 for there to be unrestricted parent access to neonatal
11 units but that they were met with resistance.
12 Can you explain what that resistance was and who
13 that was from?
14 **A.** Just to reiterate that's from -- mainly that advice
15 comes from Bliss who are the neonatal charity and they
16 worked closely with BAPM who are the British Association
17 for Perinatal Medicine and RCPCH, Royal College of
18 Paediatrics and Child Health, and they were all very
19 supportive of those restrictions being relaxed in that
20 setting.
21 I believe that the resistance to that was around
22 opening up again infection risks for Covid. I don't
23 think it took into account the impact that those
24 organisations were very strongly putting across that
25 that was having, both on the parents and also on the

1 babies themselves who didn't -- who for a lot of the
2 time were in a unit not being cared for in the way that
3 they would usually be. So just to state in case people
4 aren't aware, that usually parents have 24/7
5 unrestricted access to a baby in a neonatal unit.
6 The other thing that they do with that
7 unrestricted access and quite often, if they are able
8 to, parents will spend as much time as they can with
9 their babies, they are a very integral part of their
10 care and they are encouraged to be. So they will be,
11 for example, where possible, changing the baby's nappy
12 and supporting staff in that. So they would -- if you
13 are looking at your individual baby you are much more
14 likely to be able to say, they look a bit different
15 here, they seem to be a bit more uncomfortable, they are
16 a bit more fractious, and then staff can step in.
17 So the impact on staff of not having parents there
18 was also going to be an increased workload.
19 **LADY HALLETT:** Who would have been the on high for
20 a neonatal unit to impose what seemed to have been rigid
21 visiting restrictions?
22 **A.** I believe it was that guidance that you have referred to
23 and then individual hospitals or trusts would have to
24 make that decision. We certainly heard hospitals that
25 were, from a birthing partner perspective, close

1 geographically but had very different policies. So the
2 consistency didn't appear to be there. And there were
3 certainly families in neonatal settings, depending on
4 the care that your baby needed, you may well end up with
5 that baby having care between units and then for
6 families changing from one unit to another and seeing
7 a difference in the access that they had was also
8 difficult.
9 **MS HANDS:** Thank you. As far as you were aware, what were
10 some of the barriers to implementing more relaxed
11 restrictions on visiting in neonatal units?
12 **A.** I think the space that -- the physical space that they
13 had was probably a concern. So if your baby is in
14 a separate room compared to in one room where there may
15 be up to eight cots and staff looking after those, you
16 could see that eight families potentially coming and
17 going would be a concern. I think it is one that could
18 be mitigated and it could be considered how you reduce
19 that, and lots of different things that we could take
20 into account here as time went on, whether that's PPE,
21 whether that's testing. But as Tamsin said this morning
22 when her -- even when they are in a private room it
23 seemed like at some stages that wasn't anything that was
24 taken into account and any changes that were made.
25 In a unit typically as well you would have not

1 just the room that the babies are in, but you would have
2 a feeding -- expressing room, you would have a kitchen
3 and other areas where families are supported, as I said,
4 because they are there 24/7, they have additional
5 support to allow them to be there. That also gave them
6 the ability to cross over with other families and our
7 experience is that those additional rooms were closed as
8 infection risks.
9 **Q.** You have referred in your statement to the situation in
10 Wales and you have said that Bliss met with the Welsh
11 Government in the summer and autumn of 2021 because the
12 guidance was that one parent could be present at a time.
13 What was the intention of those meetings and if
14 and when did that lead to any changes in the guidance?
15 **A.** I think I would refer -- that's Bliss, so I wasn't
16 a part of those meetings, but my understanding is that
17 they were certainly hoping that those restrictions would
18 be reduced, given that there's guidance in place.
19 I think it took longer than that to actually see that
20 and to hear from families that a more ideal situation
21 was taking place.
22 **Q.** I think you have said in your statement that it wasn't
23 until May 2022 that in fact those changes were made.
24 And then in England and Scotland and Northern Ireland in
25 fact, it was in April 2022 that the guidance was for

1 unrestricted visiting in neonatal units.
2 **A.** Yes, it was much later than we all might have presumed
3 that the Covid period had an impact. It was actually
4 several years on.
5 **Q.** And in general what were the issues of parents being
6 considered visitors on neonatal units and, again, do you
7 think they should have been?
8 **A.** No, we don't think they should have been. I would say
9 in those early few months then yes, when we were trying
10 to understand how the pandemic and how infection worked
11 and knowing that babies are particularly vulnerable, it
12 was a huge concern for everybody. So caution in those
13 early months is completely understandable.
14 The impact that that had on families and babies is
15 significant and you have obviously had an impact witness
16 who has given you an idea of an individual family of the
17 impact that that had. As I said, that also had
18 an impact on babies themselves. Those early few weeks
19 you get to know your baby. You get to see -- they
20 change very rapidly and one of the worries that families
21 with a baby in a neonatal unit have with separation,
22 even in normal times, is: will I still be able to
23 recognise my baby? They may have masks on them, they
24 may have breathing equipment. If you are only able to
25 see them for one or two hours a day that is exacerbating

1 the trauma that neonatal parents go through anyway.
2 **Q.** Thank you. There were some initiatives that were
3 introduced to try and promote contact where it couldn't
4 be in person, for example video calls in England, and in
5 Scotland there was funding for taxi fares for parents to
6 be able to travel to the hospital where they may be
7 travelling more often than they would have otherwise
8 done and perhaps further. Do you have any feedback on
9 those initiatives and whether they were successful and
10 whether there could be recommendations for further
11 initiatives in the future?
12 **A.** My understanding is that we certainly did support those
13 and it recognised the difficult situation that families
14 were in. So just -- Tamsin was talking about that it
15 was a one-and-a-half-hour round trip, I believe. That's
16 not uncommon for families to have to go through and
17 obviously in this period where you have got other
18 children, it is very difficult and, again, we wouldn't
19 want the access and the support that parents have to be
20 negatively impacted for any financial reason.
21 I think we would certainly need to look at studies
22 and actually have an evidence base for how we best
23 support families to have the maximum access to their
24 baby that they can and if that involves more funding
25 then absolutely we would support that.

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

1 think about is how you use PPE. So if you are -- and
2 I know you have already had another impact witness whose
3 baby was sadly at end-of-life care and she reiterated
4 they still had to use PPE even knowing that. So I think
5 actually understanding where that fits in and -- having
6 more specific guidance to allow that because that
7 shouldn't have been the case. It is a tragic situation
8 there.
9 **Q.** Were PBPO made aware of communication issues with the
10 use of PPE?
11 **A.** Yes, absolutely. And specifically in groups that we
12 would class as vulnerable. So people who were maybe --
13 had difficulties with particular access, whether that's
14 speaking another language or having issues with hearing,
15 they found that particularly difficult.
16 So there is a National Bereavement Care Pathway
17 that covers all types of pregnancy and baby loss and
18 that very much reiterates across those that -- and it is
19 accepted by just about every Trust in the country, that
20 communication is absolutely key and understanding how
21 somebody is comprehending the news that you are giving
22 them is very much -- being able to see them very much
23 aids you to know, as a professional, whether you need to
24 give them more support in that messaging.
25 **Q.** Were you aware of any training for healthcare

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

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

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

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

1 ones. My understanding is that most of the classes they
2 run today are back to being face to face.
3 I would, again, reiterate that there are access
4 issues particularly with digital poverty that we would
5 be very concerned about. But actually the support
6 networks were gone. So having a call where you have
7 maybe eight people joining there, you can't have a chat
8 with them in the same way as you would while you are
9 having -- while you are getting a cup of tea and those
10 are the things that really impacted on people's mental
11 health and their confidence in parenting.
12 Q. I want to ask you some questions about health visiting.
13 Again, this isn't addressed in your statement, but
14 I believe you have received the statement that we have
15 received from the Institute of Health Visiting.
16 For context, from 28 March 2020, the NHS England
17 guidance was that health visitors should be considered
18 for redeployment to the frontline, and essentially that
19 the health visiting should be stopped and provided only
20 as a partial service offering antenatal contact and new
21 baby visits only, and face to face only if there was
22 a compelling need and with PPE. The Institute of Health
23 Visiting described this as a profound mistake, and that
24 partial stopping of redeployment remained in England
25 until 3 June 2020.

1 Before asking you about the impact of those
2 decisions, can you just explain to us a little bit about
3 the importance of health visiting services throughout
4 the pregnancy journey?
5 A. Yes, of course. A health visitor is a specialist public
6 health nurse. They work directly with families, often
7 the most vulnerable, so a lot of their time will be
8 spent with those families, and they could have hundreds
9 of families that they look after individually. They
10 will focus on those that they know to be the most
11 vulnerable. So they often go out to those families
12 direct in the early weeks after a baby is born and
13 through up to, I think, when the baby is about 2 or 3,
14 maybe, something like that. They have more regular
15 contact.
16 They would also have contact through something
17 like a baby clinic, so somebody could go in proactively
18 and say, "Can you weigh my baby?" So they do general
19 checks. They do general checks of the family and of the
20 baby. But they are also there as somebody to listen to,
21 and they do have a safeguarding role to play in that as
22 well. So, yeah, that's what health visitors are there
23 for.
24 Q. And were any of the PBPOs made aware of issues or
25 concerns caused by the change in service provision

1 during the pandemic?
2 A. Yes. From our perspective, in The Lullaby Trust we work
3 closely with health visitors. They are one of the key
4 areas that safed sleep advice goes out. They also run
5 a programme that we run, called CONI, which is Care of
6 Next Infant. So that is more intensive health visiting
7 who have had a baby die suddenly and unexpectedly,
8 previously. And it was those health visitors who were
9 trained in the CONI programme who called us immediately,
10 that is, this is the first wave that we were aware,
11 saying, "I'm being redeployed, there is nobody to look
12 after my families, are you going to be there? Can
13 I refer them to you because I'm really worried about
14 them?"
15 And we were -- we did manage to stay open.
16 Usually we would offer support through health visitors
17 for CONI families, but in this respect, we were -- we
18 said give them our contact details. So health visitors
19 were the ones that contacted us, worried about the
20 families that they were being redeployed and leaving
21 behind.
22 Q. Obviously, as a charitable organisation, you wouldn't
23 have been able to help everybody; were you aware of
24 examples where the health visitors weren't -- were
25 redeployed and there wasn't anybody available to look

