Witness Name: Shanthi Gunesekera
and Janaki Mahadevan
Statement No: M3/BIR/01
Exhibits: JM/SG/01 - 04
Dated: 14th August 2023

UK COVID-19 INQUIRY

WITNESS STATEMENT OF SHANTHI GUNESEKERA AND JANAKI MAHADEVAN

We, Shanthi Gunesekera and Janaki Mahadevan will say as follows: -

1. We are co-CEOs of the charity Birthrights having been appointed in January 2023 to this position.

2. We have written this statement in response to the letter from the Inquiry dated 13 March 2023 (M3/BIR/01) requesting evidence under Rule 9 of the Inquiry Rules 2006 for matters relating to Module 3 of the UK Covid-19 Inquiry.

3. We were appointed as co-CEOs of Birthrights after the period of time that this request focuses on (1 March 2020 to 28 June 2022). Therefore, we have prepared this statement ourselves with the support of information held by the charity and the support of the wider Birthrights staff team and Chair of Trustees.

Statement of Truth

We believe that the facts stated in this witness statement are true. We understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: PD PD

Dated: 14th August 2023

1. **Overview**

1.1. Established in 2013, Birthrights is the UK-wide charity dedicated to improving women and birthing people's experience of pregnancy and childbirth by promoting respect for human rights. We believe that everyone who is pregnant is entitled to respectful maternity care that protects their fundamental rights to dignity, autonomy, privacy and equality. We provide advice and legal information to women and individuals, train healthcare professionals to deliver rights-respecting care, and campaign to influence and improve services and practice throughout the maternity system.

1.2. During the pandemic, we saw a 300% increase in demand for our advice service, meaning we provided advice and information to 2,255 women and birthing people and their families and healthcare professionals and supporters. The most common concerns related to Covid-19 restrictions that included: preventing partners from accompanying women and birthing people to healthcare settings; limitations on choice – home birth services or birth centres closing, water births or caesareans being denied – and; complaints about poor care, especially on postnatal wards. We escalated numerous advice cases to Trusts to change local policies that contravene basic rights, writing formally to Trusts to secure positive policy change or push for exceptions to ensure safe and personalised care.

1.3. Our online Frequently Asked Questions on "Coronavirus – how will it affect my rights to maternity care?" was viewed over 20,000 times during this period and our factsheet on right to a c-section was the second most frequently viewed page.

1.4. The Covid-19 pandemic brought the already precarious position of human rights in childbirth into sharp focus, with many Trusts applying policies in a blanket way and not considering exceptions based on women's individual circumstances, as required by human rights law. Many Trusts acted too quickly to withdraw services, without providing for exceptions, including aspects of services that are essential to women and birthing people's psychological and physical safety. As set out in paragraph 2.2 this included restricted support from birth partners, restricted access to pain relief, and restricted access to home birth and midwife-led units. Decision-making was not always proportionate or transparent.

1.5. The restrictions in maternity services, too often focused entirely on infection control and led to women and birthing people hearing devastating news or even giving birth alone, parents being separated from babies, and severe limitations on birth choices. The long-term impact of these experiences are clear. Throughout the last two years the first or second highest theme of enquiries on our advice service has remained "complaints - birth trauma". These are women and birthing people who wish to make a complaint about their traumatic birth during the pandemic. This issue has continued to constitute 20-35% of our enquiries every month for over 24 months.