1 after those families?
2 A. Yeah, we certainly heard from families in those
3 situations. There are some practical elements to this
4 programme, to health visiting, as I said, in terms of,
5 like, weighing a baby, for example, answering questions
6 on feeding. But when you are sitting there with
7 somebody, families tend to open up a bit more, and in
8 the Care of Next Infant programme where we have
9 evaluated it in the past, the part that families always
10 say is the most important part isn't the monitor that
11 they are given, or the guidance, or the extra equipment;
12 it is actually somebody to listen to them.
13 So I think, actually, that is a really significant
14 thing that we may not be able to measure, but it again
15 increases that isolation that the most vulnerable felt.
16 Q. And would the same level of care have been able to be
17 provided through the use of online and remote
18 consultations that you have just described?
19 A. No, not the same, and just to also reiterate that,
20 I touched upon the safeguarding role that health
21 visitors play, and looking at the wider family setting.
22 So, for example, thinking about mother's maternal health
23 but also going in, and practically they might say things
24 like "Show me where your baby sleeps" or ask them how
25 they are doing, or be aware of other issues that they

1 might, by being in the home, be able to pick up. And
2 that's a lot more difficult to do in a call.
3 **Q.** And were you made aware of any issues with access to
4 suitable PPE in order to carry out the visits that were
5 deemed necessary?
6 **A.** Not in terms of PPE. What we did hear were health
7 visitors who, when they were able again to go out and
8 visit families, weighing babies on a doorstep; so the
9 family having to pass the baby to the health visitor who
10 weighed the baby outside and then handed them back
11 again.
12 **Q.** And as far as you are aware, had health visiting
13 services been fully reinstated by the middle of 2022?
14 **A.** No, I think that they -- their -- they -- we need more
15 health visitors than we have already, and my
16 understanding is that it is still not back in the place
17 that it was prior to the pandemic.
18 **Q.** A different topic. You have addressed, in your
19 statement at paragraph 49, the inclusion of pregnant
20 women in medical trials and treatment programmes for
21 Covid-19. Can you just elaborate on that, please?
22 **A.** Generally, I think it is right to say that even outside
23 of Covid, pregnant women are not included in medical
24 trials in the same way as other groups might be, and
25 that was certainly the case for Covid-19.

1 **Q.** And then the Department of Health and Social Care has
2 told the inquiry that there was funding made available
3 to bless Tommy's and Sands organisations within PBPOs in
4 April 2020 to provide bereavement support and to share
5 the Covid-19 messaging to a wide audience. Did that
6 funding have any positive impact on those two areas?
7 **A.** Absolutely -- I can't reiterate enough the good work
8 that the 13 organisations do. Any funding that was
9 available in that time would have been put to good use,
10 and -- I don't want to downplay the funding that was
11 given, but it was given for a short period at a time
12 when, as organisations, we were all receiving far more
13 contacts and trying to give out messaging to people in
14 completely new ways, whilst also being at home ourselves
15 with those challenges.
16 But, for charities, we saw from March 2020 our
17 incomes go off a cliff. So any funding was helpful, but
18 the funding available there, yes, it didn't pick up the
19 level of income that charities saw dropping, as I said,
20 at the same time that our services were stretched to
21 the -- we had more calls than we had ever had before.
22 **Q.** Was there funding provided later in the pandemic as
23 well? You said it was short-term, but was there further
24 funding?
25 **A.** There was some through the National Lottery; there were

1 other trusts and organisations who did an amazing job
2 trying to offer emergency funding, but our incomes are
3 not back to where they were pre-pandemic. And I think
4 that's -- across the board, that is fair to say, it has
5 had a huge impact on all of us.
6 **Q.** And, in turn, has that had an impact on the service that
7 can be provided?
8 **A.** Yes. Yes, it has. Yes.
9 **Q.** You have helpfully set out a number of lessons learnt
10 and recommendations in your statement. Are there any
11 that we have not covered that you wish to draw attention
12 to today?
13 **A.** I think just the general issues worth reiterating of the
14 prioritisation that we believe should have been given to
15 this area of healthcare, and I think it goes wide; it is
16 not -- it is visiting, it is funding, it is the impact
17 longer-term on babies, the impact on staff, the
18 safeguarding issues around having contact with people in
19 a very vulnerable part of their lives, but also in terms
20 of bereavement as well. So all those areas, we would
21 like to see that there. I think -- I mean we have
22 touched on it quite a bit, but the communications are
23 really, really key, and all of us work really hard.
24 I think all my colleagues, when we are putting together
25 advice, we use researchers and we use experts, and we

1 also use the people who the advice needs to get out to.
2 So, using us as organisations, understanding the role of
3 charities and voluntary organisations and the direct
4 work they do, I think, could have had a much better
5 impact. Also supporting staff. So we did support staff
6 as well and we certainly realised the heavy impact on
7 them and the lack of training that many of them had.
8 So those are things that we would also like to
9 reiterate. But yes, it was a very difficult period for
10 everybody.
11 **MS HANDS:** Thank you, Ms Ward. I don't have any further
12 questions.
13 My Lady, do you have any questions?
14 **LADY HALLETT:** No, I don't. Thank you very much indeed,
15 Ms Ward. You are a superb advocate for the causes that
16 you are representing. Thank you so much for your help,
17 it has been extremely constructive and at times very
18 interesting. Things have moved on a bit since I gave
19 birth.
20 **A.** Thank you.
21 **LADY HALLETT:** Thank you.
22 **(The witness withdrew)**
23 **MS HANDS:** My Lady, I understand that this afternoon's
24 witness will be arriving shortly. So perhaps I may
25 invite you to take an early lunch. I know it is quite

1 early but she will be arriving shortly this afternoon.
2 **LADY HALLETT:** And obviously you would like to speak to her
3 before --
4 **MS HANDS:** I would, if possible, my Lady.
5 **LADY HALLETT:** Very well. If I return at 1.30 pm?
6 **MS HANDS:** Yes, I'm grateful, my Lady.
7 **(12.27 pm)**
8 **(The short adjournment)**
9 **(1.30 pm)**
10 **LADY HALLETT:** Good afternoon.
11 **MS HANDS:** Good afternoon, my Lady. If I may call Gill
12 Walton who will affirm.
13 **MS GILL WALTON (affirmed)**
14 **Questions from COUNSEL TO THE INQUIRY**
15 **MS HANDS:** Ms Walton, you should have your witness statement
16 in front of you. That is INQ000347411.
17 Ms Walton, you are here today to give evidence on
18 behalf of the Royal College of Midwives and its members;
19 is that right?
20 **A.** That is right.
21 **Q.** You hold the role of Chief Executive and General
22 Secretary, a role you have held since September 2017?
23 **A.** That is correct.
24 **Q.** And you also have been a midwife since 1987 and prior to
25 joining the College you had midwifery experience in the

1 NHS; is that right?
2 **A.** That is right.
3 **Q.** And it is correct that the Royal College of Midwives is
4 a trade union and professional association across the
5 UK?
6 **A.** That is correct.
7 **Q.** And can you give us an idea of the size of the team that
8 work within the College?
9 **A.** So the Royal College of Midwives has got 100 staff and
10 we work across all four countries of the UK and actually
11 also the Channel Islands as well.
12 **Q.** Thank you.
13 My questions today are going to focus on the role
14 of the Royal College during the pandemic and then go
15 through the maternity journey, as it were, with a focus
16 on the provision of maternity care and visiting
17 restrictions and then to look at the categorisation of
18 pregnant women as clinically vulnerable, IPC measures,
19 and then mental health and well-being support and the
20 impact of Long Covid on the midwifery workforce.
21 Starting, then, with the role of the College in
22 formulating and issuing guidance for the maternity
23 sector during the pandemic, is it right that outside of
24 the pandemic the College had a role in producing
25 guidance and worked with the Royal College of

1 Obstetricians and Gynaecologists to do so?
2 **A.** We did. In fact, the guidance -- we were quite separate
3 in terms -- before the Covid pandemic we produced
4 guidance quite separately as two organisations. The
5 pandemic actually brought us together to produce
6 guidance -- and with other organisations. So it was
7 different. It is something we started almost
8 immediately -- well, even before lockdown, actually, we
9 got together and said we really need to do something
10 about providing advice and guidance.
11 We are quite different from the Royal College of
12 Obstetricians and Gynaecologists and other medical Royal
13 Colleges because we don't produce educational standards,
14 it is just guidance and advice, and that
15 misunderstanding is quite -- is difficult at times
16 because we can't hold our members or the organisations
17 they work in to account, in terms of: you must do this.
18 It is just guidance that then is accepted by the NHS or
19 the organisations that are members working. So we are
20 very --
21 **LADY HALLETT:** So who does provide -- sorry to interrupt
22 you -- who does provide the educational standards for
23 midwives?
24 **A.** That is the Nursing and Midwifery Council provides
25 standards and proficiencies for midwifery.

1 **MS HANDS:** And in terms of the clinical guidance that was
2 available for maternity services before the pandemic, is
3 it right that that was produced by the maternity
4 services themselves, so local protocols and NICE
5 guidelines?
6 **A.** That is correct, and NHS England to some extent as well.
7 **Q.** Is it right that the Royal College of Obstetricians and
8 Gynaecologists and the Royal College of Midwives and the
9 Royal College of Paediatric Child Health all took the
10 lead together, as you've mentioned, on developing
11 guidance on managing Covid in pregnancy?
12 **A.** Yes, we did because we realised that clinicians working
13 in services would need some help and guidance, and we --
14 for the Royal College of Midwives, we became very
15 focused on that piece of work and basically stopped
16 business as usual in order to do that. We felt it was
17 essential to be as helpful as we possibly could be for
18 clinicians, and hopefully for the NHS, in terms of then
19 adopting that guidance.
20 **Q.** And were you asked to take on that role or was that
21 a role that just naturally happened?
22 **A.** No, we weren't asked to take on that role at the
23 beginning. We took it on as we thought it was the most
24 useful thing that we could do as a collective team.
25 **Q.** And is it right that the Royal College of Midwives and

1 the Royal College of Obstetricians and Gynaecologists
2 set up a guidance cell which initially was meeting daily
3 in order to develop the guidance?
4 A. Yes, so we set up the guidance cell with appropriate
5 people on there. People who had a background maybe in
6 research or clinical practice, expert clinical practice.
7 They called in other people when they needed it
8 depending on what guideline they were looking at.
9 I think the Covid cell was daily. I can honestly
10 say that myself and Eddie Morris, who was the president
11 of the RCOG at the time, spoke, if not daily, sometimes
12 several times a day, so that we could try and be on top
13 of the constant changing nature of the pandemic, of the
14 Covid virus, and people's understanding of it.
15 So we tried really hard to make sure that the
16 guidelines and the advice that we were given was as up
17 to date as it possibly could be.
18 Q. And on that very point, it is right, isn't it, that the
19 first published guidance on pregnancy during Covid was
20 published on 9 March 2020 and there were a further four
21 updates in that month to that piece of guidance?
22 A. That's absolutely correct. You will see with the amount
23 of guidance that was produced both jointly and us as
24 an organisation ourselves, we had guidance that we
25 constantly reviewed, updated, re-wrote, and re-published

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

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

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

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

1 local services, we had loads of meetings with midwifery
2 leaders, we were very in touch with the frontline. One
3 of the things we were really concerned about was that
4 maternity services weren't seen as an essential service
5 locally and potentially nationally, and that's having
6 a major impact on the ability to deliver safe care
7 because, you know, the focus was really on intensive
8 care units, respiratory areas and emergency departments.
9 And maternity is an essential service, you can't stop
10 it. You know, delivering that safe care is absolutely
11 a priority for any NHS service.
12 So we called that meeting in April and said we
13 really needed to be -- it needed to be a guarantee that
14 all NHS services recognised that maternity was
15 essential. So, for example, there were definitely
16 issues were some midwives who were duly qualified, so
17 there were nurses and midwives maybe then redeployed to
18 an intensive care unit or a gynaecology unit, and then
19 depleted that midwifery staffing even further.
20 Anaesthetists were definitely an issue, they were also
21 redeployed which then led to issues around being able to
22 provide safe epidural services. So there were lots of
23 examples that were raised with us as a huge concern and
24 a huge anxiety amongst the staff, but also in terms of
25 the women as well accessing care.

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

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

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

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

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

1 of what happens in every single organisation. My hope
2 would be that if something was going to be done
3 differently, like telephone triage that there would be
4 training for the staff that were going to be doing that.
5 Q. And you have touched on the "Stay at Home" messaging but
6 in the college's experience, was there an impact caused
7 by the reduced access to primary care, so GP services as
8 well?
9 A. Yes, I think the "Stay at Home" message impacted women
10 accessing primary care, midwifery care, and coming into
11 hospital. I think there was a lot of anxiety around
12 particularly when women were classed as vulnerable, and
13 that absolutely impacted on access to appropriate
14 maternity care.
15 Q. I want to ask you some questions about the visiting
16 guidance in antenatal settings. We have heard quite
17 a lot of evidence about this already, but the Royal
18 College did issue a briefing in July 2020 on the
19 re-introduction of visitors to maternity units across
20 the UK. You have summarised that paragraph 35 of your
21 statement, can you just explain what that briefing
22 included?
23 A. So, after the first lockdown, where access to NHS
24 services was -- there was almost a blanket ban on
25 visitors and we definitely were part of the advice to at

1 least let partners in during labour for women. That was
2 absolutely important. The issue about opening up, so
3 the visiting opening up and absolutely I -- you know it
4 was such a stressful time for women and families, for
5 the staff who were looking after them, staff didn't want
6 to tell people they couldn't have their partners with
7 them during their whole maternity experience because
8 that isn't what midwives do. But they were working in
9 difficult environments, tiny spaces, really difficult to
10 socially -- to have a socially distanced care. There
11 was a shortage of PPE still. And so, bringing more
12 people into inappropriate environments was really
13 difficult for lots of services, and midwives were really
14 worried about the impact on increasing infection for the
15 staff but for the women and families and the babies that
16 were in the services.
17 So opening up the visiting was a really difficult
18 thing for people to do. They really wanted to do it,
19 but the practicalities of doing it was a different
20 story.
21 I think the other thing that happened at the time,
22 we have some really great maternity services round the
23 country that are very new, have single rooms where women
24 and their partners can stay practically the whole stay
25 in the maternity service. Those services did really

1 well in terms of being able to open up, but those
2 services that didn't have those sorts of environments
3 really struggled. So, for example, in antenatal clinics
4 there were some that were co-located with gynaecology
5 services or gynaecology cancer services, and then there
6 were also pregnant women with their partners. It was
7 very difficult to create a safe environment for opening
8 up a maternity service to what was happening before.
9 **Q.** So if I could just bring you back to the question of
10 this briefing in July. What led to the College
11 producing guidance on reintroducing visiting at that
12 point in time?
13 **A.** We just wanted to make sure that it could be managed
14 appropriately. We would have hoped that NHS England
15 would put out very clear guidelines for opening up that
16 could be then localised but that wasn't happening
17 which --
18 **Q.** We are going to come onto that in a moment --
19 **A.** Okay.
20 **Q.** -- that specific example that I think you are talking
21 about. So at that point in time in July, it is right,
22 isn't it, that the guidance across the UK was quite
23 varied as to whether services were opening up visiting
24 or not?
25 **A.** Yes. And also they were localised, there were different

1 lockdowns in different parts of the country. I think
2 that caused huge confusion. And social media didn't
3 help. I think it was -- on social media there were
4 different stories from different parts of the country
5 and then people jumped on that bandwagon and created
6 some more confusion. Social media didn't help the: what
7 should we do? What's the important thing for the NHS to
8 do? How do you keep staff, and women and babies safe
9 and how do you do this in a clear logical way?
10 And while that was being sorted, of course the
11 infection rate started to go up again. So some services
12 hadn't even managed to open up hardly at all before we
13 knew that there was an increase in infection rates.
14 **Q.** You have spoken there to the inconsistencies and
15 variation across services, so not just across the UK,
16 but across services as well, as to whether the guidance
17 was in fact implemented or followed. What impact did
18 that have not only on pregnant women but on healthcare
19 workers in those settings as well?
20 **A.** I think it made people very anxious because at the time
21 I think NHS England were praising those services that
22 were opening up, and some could, and then being quite
23 critical and putting targets on services that couldn't
24 open up and giving them deadlines to open up and I think
25 that caused a huge anxiety and we had lots of meetings

1 with midwifery leaders who expressed how difficult it
2 was to keep thinking about the safety of women and
3 families and their staff in quite often poor
4 environments that they were working in and they could
5 not see how they could completely open up services
6 safely.
7 **Q.** Who would be responsible in a hospital or maternity unit
8 for implementing the guidance actually on the ground, do
9 you know?
10 **A.** So, in the maternity service itself it would be the
11 director or head of midwifery who would really know
12 their service. But the infection control teams in
13 a Trust would absolutely have a view on that and I think
14 sometimes -- I remember some of the heads of midwifery,
15 directors of midwifery saying to us that there was
16 a change in policy and the infection control departments
17 were putting in processes for opening up. But actually
18 the midwives themselves were saying: but actually, I'm
19 not sure this is going to work, we have got a very
20 small, for example, four-bedded postnatal ward where the
21 beds are really close together, there is four mums,
22 there is four babies, and then we have mum and dad and
23 maybe grandma as well. That is a huge infection risk
24 and not being able to distance.
25 So there were lots of pressures and I know from

1 speaking to our members at around that time, their
2 anxiety levels were huge. They could see that the
3 country seemed to be opening up but infection rates were
4 starting to pick up again and they were thinking of ways
5 of preventing harm. So it created a huge anxiety for
6 the staff and for the women.
7 Q. And a lot of the guidance around this time in July 2020,
8 in the summer, moved to local risk assessments and
9 a local approach. Was there support, I suppose, and
10 advice on how to undertake those kind of local risk
11 assessments in the context of Covid-19?
12 A. From the NHS I think some of that advice was quite
13 limited. Because we are also a trade union our health
14 and safety activists in those services were helpful and
15 we provided them with some support and guidance for
16 that. So I think we were quite lucky in that because we
17 are a trade union we could also provide support and
18 guidance to people locally.
19 But I think this was a bit of a theme. There was
20 slow information coming into services for local services
21 then to do the right thing.
22 Q. And was there enough information about the rationale for
23 the changes to the guidance for healthcare workers who
24 were implementing it but also for pregnant women as well
25 who were --

1 A. I think, as I have said before, I think it was very
2 confused.
3 Q. And did the College take any view on parents being
4 designated as "visitors" in maternity settings?
5 A. Actually, they shouldn't be visitors. Our view was that
6 they are equal partners, parents of the baby. But we
7 absolutely recognise the difficulty in having additional
8 people in some areas within some hospitals and the risk
9 that potentially that caused. It was horrible. It was
10 horrible for those parents. It was awful for the staff
11 because they didn't want to do it either. Midwives
12 absolutely see parents as both parents of the baby, even
13 though the mother is the one having the baby, and
14 I think it caused a lot of stress for them.
15 I think the guidance created some friction
16 sometimes between the staff and the parents because of
17 course they wanted to be there and it was right but
18 actually there was still a risk and that caused some
19 really difficult moments, I think, in maternity
20 services. And on social media.
21 Q. And does the College see that there would be any merit
22 in having, for example, a national framework for
23 visiting perhaps with an element specific for maternity
24 settings to ensure that there was consistency,
25 predictability, but also that support as well for those

1 that are having to deliver the news, that there would be
2 restrictions?
3 A. Yes, and I think that would be a recommendation going
4 forward, a single truth but with a framework that has to
5 be -- it has to come from NHS England, not from the
6 colleges, that give people a framework in which to
7 assess their services and localise them if necessary but
8 the most important thing that that is then transcribed
9 into really clear communication to the local population,
10 so everybody is clear what that service is doing, and
11 why, for that reassurance.
12 I think -- I mentioned social media before because
13 I think social media created some confusion itself
14 because different services talked about what they were
15 doing and how unfair it was that the service down the
16 road wasn't doing it and it didn't help the anxiety
17 between groups of parents and staff and it made people
18 angry, it made parents angry which I absolutely
19 understand.
20 Q. You have said in your statement that the extent of the
21 guidance that the Royal College of Midwives provided was
22 an indictment of the lack of guidance and leadership
23 provided by central government and NHS England, and we
24 are going to come on to look at a specific example of
25 that in a moment, but was that also the case across

1 Scotland, Wales and Northern Ireland?
2 A. Scotland, Wales and Northern Ireland, it was different
3 because they are such small countries and I can talk
4 from the Royal College of Midwives' perspective. The
5 midwives in the government and the senior midwives in
6 the NHS in those countries and the RCM all knew each
7 other and they had worked really closely together in the
8 past and they provided -- they sat down and worked it
9 out together probably more than England. Different
10 countries did things at different times and I can't
11 remember what all of those things were but they did
12 visiting restriction, they lifted visiting restrictions
13 at different times, they had different rules and that
14 caused a confusion. But I do think the way the other
15 countries managed it was clearer for both the public and
16 the staff working in the services.
17 Q. So if we were to look forward to having some form of
18 national framework, would you support that being across
19 the UK?
20 A. Yes, definitely because different countries would look
21 at each other and say, well, in Scotland visiting has
22 been lifted, that's not fair for England and that then
23 creates that anxiety amongst women and staff.
24 Q. Moving on, then, to specific examples where the Royal
25 College of Midwives and the Royal College of