1.6. The Healthcare Safety Investigation Branch (HSIB) - who are hosted by the NHS and undertake independent investigations - investigated 19 maternal deaths in the period 1 March 2020 and 31 May 2020 and found that 'families were concerned about their health or the risk of exposing their unborn baby to COVID-19, and about the requirement to attend hospital without the support of their families. Because of these concerns they put off going to hospital for longer than they otherwise may have done' and removed the ability for partners to advocate on behalf of the woman or birthing person or "bring knowledge of the individual woman's personal circumstances, medical history and preferences [...] particularly important where there are cultural or language differences." This demonstrates that breaches of women and birthing people's rights to have birth partners present could have been a contributing factor in maternal deaths during the pandemic. The report also finds that 'eight (42%) of the 19 women included were from Black, Asian or other minority ethnic backgrounds, compared to 13.9% of the UK population' demonstrating the disproportionate impact of these policies on Black and Brown women and birthing people. [JM/SG/01 - INQ000216631]

1.7. While some Trusts adjusted rapidly during the pandemic to provide women and birthing people with continued access to safe and supportive maternity care that respects their informed decisions, in other Trusts the opposite has happened.

1.8. Covid-19 restrictions implemented in many Trusts as a result of the pandemic have continued long beyond. Furthermore, the precedent that such decisions set has enabled a longer-term justification of restrictions as Trusts continue to find themselves in crisis as a result of staff shortages and under-resourcing. What is

deeply worrying is that we continue to hear from women and birthing people who face blanket policies ranging from the restriction of pain relief to partners only being allowed on the postnatal ward within tight time frames. Many birth centres remain closed or opened only on a sporadic basis, and in some parts of the UK there has been no, or no consistent homebirth service for three years.

2. The law

2.1. Women and birthing people's rights to make choices about where and how they give birth and who is present to support them are protected by Article 8 of the European Convention on Human Rights (ECHR). Restrictions to human rights can only be imposed if they are to meet a legitimate aim, and are both necessary and proportionate. Where restrictions are imposed, individual exceptions must be considered on a case-by-case basis. Exceptions to restrictions must be proactively considered where they may comprise reasonable adjustments under the Equality Act 2010. Article 3 of the Human Rights Act prohibits inhuman or degrading treatment. Article 14 protects people against being treated in a discriminatory manner in the application of the other rights within the Human Rights Act.

2.2. During Covid-19 we saw many examples of breaches of human rights at the most basic level. These included:

2.2.1. Restricted access to pain relief, women and birthing people being left to give birth alone in the dark with no partner at all, plus women and birthing people who had recently given birth being left on the postnatal ward without any support to clean themselves, without catheters being changed, and **without ongoing access to water or help to lift their baby**:

2.2.2. Preventing women and birthing people from having a partner with them for support when they were already experiencing a miscarriage or who were being told that their foetus had not survived in the womb.

2.2.3. Suspension of core maternity services, including home birth and midwifery-led birth centres.

2.2.4. **Preventing birth partners** being present to support women and birthing people before, during and after labour.

2.2.5. **Coercion of women and birthing people** to accept a vaginal examination they did not want to consent to, in order for their partner to be allowed to join them.

2.2.6. **Bullying behaviour by staff** towards women and birthing people who were exempt from wearing a face covering, including refusal of scans without a face covering or forcing them into wearing a visor or face covering (in some instances the people were then physically sick) in order for them to receive an antenatal scan

2.2.7. **Racism** towards racially minoritised women and birthing people on postnatal wards

2.3. Decisions must be made with the human rights of women and birthing people and partners front-and-centre and restrictions to human rights in maternity services must be proportionate to the real risks involved. Any restrictions that are imposed must be regularly reviewed and lifted as soon as possible. Individual exceptions must be proactively considered on a case by case basis, especially where they may comprise reasonable adjustments for women and birthing people under the Equality Act 2010. Appropriate support must be offered to those in need, including women facing disadvantage.

3. Restrictions on partners and visitors

3.1. An individual's right to companionship of their choice during labour is a vital aspect of respectful maternity care. Prohibiting birth partners is a serious infringement of women and birthing people and their partners' Article 8 rights to family life.