1 Obstetricians and Gynaecologists took action in response
2 to guidance and visiting guidance specifically in
3 England.
4 If we could please go to INQ000280503.
5 At the bottom -- this is an email, sorry, from
6 Mr Morris from the Royal College of Obstetricians and
7 Gynaecologists sending to NHS England, with you cc'd in,
8 on 10th July 2020. So, again, around this time that we
9 are talking about, the changes in guidance.
10 In that last paragraph there on page 1 he said
11 that:
12 "While we understand restrictions on visitors
13 remain in place in some Trusts in England to ensure
14 compliance with social distancing measures and prevent
15 the spread of Coronavirus, we think it's vitally
16 important that NHSE/I urgently produce a framework or
17 set of principles to enable Trusts to take a consistent
18 approach to the approach to the relaxing of out-patient
19 and in-patient visiting restrictions on maternity units.
20 There needs to be a reasonable balance between
21 continuing to protect women and staff from in-hospital
22 transmission and enabling vital support at appointments,
23 during induction of labour and from visitors on
24 postnatal wards."
25 If we go up we can see the response that in fact

1 comes from NHS England the following day and that is the
2 second paragraph:
3 "You will no doubt appreciate that we cannot
4 address this issue within maternity in isolation,
5 notwithstanding the particular need women have for
6 support during maternity appointments, and we are
7 operating within a fixed set of parameters, including in
8 particular the decision that there will be no relaxation
9 of the 2m social distancing rule in hospitals in
10 England."
11 What was the College's response to that response?
12 **A.** If I remember correctly we wanted NHS England to not
13 have a blanket approach for all NHS services and have
14 maternity as a separate consideration. But bearing in
15 mind that there would still have to be consideration
16 about keeping everybody safe. But I think the key issue
17 about these emails was about the lack of response. It
18 was taking a long time to sort out a growing concerning
19 issue around visiting and the inconsistencies and how
20 unhappy women and families were and the staff were about
21 not having clear guidance.
22 I think we were trying to ask very clearly that
23 NHS England had to put in some -- a much clearer
24 consistent framework so that everybody knew what they
25 should be doing because the confusion was causing more

1 stress and particularly for women, it is a very
2 stressful time having a baby, having a baby in
3 a pandemic with inconsistent guidelines is even worse
4 and staff then not being able to be really clear
5 themselves about: this is what we are doing, this is
6 why, this is when it will start or end. It was very
7 unclear.
8 **Q.** And is it right that around this time both colleges had
9 actually been working with NHS England to produce
10 guidance but there was a delay, I think it was until
11 8 September, when guidance is actually issued by
12 NHS England. Is that right?
13 **A.** That is correct, and I think it was a general, you know,
14 looking again at recommendations, that if everybody is
15 working together to produce guidance, how is the red
16 tape removed in terms of getting them through various
17 processes to get that guidance out quickly? Because
18 I think we were working really hard and really quickly
19 to produce guidance that was asked of us by clinicians
20 in services and we couldn't endorse it. It was almost
21 a gift to the NHS to say, look, we have done all this
22 work, it needs to go out. And I think there were delays
23 and this was absolutely one of them where if that
24 guidance had come out even three or four weeks earlier,
25 then the upset, the harm, the anxiety may have been

1 reduced just over that period of time.
2 **Q.** The guidance that was produced in September was
3 a framework to reintroduce access for partners, visitors
4 and supporters of pregnant women in England and focussed
5 on local risk assessments and regular reviews, with
6 a look towards parents being considered essential
7 visitors.
8 Did the College agree with the approach towards
9 local risk assessments at that time and did it endorse
10 that guidance?
11 **A.** We did endorse that guidance but my memory is that we
12 felt anxious about the local risk assessments because,
13 again, services that could accommodate easily and safely
14 women and their partners could have a risk assessment
15 that would say, yes, this is fine and then others would
16 really struggle with that. So we were anxious about it.
17 **Q.** And were you aware of any issues that Trusts had
18 implementing that guidance?
19 **A.** My understanding was that there were concerns and they
20 were trying to feed that back. They fed that back
21 through us and then directly to NHS England.
22 There was an issue, I think, at the time, and it
23 goes back to maternity services sometimes being the
24 forgotten service in the NHS and where midwifery leaders
25 don't have a voice at the board, for example. So when

1 there were local issues some midwifery leaders struggled
2 to have their voices heard in terms of: we are
3 struggling with this, we need some help, you know, we
4 can't do this. I think there was definitely some
5 tension there about how maternity services are
6 structured within the NHS and it is very difficult to
7 raise issues appropriately.
8 **Q.** Were there any changes to the guidance in response to
9 those concerns that you have just mentioned?
10 **A.** I think so. Have I got that in my statement? You will
11 have to refer me.
12 **Q.** I think the next changes to the guidance in fact are in
13 December.
14 **A.** That is right. So it took until December. And I think
15 you will find in some of the evidence lots of email
16 exchanges and conversations -- there were lots of
17 conversations that obviously aren't recorded.
18 **Q.** In December the guidance from NHS England was that
19 a woman should be supported by another person throughout
20 the pregnancy journey. So it moved away from that local
21 risk assessment approach --
22 **A.** Yes.
23 **Q.** -- and encouraged units to change the layout and to
24 ensure there was regular testing. Again, is it right
25 that the College had some concerns about increased

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

1 distressing for women and partners to come even into
2 a labour ward setting and partners to be tested and were
3 positive even though they were unwell and not able then
4 to come into the service. Obviously women were asked to
5 designate another person in case that happened but that
6 caused serious anxiety, concern, some really awful
7 behaviour as well and I absolutely understand that, but
8 I know midwives really struggled at that time.
9 **Q.** And it is right, isn't it, that the College didn't
10 endorse that guidance in December, but in fact issued
11 its own ten commonsense principles which was focused on
12 localised decision-making and risk assessments. What
13 were the reasons, if there's any additional ones to
14 those you have already given, to the College issuing
15 those principles then?
16 **A.** So those principles actually came from our conversations
17 with midwives on the ground who were saying that they
18 still need to have -- there needs to have a -- a
19 framework that was based on the local services that were
20 commonsense principles that they could then communicate
21 to women and families: so we thought, and most -- they
22 were mostly adopted then by NHS England, but they came
23 from clinicians, they came from midwives and maternity
24 support workers working in clinical services and what
25 they thought would be most helpful in keeping everybody

1 safe.
2 **Q.** And in the development of that guidance in December by
3 NHS England, had the College sought to bring those
4 principles to their attention?
5 **A.** Yes, we did. Yes.
6 **Q.** Are you aware of why they couldn't support them at that
7 time?
8 **A.** I think it was because they were still looking at
9 a whole-blanket NHS approach, and that they wanted to
10 open up maternity services for parents because there was
11 a lot of pressure from parent groups, rightly so, from
12 the public, from the media, from politicians, from
13 journalists. So I think NHS England -- and I can
14 remember speaking to them -- were under huge pressure to
15 respond to that, but actually were maybe not thinking
16 about the total risk of keeping staff safe, and keeping
17 women and babies safe. And it is a difficult decision
18 to make when you are under that much pressure from
19 external agencies. I get that. But, actually, we are
20 a membership organisation, the staff were really
21 important; if staff were sick or having to isolate, they
22 can't look after women and families, and it was really
23 important that we helped to try and get this right.
24 **Q.** And do you know if those principles were used across the
25 UK?

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

1 Q. And did the College communicate with the chief nursing
2 officers or chief midwifery officers in the four nations
3 regarding the guidance?
4 A. Yes, we did, and we had lots of conversations about
5 that. In England we did escalate some of the issues and
6 the discrepancies we had, and the length of time, to
7 Dame Ruth May who was the chief nurse, and she was quite
8 helpful in terms of unblocking the way in some of those
9 issues.
10 Q. You have touched upon the issue of testing to facilitate
11 visiting in hospitals. And that that came in, certainly
12 in England, at the end of 2020 and in Wales in middle of
13 2021. Could the introduction of IPC precautions, for
14 example, testing and access to PPE earlier, could have
15 helped to facilitate visiting?
16 A. Absolutely. Definitely would. I mean, if there was PPE
17 for visitors, for partners, for the staff, testing for
18 everybody, it would reassure people that -- of the
19 situation, you know, who they were looking after and
20 what the risks might be, that absolutely would have made
21 a massive difference.
22 I mean, it is interesting, isn't it, that -- I'm
23 not sure now whether the testing was available elsewhere
24 in the NHS before it reached maternity, but I think
25 there was an issue there, again, maternity not being

1 seen as a key part of NHS care, an essential service.
2 Q. Thank you. I want to ask you one more question
3 regarding support during antenatal services before
4 moving on.
5 If we could have on the screen, please,
6 INQ000474233.
7 This is the "Every Story Matters" report that the
8 Inquiry has received and the quotation here regarding
9 maternity services is that:
10 "Going through maternity services and giving birth
11 when the NHS was crashing around me with added layers of
12 having sight loss was hard. All information was paper
13 based, I couldn't see the sonogram and didn't have
14 a partner there to explain things to me, I was full of
15 anxiety. My sight loss wasn't accounted for, they were
16 focussed on navigating care in covid - reading out
17 letters to me wasn't a priority."
18 That is from a woman who used maternity services
19 during the pandemic. Were you aware of there being
20 communication issues due to the restrictions on visitors
21 and supporters during antenatal appointments and scans,
22 and whether there was any guidance or support available
23 from healthcare professionals for that?
24 A. Yes, so we were producing guidance about prioritising
25 services for vulnerable women, disabled women, women

1 from a black and Asian minority ethnic background where
2 we know that their experiences and outcomes were
3 different, so this lady -- would be her experience. So,
4 absolutely, that was -- we really encouraged services to
5 prioritise their care, which was important because their
6 staffing was depleted. So it was really important that
7 whatever they could provide was to people who really,
8 really needed it and they could improve their outcomes.
9 Q. Thank you.
10 I want to move on then to birthing options and the
11 changes during the pandemic. We heard this morning
12 about the different birthing options outside of the
13 pandemic being hospital, midwife-led units, whether
14 free-standing or adjacent to a hospital, or a home
15 birth; is that right?
16 A. That is correct.
17 Q. It is right, isn't it, that the College, along with the
18 Royal College of Obstetricians and Gynaecologists issued
19 guidance in April 2020 for midwife-led settings and home
20 births in the Covid pandemic which set out a staged
21 approach to support the continuation of home births and
22 births in midwife-led settings, where staffing levels
23 and ambulance capacity allowed, and then also set out a
24 move towards centralisation of services with
25 restrictions and suspensions of other birthing options,