3.2. All NHS Trusts imposed restrictions on visitors to hospitals during the pandemic. Some Trusts initially prevented women and birthing people from having a partner at all during labour. NHS England revised its guidance on 14 December 2020, clarifying that partners had a critical role in maternity care and should be accommodated, if at all possible, but ultimately decision-making was left to

individual Trusts. In most cases the decision-making process and the evidence that informed this was not transparent and there were few mechanisms for challenging decisions once made. The result was that pregnant women and birthing people faced a postcode lottery with some Trusts continuing to place restrictions on birth partners being present at all stages of the maternity journey.

3.3. Many Trusts continued to impose restrictions within maternity care, especially on birth partners, even as restrictions in other areas of life were being lifted. In the summer of 2020, when people were allowed to go out to shops, pubs and restaurants and indeed were encouraged to "eat out to help out" restrictions in many Trusts included:

3.3.1. Partners not permitted to attend antenatal appointments and scans, which can reveal that a baby has died or is suffering from abnormalities. Some, but not all Trusts permitted partners to join scans by video.

3.3.2. Women and birthing people prevented from having a birth partner with them during an induction on antenatal wards, leaving women and birthing people alone, sometimes for several days, during a difficult and physically demanding experience with a real risk that they would give birth without their partner.

3.3.3. Partners not being allowed to join an individual in labour until they were in established labour leading to some women and birthing people feeling coerced into having a vaginal examination to determine if labour was established.

3.3.4. Partners prevented from being present in theatres during caesarean section and assisted deliveries

3.3.5. Women and birthing people on postnatal wards not permitted visitors for more than two hours at a time (although some Health Boards banned all postnatal visiting). Women and birthing people were required to do almost all of the care and feeding of their babies while they recovered from birth, including surgical and instrumental birth, alone. They were left without vital support from either staff, who were facing severe time pressure and staffing shortages, or from their loved ones or partners. This is

particularly difficult for post-operative women and birthing people, who may struggle to move around or look after their baby, and for women and birthing people with physical or psychological conditions who require extra support.

3.4. We heard that exceptions were not being made for women and birthing people even when they were in a particularly vulnerable situation, including **women who were not allowed visitors or time to make memories after their babies had died**. Families with newborns admitted to NICU continued to face disproportionately restrictive neonatal visiting for some time.

3.5. As is too often the case, such **restrictions had a particularly acute impact on specific groups of people with additional needs** including women and birthing people living with trauma, a disability, and/or autism who were denied their sole birth partner at any appointments, or denied their second birth partner during labour and birth (even when the partners were double vaccinated and prepared to wear a mask and socially distance)

3.6. We also heard from a disabled woman suffering miscarriage who was prevented from having their partner, also their registered carer, attend for miscarriage treatment with them.

3.7. By the end of the pandemic, most women and birthing people were able to be supported by a birth partner during active labour. However it is extremely concerning that the initial crisis response by some Trusts was to restrict support altogether. We continue to have concerns about how and when restrictions to visiting and birth partners are being used against current guidelines, as we continue to hear about broader restrictions to postnatal units in particular.

4. Restrictions on place of birth

4.1. At the outset of the pandemic, during the first lockdown, the Government's message to the public was "stay at home". This led to a huge increase in interest in home birth, and birth in smaller midwifery-led units. Pregnant women were often scared about going to hospital and exposing themselves or their baby to Covid-19, and/or being separated from their partner.

4.2. However at the same time, the immediate response of around half of maternity services in England was to centralise their maternity services on labour wards and the **suspension of midwifery-led services including home birth and community birth centres**. We heard from women who did not feel safe attending hospital because of the risk of infection or restrictions on birth partners. Some gave birth at home alone instead.

4.3. Through our advice service we supported individuals to have their legal right to choose place of birth upheld by advocating for constructive solutions – e.g. outpatient antibiotics for home birth and birth pools on the ward.

4.4. Concerningly, closures of midwife-led units are becoming the norm due to chronic underinvestment in the health service, staffing shortages and pressures on local ambulance services, resulting in women and birthing people unable to make an informed decision about how and where they can give birth. We are still seeing poor communication regarding changes in service restrictions and women and birthing people who feel coerced into changing their birth plans due to risk of service closures.