1 with reinstatement when it was safe to do so. Is that
2 a fair summary of that guidance?
3 A. Yes, it was a toolkit to be able to maintain services if
4 staffing levels allowed, including the ambulance
5 service, so we were hoping that was going to create some
6 helpful decision-making, and try and create some
7 equality amongst services, because I think at the time
8 some services -- because their staffing levels were
9 fine -- were able to maintain the home birth service and
10 others wouldn't and that was creating competition,
11 really, between services and making women feel that if
12 they wanted a home birth, for example, they would have
13 to change to a different hospital, and it was
14 unsatisfactory in terms of then provision of services.
15 Q. If we could then -- leads me on to my next point,
16 actually, which is some data we have received from
17 NHS England showing the closures and suspensions in
18 April 2020. This is at INQ000485652.
19 This is data taken from England in April 2020 and
20 across 130 trusts. You should be able to see that in
21 front of you.
22 A. Yes.
23 Q. We can see here that there was, during that month, the
24 suspension of home birth in 60 of those trusts, so just
25 under 50%; a closure of -- alongside midwifery units

1 there were eight closures, 11 free-standing units were
2 closed, and two obstetrics service units were also
3 closed.
4 The closures that we can see there, are they
5 examples of services essentially having to centralise,
6 as you have set out in that toolkit?
7 A. Yes, basically in order to deliver safe care to all
8 women, with the depleted number of staff and access to
9 ambulance services. The directors of midwifery used
10 that to make sensible decisions about keeping all women
11 safe. Midwives really support home births and it was
12 a hard thing for them to do, but a home birth takes two
13 midwives, and that, when you haven't got enough staff,
14 is difficult to do where you don't have enough midwives
15 even to provide one-to-one care to women who are may be
16 giving birth in a local hospital.
17 I think it is testament to this that not every
18 service closed their home births. They were really
19 agile in terms of doing what they could, based on their
20 staffing numbers and availability of ambulances at any
21 one time, and they always tried their best to reopen
22 parts of the service if they could. I think you know
23 locally some services communicated that really well to
24 the population. Other services may not have done and we
25 really -- we as a college really encourage good local

1 communication with women about the status of service
2 provision at any one time.
3 That was really stressful for women, and you will
4 see in some of my evidence that there was then
5 an increase in free births because women really wanted
6 a home birth, there wasn't staff available so they gave
7 birth without a health professional. Some of those
8 women did because they were scared of going into
9 hospital as well, but it definitely had an impact on
10 women being able to access the service they wanted, but
11 it was all done to keep services as safe as possible,
12 that was always the intention, not to deprive people,
13 women, of choice.
14 Q. Thank you. I'm going to look at some more data in
15 a moment in regard to slightly later on in the pandemic
16 but I just want to stay in this early stage.
17 It is right, isn't it, that the College made
18 a plea at the end of March 2020 to ringfence maternity
19 services by stopping the redeployment of maternity
20 staff?
21 A. Yes, we did, and we made that plea quite loud because we
22 heard from our members that staff were being redeployed,
23 and it was having a serious impact on them being able to
24 deliver safe maternity care. That did happen. Staff
25 were ringfenced although we still had people telling us

1 that it wasn't consistent, and in fact even moving into
2 the next wave of the pandemic, sort of December/January
3 time, NHS England were asked again to make it absolutely
4 clear that maternity was an essential service, and staff
5 should not be redeployed. And that did happen.
6 Q. Thank you. Were you aware of services having to use
7 healthcare assistants or senior managers or other
8 members of staff who were redeployed into maternity
9 settings to support service delivery?
10 A. I am not aware of from other services; I know some of
11 our midwifery leaders that we met with regularly were
12 working clinically, because they had to, but they also
13 had leadership responsibilities in terms of managing the
14 services and making decisions, so I think that was quite
15 difficult for them.
16 Only midwives can -- you know, it's -- midwives --
17 nobody else can carry out the role of the midwife,
18 that's actually illegal. So I'm not aware of others,
19 from other parts of the unit, coming into maternity, to
20 work clinically, because that wouldn't be possible,
21 which is why maternity services had to be ringfenced.
22 You can't take midwives out of maternity services to do
23 other things because nobody else can replace them. That
24 can't happen.
25 Q. Thank you. Moving on, then, into June 2020. Data from

1 Scotland shows that of the 14 Health Boards there, only
2 two of them at that period of time were offering the
3 full suite of antenatal care and a survey by the Royal
4 College of Midwives in Scotland showed that there had
5 been significant redeployment in the maternity services
6 in Scotland.
7 So were you aware of any action being taken to
8 prevent redeployment not just in England but in
9 Scotland, Wales and Northern Ireland as well and whether
10 that had any impact?
11 A. Yes. So the directors of -- the Royal College of
12 Midwives directors in those countries, and I believe the
13 RCOG as well, very rapidly asked for maternity services
14 to be ringfenced and redeployment not to happen. My
15 understanding is that that did happen quite quickly.
16 Q. Thank you. In terms of the guidance from the College,
17 after the first wave you have described that a more
18 nuanced and localised approach was required, rather than
19 a "one size fits all" in your statement and the College
20 developed a set of service principles in May 2020. What
21 was the focus of those principles during that period of
22 time?
23 A. Can you just bring me to --
24 Q. Yes. I believe it is paragraph 32 of your statement.
25 A. That's about visiting again.

1 Q. Yes, I beg your pardon it is at 34. You have talked
2 there about ...
3 A. So that was --
4 Q. That's all in terms of visiting?
5 A. It's all the -- no, that's not visiting, that's about
6 ringfencing maternity staff. By September 2020 all the
7 groups we set up during the first wave we knew that the
8 infection rates were increasing, so we reconvened all
9 our working groups but we had to reiterate the
10 ringfencing of maternity staff and we published that as
11 a press release so that it was out in the public domain,
12 but also making sure that NHS leaders knew how important
13 that was.
14 Q. Thank you.
15 If we could have a look, please, at INQ000485652.
16 Again, this is data from England on the closure
17 and suspensions of home birth services, freestanding
18 midwifery units, the alongside midwifery units, and
19 obstetric units. This is data that was collected from
20 May 2020 because that's the date that the maternity
21 services were formally included in the sitrep data in
22 England. So we can see here that there is, again,
23 a suspension -- a number of suspensions of home birth
24 services during the second wave.
25 What was the guidance from the Royal College

1 around that time for services to continue during that
2 second wave?
3 A. So in the second wave our guidance was the same. The
4 toolkit for making sure there was safe staffing, safe
5 transfer, ambulances, so that all women could be kept
6 safe but to open up those services if they could, if
7 staffing levels allowed. London had a particular issue
8 during that time, being able to -- being able to have
9 enough staff to provide home birth as a choice and so
10 the choices were withdrawn and we were really supporting
11 our members to make those commonsense decisions about
12 making sure there was enough staff in central places in
13 order to care for the women as safely as they could.
14 And it did reduce choice for women. It did. And that
15 was a consequence of the pandemic and what was happening
16 to the staffing levels.
17 Q. Thank you. We can see also from this graph that from
18 around June 2021 onwards, the closures and suspensions
19 of services increases across almost all of the services
20 in the options for birthing -- the birthing options in
21 England.
22 What are the College's views on the reasons for
23 this in the data?
24 A. I think some of it was that -- my understanding was that
25 staffing levels hadn't improved, people were exhausted.

1 The mental health of the staff was poor. And they were
2 really struggling to provide very basic services. So to
3 start opening up more complexity of a home birth service
4 just didn't seem possible and so it was easier to keep
5 them shut than it was to re-open them. And I would say
6 that was the safest thing to do. That would be our
7 view. Keeping staff and women and families safe during
8 this time was the most important thing even though it
9 was difficult to give that message and it restricted
10 women's choice it did help maintain a level of safe
11 services.
12 Staffing levels at the end of the pandemic as well
13 weren't just about current staffing levels. A lot of
14 midwives when the pandemic started stayed, they might be
15 retiring soon, some of them had just retired and they
16 came back. As we went into the second wave a lot of
17 midwives who were exhausted then left. So there was
18 an increased staffing problem not just sickness and
19 isolation from the pandemic.
20 Q. And to your knowledge, were those levels of closures
21 pervasive across the UK or was that an England problem?
22 A. It was across the UK but I think England, there was
23 a particular problem in London definitely.
24 Q. And ultimately did you hear reports of that impacting on
25 women's birthing options?

1 A. Yes, we did and some of the women would phone the
2 College. They would comment on social media and
3 I absolutely understood where they were coming from.
4 You know, women have one opportunity in that pregnancy
5 and birth to have a good experience and they were really
6 disappointed, anxious, and it was a really difficult
7 time for them and for the staff who were looking after
8 them because they didn't want that either, but they had
9 to make safe decisions and this is a decision they had
10 to make which we tried to support.
11 Q. Thank you. Moving on to the topic of miscarriages.
12 Were there any changes in the guidance on the management
13 of miscarriages during the pandemic?
14 A. Obviously in early pregnancy miscarriage is not managed
15 by midwives. Some women miscarry before they have even
16 booked with a midwife. I think that the same applies to
17 all of the maternity journey that at the beginning it
18 was the "Stay at Home" message caused some issues and
19 then access to services where keeping away from the NHS
20 was part of the other story.
21 I can't comment on gynaecology staffing issues or
22 early pregnancy units because it is not a place where
23 midwives normally work.
24 Q. Thank you. In terms of pain relief, was the College
25 made aware of examples of limited or delay access to

1 pain relief including water births, birthing pools, or
2 epidurals?
3 A. Certainly at the beginning of the pandemic, it was in
4 the first wave, when we weren't quite sure about the
5 virus transmission, there were definitely issues about
6 whether the virus could be transmitted in water, so
7 there was a restriction then on water birth. And
8 I think a joint guidance with the RCOG did talk about
9 restricting water birth particularly if we were unknown
10 of the virus status of the women, because we weren't
11 testing.
12 It changed because then it was an airborne virus,
13 so water births started to be provided in services again
14 and we again updated our guidance with that.
15 The other issues were about anaesthetics and
16 access to epidurals. That was another reason for
17 ringfencing staff. Anaesthetists were -- they were
18 short of anaesthetists in ITUs so anaesthetists were
19 redeployed away from obstetric services, so much -- not
20 completely, but there were less staff available. So
21 having access to epidurals and quickly was a concern to
22 midwives who were looking after the women.
23 LADY HALLETT: Can I ask about that -- sorry to interrupt
24 you. But it is a subject we touched on before. But if
25 the anaesthetists are needed in intensive care units