5. Restrictions on services and procedures

5.1. Some Trusts **stopped respecting women and birthing people's requests for elective c-sections**. Whilst Trusts may classify these caesareans as "maternal request" many women were seeking them because of long-term physical and mental health conditions. One woman who contacted us with a serious genetic medical condition, which had led to the death of a relative in childbirth, was told she would only be offered an induction. We wrote directly to the Trust, which resulted in their policy not to carry out maternal request caesareans during the pandemic being reversed.

5.2. For much of the pandemic we had **concerns about access to pain relief,** especially to using water pain relief. A number of Trusts and Health Boards suspended the use of birth pools for all women in labour without sufficient evidence to support their restriction.

5.3. As with all restrictions, the impact on certain marginalised groups or on those with additional needs was felt more acutely. This includes **denial of access to a**

proper interpreter, leading to women unable to exercise informed decision-making.

5.4. Despite the World Health Organisation (WHO) coming out early with guidance to say that women who were in labour should not have to wear a mask, we heard from many women who were made to wear a mask during labour, especially during a surgical or caesarean birth.

6. Regional differences

6.1. We were contacted about a number of issues in relation to changes in maternity services in **Scotland**, at the outset of the pandemic, particularly in relation to the withdrawal of home birth services. However, the guidance issued by the Scottish Government in July 2020 meant Scotland's maternity services were the most open to partners than the other countries across the UK.

6.2. Most Health Boards in **Wales** maintained two hours of visiting on maternity wards for many months after guidance from Welsh government stating that visiting restrictions should be based on local risk assessments of the threat of Covid-19. We legally challenged two Health Boards who offered less than two hours visiting when it was not clear why longer visiting could not be facilitated as per other parts of the UK.

6.3. For many months new mothers and their babies in **Northern Ireland** could only be visited once a week on the postnatal ward. The guidance then changed to give discretion on visiting to the healthcare professional in charge of the ward making it very difficult for individuals to know what to expect and also for outside organisations to assess what visiting was being permitted and whether proportionate decisions were being made.

7. Racial disparities

7.1. In 2020, NHS England reported that Black pregnant women were eight times more likely and Asian women four times more likely to be admitted to hospital with Covid-19, compared to white women. Public Health England outlined how a combination of structural racism, socioeconomic disadvantage, housing challenges and occupation (frontline care, retail, transport) make Black and

Asian people more likely to contract, become seriously unwell and die from Covid-19. The Royal College of Midwives notes "socio-economic disadvantage and being from a BAME background are closely associated with higher prevalence of obesity, diabetes, hypertension, and cardio metabolic complications", which increase the risk of both severe Covid-19 symptoms and pregnancy-related risks. Yet an MBRRACE review of eight deaths from Covid-19 (seven from Black and minority ethnic groups) found that "pre-existing diabetes, hypertension or cardiac disease were identified in very few of these women". [JM/SG/02 - INQ000221912]

7.2. Our year-long inquiry into racial injustice in maternity care found that for too long, evidence and narratives about why racial inequities in maternal outcomes persisted have focused on issues with Black and Brown bodies. The inquiry's report *Systemic Racism, Not Broken Bodies* presented the devastating impact that systemic racism within maternity care is having on Black, Brown and mixed ethnicity women and birthing people's safety, dignity, choice, autonomy and equality - from individual interactions and workforce culture through to curriculums and policies. [JM/SG/03 - INQ000221911]

7.3. As outlined in the examples above Covid-19 compounded many of these pre-existing inequalities. The inquiry heard directly from over 300 people with lived and professional experience of racial injustice in maternity care and we received 1,069 responses to our survey. In the written call for evidence one example we heard was of an Afghani woman giving birth during the pandemic who was denied pain relief and her concerns were ignored; she ultimately had a stillbirth.

8. Challenging decisions made

8.1. We escalated numerous advice cases to Trusts and Healthboards to change local policies that contravened basic rights during the pandemic, in some cases taking legal action to secure changes to policies. Some examples include:

8.1.1. We launched legal action in partnership with Leigh Day to achieve exemptions to self-isolation rules for birth partners

8.1.2. We launched legal action with Irwin Mitchell to challenge blanket policies banning partners from attending scans remotely.

8.1.3. we worked with individuals through our advice service to secure exceptions to general partner restrictions for people with additional needs e.g. disability, mental health issues, multiple pregnancy, or previous birth trauma.

8.1.4. We wrote to all Trusts and Healthboards with visiting hours of less than two hours as part of a joint campaign with the But Not Maternity Alliance. This led to positive policy change or exceptions being made in at least 13 cases.

8.1.5. **A NHS Foundation Trust in England** hanged their policy of separating parents who were close contacts of someone with Covid-19 from their baby, even if the parents were testing negative, allowing a mother to be reunited with her baby in Neonatal Intensive Care Unit (Mother and baby both continued to test negative).

8.1.6. A NHS Wales Health Board changed their inpatient visiting policy from one hour to 2.5 hours in February, just before we were about to launch our judicial review against them.

8.1.7. After correspondence with us, **a hospital in England** agreed to make an exception for a second birth partner for someone who had a strong case for additional support due to previous birth trauma.

8.1.8. We launched a legal challenge against **a Health Board** in Wales for not allowing any postnatal visiting - the Board quickly changed policy to an hour and have continued to gradually increase it.

8.1.9. Upholding the right to choose place of birth for individuals with additional health considerations (such as epilepsy or diabetes) who choose to birth in midwifery led settings outside of usual Trust/Board guidelines.

8.1.10. Protecting people's right to informed choice of maternal request caesarean section by securing a change in caregiver where healthcare professionals were not following the Nice Guidance and Interim Ockenden Report Essential Action 7.

8.1.11 **A hospital in Scotland and a hospital in London** changed their policies on partners being present in theatres due to our intervention.

8.1.12. A hospital in England reversed their policy not to carry out maternal request caesareans during the pandemic.

8.1.13. A hospital in England reintroduced their home birth service.

8.1.14. A hospital in England apologised and reviewed their policy on making exceptions for women and birthing people with physical disabilities.

8.2. The changes to policies that were made by Trusts and Healthboards as a result of our interventions, demonstrates that Trusts and Healthboards were not confident that their policies were lawful.

9. Long term impact

9.1. We are concerned about the disturbing precedent that the pandemic set for imposing blanket restrictions with little regard for individual circumstances or consideration of case-specific needs - these restrictions during the pandemic took place across the UK regions and included restricted support from partners, restricted access to home birth or midwife led units and restricted access to pain relief . Many Trusts are continuing to use such measures in response to longer-term, chronic issues related to underinvestment, staffing and resources, ultimately leading to more frequent breaches of rights.

9.2. We still hear through our advice service that some Trusts and Hospitals continue to:

9.2.1. Implement blanket policies to maternity care that do not take into account individual need,

9.2.2. Suspend midwifery-led services including home birth and community birth centres,

9.2.3. Restrict partners on postnatal wards,

9.2.4. Restrict access to pain relief.

9.3. Although we do not currently have statistically hard evidence, we are hearing increasingly about the numbers of people choosing to have completely unassisted births also known as freebirths. While this is a completely legal option for people who desire to do so, we believe there is a link to people's first hand or second hand experiences of poor maternity care, which may be leading to more people seeking to avoid any interaction with the maternity system.