1 where people are dying, can one really object to
2 redeployment of anaesthetists away from pain relief,
3 much as obviously somebody in labour, a woman in labour
4 would like to have pain relief, of course, but I'm not
5 sure there is a comparison between pain relief and
6 people dying and needing the services of
7 an anaesthetist.
8 A. Yes, my Lady, that is right apart from there's not many
9 anaesthetists available in a maternity unit, usually
10 there is only one, and they are needed for the emergency
11 part of child birth, so emergency caesarean sections,
12 epidurals when there may need to be an operative
13 delivery, and also women who collapse. As part of
14 an unfortunate consequence of labour, some women have
15 a medical emergency, and most units have only one or two
16 anaesthetists available at any one time so having no
17 anaesthetists was a huge risk.
18 In terms of pain relief there are other options
19 for pain relief and midwives obviously would talk to
20 women and offer all of those methods of pain relief if
21 there wasn't an anaesthetist available but we had
22 reports from women who were traumatised by not having
23 access to an epidural for pain relief, not necessarily
24 for an emergency caesarean section.
25 So it was definitely an issue because there are

1 not loads of anaesthetists in maternity units.
2 LADY HALLETT: And really the answer to my question is it is
3 going far beyond the pain relief, much as the --
4 A. Oh, yes.
5 LADY HALLETT: -- (overspeaking) -- traumatised -- the use
6 of the anaesthetists, for many other purposes than just
7 the epidural for the --
8 A. Absolutely. Absolutely, it is.
9 LADY HALLETT: Thank you.
10 MS HANDS: And I just want to touch briefly on one issue
11 around the guidance on visitors and birthing partners
12 around active labour, and the Inquiry has heard some
13 evidence around the definition of active labour within
14 the guidance or the lack thereof, and the interpretation
15 of when a woman may be in active labour and therefore
16 allowed to have a birthing partner attend.
17 Did the College hear of any problems with
18 interpreting active labour, and did it seek to raise any
19 of those concerns?
20 A. Yes, and in fact it wasn't about the definition of
21 active labour, it was much more about the environment in
22 where women were being cared for, in that first part of
23 the pandemic, where partners could be there in labour.
24 So, quite often, women who were induced or were in early
25 labour were not on a labour ward, they are in a -- maybe

1 in a four-bedded bay, so -- with other women. So that
2 was more of the issue rather than definition of active
3 labour. When women are in active labour and then
4 require midwifery care, maybe requiring pain relief,
5 extra monitoring, they then move to a labour ward, which
6 was where we knew that partners could be.
7 So it was about the environment is the main issue,
8 because women in early labour are quite often not on
9 a labour ward.
10 **Q.** And did raising those issues lead to any changes in the
11 guidance that you are aware of?
12 **A.** I'm not aware that it did, although there were lots of
13 conversations about it, definitely.
14 **MS HANDS:** Thank you. My Lady, I'm about to move on to
15 a new topic --
16 **LADY HALLETT:** If I could just ask one question before we
17 break -- sorry to cut across you, Ms Hands -- in
18 relation to the guidance, I appreciate the Royal College
19 was doing its very best to issue the guidance its
20 members it so desperately wanted, especially in
21 a fast-moving situation. I have heard a lot about
22 guidance whilst conducting this Inquiry. How did the
23 College go about trying to get the balance right between
24 issuing the guidance that was needed, updating it when
25 it was necessary but not doing it so often and so much

1 that the hard-pressed midwife who is trying to implement
2 the guidance, understand it -- I mean, there is
3 a balance, isn't there, between issuing too much
4 guidance and flooding the midwives with guidance and
5 issuing the right amount? Did the College analyse?
6 I think at the beginning Ms Hands talked to you
7 about four updates in March. Did the College analyse
8 how you got that balance right?
9 **A.** We didn't analyse it, but we were told by our members
10 that it was overwhelming, at times, the amount of
11 guidance that was being produced, but then it was
12 a quickly changing situation and we didn't want the
13 guidance to be out of date that potentially might cause
14 harm. So I do not think we had any choice. So we did
15 try to balance it. I mean, sometimes we would hear of
16 an issue on a Monday and produce or analyse or change
17 our guidance so it went out on a Friday. Certainly our
18 members told us that constantly giving them new guidance
19 on a Friday was really difficult -- (overspeaking) --
20 and we did take that on board and tried really hard not
21 to send out guidance to them on a Friday.
22 It is hard to get that balance right, but I think
23 it is a risk issue not to have accurate guidance where
24 if the old guidance may be causing harm.
25 So it is one of those things you have to accept,

1 I think.
2 **LADY HALLETT:** Thank you. We will break there and I shall
3 return at 3 o'clock.
4 **(2.45 pm)**
5 **(A short break)**
6 **(3.00 pm)**
7 **LADY HALLETT:** Ms Hands.
8 **MS HANDS:** I'm grateful, my Lady. I have two distinct
9 issues to deal with in terms of guidance, and then we
10 will be moving on to the next topic.
11 Firstly, in relation to neonatal units, did the
12 College have any role in developing or issuing guidance
13 for neonatal units?
14 **A.** No, we didn't.
15 **Q.** Thank you. And then in terms of the services following
16 the guidance that was produced by both the College of
17 Midwives and Obstetricians and Gynaecologists, there was
18 a review by MBRRACE during the pandemic looking at women
19 who died with Covid-19 during that period, and found
20 that only one in ten who died were treated in accordance
21 with the guidance developed by the two colleges.
22 Did the Royal College of Midwives have evidence of
23 that at the time and why that might be happening?
24 **A.** We didn't have evidence of that at the time. I think
25 the guidance -- it is guidance. We had no -- we

1 couldn't mandate the guidance. You know, NHS England
2 would have to adopt the guidance. So the guidance to
3 protect women, particularly black women who were more
4 likely to have an adverse outcome and die, we were
5 starting to be aware of that issue and therefore
6 produced guidance, but it would need to be implemented
7 by the NHS and by the government, not by the colleges.
8 **Q.** Thank you. Moving on then to the categorisation of
9 pregnant women as clinically vulnerable and the guidance
10 in that respect. It is correct isn't it that the
11 College were not consulted on that decision or given
12 prior notice of that decision before it was announced in
13 March 2020?
14 **A.** That is correct, and it was probably the thing that --
15 by not consulting with us, that expert team, was
16 unfortunate because had we known that women were going
17 to be classed as vulnerable, and the conversations then
18 went to which gestation would they need to have -- be
19 isolating? We could have thought about mitigating some
20 of the risks that then happened, particularly around
21 pregnant healthcare workers. So we were surprised when
22 that guidance came out without consultation with us,
23 because I think by that time we had been recognised as
24 an expert group that can give good and quick information
25 to the NHS and the government. So I think that was

1 really concerning.
2 Q. And it is right, isn't it, that the College, along with
3 the Royal College of Obstetricians and Gynaecologists,
4 issued occupational health advice for employers and
5 pregnant women during Covid-19 on 26th March 2020, which
6 was again updated multiple times throughout the
7 pandemic?
8 A. That is correct, but that wasn't really our place to do
9 so. We had to do something to fill a gap to protect
10 staff who were pregnant, particularly in healthcare but
11 in other services as well that were public-facing,
12 because with the classification of women being
13 a vulnerable group and with then some data about some of
14 those women then coming to harm, we felt that we needed
15 to produce some guidance.
16 It was complicated producing that guidance, and
17 I think you will find in my evidence that in the end we
18 withdrew it and gave that responsibility completely back
19 to the employer, to NHS England.
20 Q. Yes, I wanted to ask you about that, actually. Could
21 you summarise that period in which there were
22 communications with the government and public health
23 bodies around the ownership of that guidance and the
24 outcome of that?
25 A. I think it was the time where it was confused that the

1 colleges have a responsibility to provide that guidance
2 and there was definitely an ask for us to produce it,
3 own it and implement it, and that wasn't our role and we
4 made that really clear.
5 Q. Why was it important to have it coming from the
6 government or public health bodies?
7 A. Because we are not accountable for delivering services
8 in the NHS. We are there to support our members to
9 practice safely.
10 Q. And did the chief nursing officers or midwifery officers
11 get involved in advocating for that guidance to be
12 provided by the government or NHS England or public
13 health bodies?
14 A. Yes, they did in the end, and I think it was probably
15 one of those occasions where the senior team in
16 NHS England got involved.
17 Q. And it is right, isn't it, that in fact the maternity
18 team in the Department of Health and Social Care did
19 take ownership of the guidance in October 2020?
20 A. They did. They took ownership eventually which we were
21 pleased about.
22 Q. Do you know whether any action had been taken in Wales,
23 Scotland or Northern Ireland in relation to this
24 guidance?
25 A. I'm sorry, I don't know.

1 We can get that information to you, though.
2 Q. Thank you. The first guidance that is produced by the
3 Department of Health and Social Care was published in
4 December 2020, and that removed the requirement that had
5 been in the guidance from the colleges, for women that
6 were more than 28 weeks' gestation to not work in
7 public -- in patient-facing roles, so to move towards
8 a more precautionary approach. Were the colleges
9 consulted or did they advise on that guidance?
10 A. We weren't consulted but we didn't approve that
11 guidance. We thought that would create an element of
12 risk.
13 Q. Did you seek to raise those issues?
14 A. Yes, we did.
15 Q. What was the response?
16 A. I think -- so my memory is that it was quite a confused
17 response, which is one of the reasons why we withdrew
18 our support for that guidance and said it was the
19 responsibility of NHS England.
20 Q. Did the College produce any guidance?
21 A. We did produce guidance. Yes, we did produce some
22 additional guidance at that time.
23 Q. Can you recall what the focus was of the college's
24 guidance at that time?
25 A. The guidance was making sure that there was a local risk

1 assessment for pregnant staff, that that was done as
2 part of the local occupational health risk assessments,
3 that pregnant staff who had comorbidities or more likely
4 to be sick with Covid could then have the option not to
5 work in a patient-facing environment, and that at 28
6 weeks, that, again, staff would not be in
7 a patient-facing environment.
8 There was then an ongoing issue about how they
9 would be paid if they weren't able to work, if there
10 wasn't a suitable alternative employment for those
11 staff. There was definitely an issue about whether they
12 were on sick pay, whether they were on furlough, that
13 maternity leave wouldn't be possible that early. So
14 there was definitely some confusion about how those
15 staff that couldn't work would be paid.
16 Q. And it is right, isn't it, that a year later, so in
17 December 2021, the College issued guidance alongside the
18 Department of Health and Social Care which moved the
19 threshold from 28 weeks to 26 weeks' gestation. Was
20 there a change or development in the understanding of
21 risk in that period of time that led to that change from
22 28 to 26 weeks?
23 A. I don't recall, I'm sorry.
24 Q. Were you, the College, aware of any examples of issues
25 around increased risk or misinterpretation of that

1 guidance at the time?
2 A. There was some misinterpretation of that guidance.
3 I think some of it was also about the fear that pregnant
4 staff had, because there were some real issues about the
5 environment they were working in, and the lack of PPE.
6 They were classed as a vulnerable group and so working
7 in a patient-facing environment, pregnant, even up to 28
8 weeks, was really concerning for staff.
9 Q. In April 2020, the Department of Health and Social Care
10 withdrew the guidance from employers in regard to
11 pregnant women in healthcare settings. Did you hear any
12 evidence as to what impact that had?
13 A. It was in April 2022 that that --
14 Q. Yeah, sorry, did I say -- my mistake. 2022.
15 A. In April 2022 -- yes. The government withdrew the
16 guidance and we did oppose that because the legal
17 requirement to risk-assess -- the infection risk to
18 pregnant staff, because Covid was still around, was
19 a key issue for our pregnant members, so we did oppose
20 that.
21 Q. I would like to move on to a different topic now and
22 that's infection, prevention and control measures in
23 maternity settings.
24 It is right, isn't it, that midwives expressed
25 concerns around the PPE levels that were recommended in

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

1 access to PPE knowing that the impact of Covid on that
2 group of staff was higher.
3 So there were a number of issues around PPE and
4 availability and how maternity services were not
5 prioritised for the right PPE for the work that they
6 were doing.
7 Q. And did you raise those concerns?
8 A. Yes, we did.
9 Q. What was the response?
10 A. The response at the time was about availability of PPE,
11 which was that the FFP3 masks and the fitting of them
12 had to be prioritised for people who were in high-risk
13 areas, so respiratory areas and known Covid patients.
14 But that was not acceptable so we did raise that, that
15 we wanted maternity not to be treated as a separate
16 service, that midwives were working in a very high-risk
17 situation with women who potentially had Covid and they
18 were therefore at risk.
19 The other thing about -- just linking back to what
20 you said before about healthcare workers who were
21 pregnant. Maternity is largely a female workforce, and
22 we seem to have more pregnant midwives and maternity
23 support workers than any other group, so there was
24 another consideration that there were a lot of people
25 working without appropriate PPE with the wrong guidance

1 in maternity services and therefore the impact of that
2 on them was considerable and we heard a lot about that.
3 Q. And what about PPE and, in particular, the wearing of
4 masks for pregnant women particularly during labour?
5 What was the College's view on that and did it change at
6 all during the pandemic?
7 A. It did change. We did change that view because women
8 really struggled to be in labour with a mask on, so the
9 requirement to wear them -- the risk assessment about
10 not wearing the mask was then undertaken. Midwives also
11 found it difficult to wear a mask, to be able to
12 communicate well with women, particularly in labour. So
13 I think everybody struggled with it but ultimately it
14 was about being safe.
15 Q. Later on, in the pandemic, in February 2021, it is right
16 that the College signed a joint letter to Boris Johnson,
17 copied to Matt Hancock, requesting a change in approach
18 in the IPC guidance and advice on the use of PPE to
19 reflect the airborne risks in healthcare settings; is
20 that right?
21 A. That is correct and that letter was a joint letter with
22 our TUC colleagues, because obviously we are also
23 a trade union representing the safety of staff. And it
24 went to Boris Johnson because we were frustrated in
25 terms of the lack of action and that attention on proper

1 PPE guidance and access to the equipment.
2 Q. And in terms of maternity settings and the role of the
3 College in particular, did that lead to any changes or
4 further conversations?
5 A. Yes, it did and we had feedback from our members that
6 things then started to improve, which was a good thing.
7 I think there was then issues in the next wave of the
8 pandemic but certainly at that point things did get
9 a bit better.
10 Q. And it is right, isn't it, that in June 2021 the College
11 also met with the Department of Health and Social Care
12 and others to discuss IPC guidance further. What was
13 discussed specifically at that meeting and, again, did
14 that lead to any changes?
15 A. There were some training -- there was some changes but
16 it was about -- quite a lot of it was about the training
17 and the use of protective equipment because I think
18 maternity again had been left out in terms of the
19 training and how it could be used effectively. There
20 was also an issue about community staff, I'm not sure if
21 that's picked up here, because obviously midwives were
22 working in a community setting, not just in hospitals,
23 and PPE and the training and the use of it in the
24 community setting was, again, a massive issue which was
25 brought up and I think it was around the same time.

1 Q. And the community setting in the maternity settings
2 would that be around health visiting and those kind of
3 settings?
4 A. No. It is community midwives who have local clinics,
5 face-to-face clinics, but also visiting women in their
6 own home. And they really struggled to access
7 appropriate PPE, and they were a group that were
8 particularly anxious because quite often they would go
9 into a home where there were lots of people, maybe in
10 a non-ventilated environment and they felt particularly
11 at risk.
12 Q. And in terms of testing, was the College aware of any
13 issues with maternity staff accessing testing during the
14 pandemic?
15 A. Yes, when testing came in I think maternity, again, was
16 one of those areas that wasn't at the top of the list.
17 I can understand that but it was again our plea to make
18 sure that maternity was seen as an essential service and
19 therefore needed to be treated in the same way because
20 the potential for really poor outcomes for women due to
21 the pandemic but also the impact on staff being -- not
22 being able to work was considerable because nobody else
23 could look after those women other than the midwives,
24 and that was -- it was really important that testing --
25 availability of tests happened -- should have been

1 a priority within NHS services.
2 Q. You spoke briefly earlier on around some of the unique
3 issues with maternity units with what's known as
4 cohorting of patients. Can you expand on what some of
5 the issues were in hospitals and maternity units with
6 cohorting of pregnant women depending on whether they
7 had or were suspected of having Covid-19?
8 A. It was really difficult for some services because they
9 didn't have the right environments to safely cohort
10 women, Covid or no Covid. It caused considerable
11 problems. It was also difficult before testing because
12 unless women had Covid symptoms quite often staff didn't
13 know whether they had Covid or not.
14 So, that became -- that did become -- that was
15 difficult. I think it caused anxiety -- this is my
16 personal view -- of the staff as well without the right
17 PPE, then caring for women who were in an area where
18 they were known to have Covid and it made them feel very
19 vulnerable.
20 Q. Thank you. Moving on to inequalities. Firstly, in the
21 guidance for pregnant women, there is evidence of the
22 significant disparities in maternal outcomes for ethnic
23 minority women prior to the pandemic in a number of
24 reports, and in May 2020 the Royal College of Midwives
25 issued guidance to reflect the increased risk to ethnic

1 minority women in respect to Covid-19.
2 Can you briefly summarise that guidance and
3 whether there were any challenges in communicating those
4 risks to ethnic minority pregnant women?
5 A. Yes. So our guidance was to our members, so guidance,
6 we couldn't mandate it, to prioritise women from BAME
7 groups, to help them understand how important it was to
8 access maternity services but also for staff to
9 prioritise the care of those women as well, so extra
10 visiting, I think I said earlier, extra visiting, extra
11 support, that was really key.
12 Obviously, the information did come out eventually
13 from the NHS that they were a significant group to
14 prioritise and there was some very clear guidance about
15 accessing -- access those women, being able to go into
16 the communities to talk about the importance of being
17 able to access maternity care and not to worry.
18 I think women were worried. They were worried
19 when they could see that the death rates were higher for
20 that group of women. They were anxious about going into
21 hospital and accessing maternity care, which I think in
22 some cases probably created a poorer outcome. So there
23 was definitely a concerted effort by us and by everybody
24 to try and engage that group of women.
25 It also impacted on the staff because there's

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

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

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

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

1 Then, the not prioritising of maternity services,
2 then women being classed as vulnerable and then poor
3 access to PPE, having to make really difficult decisions
4 about not being able to provide home births, for
5 example, for women who really wanted them; the lack of
6 confusion around visiting and the tension that that
7 created between the women, the partners and the staff,
8 all of that contributed to a much, much higher level of
9 stress and anxiety than you would normally see in
10 a maternity staff group.
11 There was support in some services for staff to
12 access help for their mental health. We also -- we had
13 local -- we have local field staff. So our branches are
14 in the field, and we would -- we really encourage them
15 to support staff in terms of accessing support locally
16 if they were feeling very stressed and vulnerable at
17 work.
18 I believe that it had an impact on staff's ability
19 to keep going, and to keep thinking about doing their
20 best. I think staff told us that they just about
21 managed to get through day by day. Some staff didn't
22 and either left the profession, left their job or went
23 on long-term sick, and on top of that of course Covid
24 and Long Covid and all the other things.
25 So I would say that staff tried their very, very

1 best and it had a personal toll on their health and
2 their mental health. Which I think they are still
3 recovering from, I don't think it is over. I think it
4 has impacted on midwives wanting to stay in the
5 profession.
6 **Q.** On the topic of Long Covid, are you aware of the impact
7 it has had on the profession?
8 **A.** Yes. We have a number of members who have Long Covid
9 and how difficult they found that, particularly when
10 they think that they got Covid because of lack of PPE
11 and poor environments in their workplace. And I'm
12 certainly aware of members that are very clear that that
13 has happened to them.
14 **Q.** Has the College provided any support to those members or
15 signposted them to support --
16 **A.** Yes, absolutely, and we would see that as part of our
17 role.
18 **Q.** Could you provide a couple of examples of that support?
19 **A.** So, for example, we had a member -- actually she has
20 been on television recently talking about her Covid and
21 Long Covid experience -- she had support in the
22 workplace to -- and other members have had support in
23 the workplace to negotiate working in different ways,
24 also to maybe have a longer period off sick, to have
25 phased return to work, not to work in a difficult

1 clinical environment. So there are a number of things
2 that we have been able to do for those members.
3 **Q.** Thank you. Ms Walton, you very helpfully set out
4 a number of key lessons to be learned in your statement.
5 I wonder if there are any that you haven't already
6 covered today that you wanted to pick out, to bring to
7 our attention to ensure that maternity services are
8 better prepared to support pregnant women in a future
9 pandemic.
10 **A.** I think ultimately, it is that maternity services are
11 seen as an essential service. Getting it wrong in
12 maternity services is unacceptable. We went into the --
13 the service went into the pandemic in most of the
14 countries without the right number of staff or
15 appropriate environments. I believe that it is
16 important that women's voices and the voices of staff
17 who are looking after them can be heard, they are able
18 to be heard at every level of the system, and to
19 government. You know, this is primarily a women's
20 service delivered by women. I think it is really
21 important that those voices are heard, and collective
22 voices are heard. I think my key message is that the
23 colleges very quickly came together and had a huge
24 number of experts that could produce support and
25 guidance that, if we all worked together, we could have

1 had a single version of the truth that could be produced
2 quickly and maybe prevented some of the inconsistencies
3 and anxiety that then was created.
4 I think if we were to go into another pandemic,
5 I think you said it earlier, what could be done before?
6 What things would we think about in terms of, for
7 example, prioritising provision of community services,
8 how could that still be provided, but particularly when
9 there is a reduced number of staff, what could be done
10 differently to predict -- have a toolkit for predicting
11 where staff need to be to deliver safe care?
12 And that could be communicated at the beginning of
13 a pandemic and not halfway through it, so everybody
14 knew -- the women and the staff -- what could happen if,
15 for example, there was only half the number of staff
16 available, what services could then safely be delivered.
17 I think that would be really helpful.
18 **MS HANDS:** Thank you. I have no further questions, my Lady.
19 **LADY HALLETT:** Just before I turn to Mr Wagner who I know
20 has some questions, at the risk of being too
21 controversial, you have said several times that
22 maternity services are not considered an essential
23 service, they are not getting the priority or profile
24 they deserve, and you have also said, obviously, it is
25 a service basically run by women for women.

1 Do you think there's anything between cause and
2 effect, the fact that it is a service run by women for
3 women and the lack of priority?
4 A. I think potentially yes, and I think, you know, women's
5 services in the NHS don't get the right attention and
6 maternity is part of that. I think it has been seen for
7 a long time as women having babies. Actually, if women
8 having babies -- if we don't get it right, it can very
9 quickly go wrong. And the outcomes which I know you
10 will have heard of are absolutely devastating for the
11 families.
12 So I absolutely believe that getting it right at
13 the start of life, having maternity services prioritised
14 in the NHS, is the right thing to do, and it actually is
15 an investment in the future health of the population.
16 **LADY HALLETT:** Also, and if things go wrong and a baby ends
17 up born brain damaged, and it is because somebody in the
18 NHS hasn't done their job properly, then that can be
19 extraordinarily expensive to the NHS.
20 A. It is one of the most expensive in insurance claims,
21 actually, in the NHS. So getting it right is so
22 important. That's what our members want. They say that
23 all the time.
24 **LADY HALLETT:** Do we have any evidence as to whether or not
25 it is the fact that it is women's services run by women

1 for women, to suggest that's why it doesn't get the
2 priority it deserves, or is it just a feeling that you
3 and I may share?
4 A. I think there is some evidence. There is definitely
5 some evidence, because quite often, in an organisation,
6 midwives don't have access to the decision-makers as
7 often as they should, so I think there is some evidence
8 of that and that's a short answer for probably a very
9 complex issue.
10 **LADY HALLETT:** I do understand that.
11 Mr Wagner.
12 **Questions from MR WAGNER**
13 **MR WAGNER:** Thank you. Good afternoon. I ask questions on
14 behalf of the 13 Pregnancy Baby and Parent
15 Organisations. And I have no doubt that they would
16 agree with the sentiment of that final passage of
17 question and answer.
18 You have given very clear evidence this afternoon
19 about the huge anxiety amongst staff and parents caused
20 by inconsistent and poorly communicated guidance. And
21 is it right that the RCM were already raising concerns
22 about that in relation to the visiting guidance to the
23 NHS by June 2020, and this relates to those emails that
24 are referred to at paragraph 38 of your statement?
25 A. Yes.

1 Q. And then, is it fair to say that over the summer of
2 2020, in facing that lack of guidance, the RCM, the
3 Royal College of Obstetricians and Gynaecologists and
4 the society of -- and College of Radiographers stepped
5 into the breach and developed that framework agreement
6 to support the reintroduction of visitors in maternity
7 settings?
8 A. Yes, we did.
9 Q. And that was endorsed -- it was later -- sort of a month
10 later endorsed and disseminated by the NHS; were they
11 involved in the drafting, or was there a document that
12 was presented to them for their approval?
13 A. They would have been involved. I'm sorry I don't know
14 for sure, but we did communicate with NHS team
15 regularly. Quite a lot of the guidance we produced very
16 quickly and will have done it in consultation with the
17 people we were working with, some of those were women
18 and families as well, and other organisations.
19 It was really difficult to come up with the
20 commonsense approach in terms of protecting women and
21 families, in terms of the virus and the spread of the
22 virus, and the staff who were caring for those women in
23 very difficult environments. Sonography, I think you
24 mentioned, was definitely a group of staff that were
25 really concerned of, because a lot of the sonography

1 rooms in maternity do not have a lot of ventilation and
2 are very, very small. So there was a huge risk there,
3 and it was about how did we help with guidance that was
4 going to be a commonsense approach and allow -- and
5 encourage people to do those local risk assessments, but
6 with some guidance from the NHS?
7 Q. You said in your oral evidence that we, the RCM, are not
8 accountable for delivering services in the NHS; we are
9 there to support our members and practice safely. So
10 would it be fair to say that the guidance that you were
11 producing or helping to produce was coming from that
12 perspective?
13 A. Absolutely. We are a membership organisation. So we
14 are there to, as both a trade union and a professional
15 association, to support our members to be safe in
16 practice and at work, but also to deliver safe care.
17 They then deliver safe care to women and families.
18 So we absolutely were there to make sure we were
19 the voice of our members, both locally, but also to the
20 government and the NHS. That is absolutely our role.
21 Q. You were asked earlier by Ms Hands whether any
22 consideration was given to consulting with patient
23 representative groups during the development of
24 guidance. But I wasn't clear, and I'm sorry if I missed
25 it, whether -- but you then said yes, it would have

1 been, but I didn't know whether you were talking about
2 the July guidance or the December guidance.
3 A. Okay, so the Covid -- the cell that was -- the Covid
4 cell, which was the joint guideline group with the RCM
5 and the RCOG, had patient representatives as part of
6 that. Also we regularly talked to parent organisations,
7 for example, the NCT, and we had a group called
8 "One Voice" which was all of those organisations
9 together talking about key issues.
10 So we absolutely had those conversations, but
11 ultimately it was about us providing support and
12 guidance for our members, but we would also encourage --
13 and I think I said this earlier -- local services to
14 discuss guidance, changes to services, and anything that
15 they were going to do differently with their local
16 women's groups.
17 So the maternity voices partnerships, and they are
18 different in the other countries, but with the local
19 groups of women, that was really important and we did
20 encourage that.
21 Q. In relation to the December guidance, the December 2020
22 guidance -- so this is moving onto the national guidance
23 by the NHS, it is not the same structure as the previous
24 guidance that was developed by the trade unions with the
25 NHS, is that fair?

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

1 is key. So it is one of the things that I think
2 midwives struggled with, being able to do what they
3 believe was the right thing for parents but also to keep
4 everybody safe, and that's why in December we were
5 really concerned about the continued opening-up guidance
6 rather than the local risk assessment.
7 Q. Do you accept, looking back, that one consequence of
8 that guidance ending up giving individual Trusts that
9 latitude rather than mandating some visitors being
10 allowed into the room, do you agree that that would have
11 led to continued inconsistency and unpredictability
12 between different Trusts?
13 A. It did but that was -- it was going to happen because
14 different maternity environments are not suitable for
15 providing safe maternity care particularly in a pandemic
16 but if it was "one size fits all", which I think
17 NHS England wanted, that would then expose risks. The
18 problem was, and I think I mentioned about social media,
19 women had different experiences in different services
20 and so those that had their partners and others with
21 them throughout the whole experience would say: I have
22 had the best care ever, this is what my service allows.
23 And then other people got really disappointed and upset
24 because the service they accessed couldn't do that.
25 I'm not sure what the answer is to that other than

1 make sure that women's services are the best, that the
2 environment is perfect for now and for the next
3 pandemic. Because I do believe that women and their
4 partners should have had equal access to maternity
5 services together but it just wasn't safe to do so in
6 every single service across the UK.
7 Q. Do you also agree that if this inconsistency and
8 confusion was going to continue, that would necessarily
9 mean that the anxiety amongst people using the services,
10 that you complained about -- I don't say you complained
11 about but the RCM complained about in June 2020, would
12 persist during the later period?
13 A. Because the pandemic was -- during the whole time of the
14 pandemic more and more information and almost a trying
15 out of different approaches was happening all the time,
16 I think sometimes services tried something and then
17 realised it didn't work and had to change their approach
18 and I think -- actually I think it should be commended,
19 some of that flexibility with always at the top of their
20 minds keeping everybody as safe as they could.
21 I think right at the beginning of the pandemic,
22 I think you are right, very clear advice when we really
23 didn't know what we were dealing with was really
24 important but as more information came in, how could
25 those local risk assessments happen but continue to be

1 in a safe way?
2 I think in November/December where the whole
3 opening-up of maternity services was actually going to
4 create a risk, was of real concern. So it was about how
5 could it be localised but still have some very clear
6 principles of keeping people safe because all the
7 environments were so different?
8 There was also the issue of course of home
9 environments and midwives working in a community where,
10 again, that caused considerable concern about exposure
11 to the virus.
12 **Q.** Just finally on the RCM not endorsing the guidance in
13 December 2020, in your view, did the fact that you
14 didn't endorse the guidance impact on how widely it was
15 disseminated and how well it was ultimately understood
16 by the frontline professionals?
17 **A.** I'm not sure about that but I would say that we didn't
18 endorse it because we were primarily concerned about the
19 safety of the staff and the women and family that they
20 were caring for and as the infection rates were growing
21 and we were moving again into another lockdown it seemed
22 that was moving in the wrong direction in terms of
23 keeping everybody safe.
24 **MR WAGNER:** Thank you.
25 **LADY HALLETT:** Thank you, Mr Wagner.

1 Thank you very much indeed, Ms Walton. Really
2 grateful to you. Sorry if we kept you here for a long
3 stint this afternoon.
4 **A.** Okay.
5 **LADY HALLETT:** All I can say is that other people do get
6 even longer stints, but I'm very grateful for your help.
7 **A.** Thank you.
8 **(The witness withdrew)**
9 **LADY HALLETT:** Very well. I think that completes the
10 evidence for today, and I shall return to sit at
11 10 o'clock tomorrow morning.
12 **(3.46 pm)**
13 **(The hearing adjourned until 10.00 am**
14 **on Tuesday, 8 October 2024)**
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