9.4. Research by Kings College London looked at how Covid-19 context may have changed birth choices made in April 2020. Their suggest that inconsistencies across maternity services and messaging during the pandemic led to an increase in freebirth during the pandemic. [JM/SG/04 - INQ000216632]

9.5. We can also see that the traumatic experiences of too many women and birthing people and their families and loved ones during the pandemic have had longer term implications. Our advice and information service continues to regularly receive enquiries related to traumatic birth experiences that occurred through the pandemic. Throughout the last two years between a fifth and more than a third of enquiries to our advice service have related to those seeking to find out more about complaints due to birth trauma. These are made up of both those who have given birth through the pandemic and those who are processing their experiences during the pandemic and those who have experienced trauma as a result of ongoing human rights breaches.

10. Lessons

10.1. It is our view that the unique needs of pregnant women and birthing people and their families were not sufficiently considered in national, regional and local decision-making in response to Covid-19 which caused significant trauma and in some cases death. "Safety" in maternity care became about primarily reducing the spread of Covid-19 degrading any holistic view of maternity safety which encompasses staff and families' psychological safety, inclusion, and trauma informed care, all within a human rights framework.

10.2. We know there were some Trusts that were able to continue all core services and deliver safe and human rights-respecting care despite the pandemic. For example:

10.2.1 A hospital in England contracted with a private ambulance service in the early year of the pandemic so that they could continue to offer a home birth service throughout.

10.2.2. Some Trusts gave bank contracts to local independent midwives who were especially skilled at attending home births, including of twins or breech pregnancies.

10.3. However, too many women and birthing people endured traumatic experiences through their pregnancy and birth through the pandemic and continue to do so. We are clear that all decisions about maternity care must be made with the human rights of women and birthing people and partners front-and-centre and restrictions to human rights in maternity services must be proportionate to the real risks involved. Any restrictions that are imposed must be regularly reviewed and lifted as soon as possible. Individual exceptions must be proactively considered on a case by case basis, especially where they may comprise reasonable adjustments for women and birthing people under the Equality Act 2010. Appropriate support must be offered to those in need, including women facing disadvantage. We believe the lessons below are critical to minimise future trauma and poor outcomes for women and birthing people:

10.3.1. Applying blanket restrictions, regardless of individual need is not an appropriate response even in times of crisis. We saw through the pandemic decisions that prioritised infection control at all costs, regardless of any wider and longer term impact on those with additional, complex or significant individual needs or on staff forced to go against their usual standard of care and instincts. A proportionate approach must be taken which centres human rights and properly considers all alternatives before any imposition of limitations to services. Decision-making must involve service-user voices

10.3.2. Too often during the pandemic and, according to the enquiries we receive, at the present time, **decisions are being made which lack transparency, accountability and demonstrate a basic lack of understanding of human rights** and potential impact on outcomes. It is

clear that such dictats can have a hugely damaging impact on both women and pregnant people and those seeking to deliver rights-respecting care.

10.3.3. Inconsistent, confusing and contradictory messaging was put out through official channels increasing anxiety and driving more people to seek out of hospital care when these options were becoming increasingly restricted or withdrawn completely. Official messaging around whether or not to have the vaccine, whether pregnant people were a priority group, and lack of sufficient risk assessment of pregnant employees created avoidable and undue stress and drove people to seek information from non-official sources and those with additional or complex needs disengage with health services. Communication between different services is also key with stronger mechanisms to ensure that consistent and accurate information is provided to women and birthing people from, for example hospitals and ambulance services.

10.3.4. Drawing from this we submit some key recommendations for how decisions are developed and communicated about maternity care in response to future pandemics and crises:

10.3.5. All decision-makers in Trusts and individual hospitals must be fully aware of their legal obligations under human rights law and undertake appropriate training

10.3.6. There must be **transparency on how decisions relating to maternity services and changes applied to them are made**. A proportionate approach must be taken which centres human rights and properly considers all alternatives before any imposition of restrictions to services and those restrictions must be genuinely temporary.

10.3.7. All decisions must take account of **the disproportionate impact on some women and birthing people** including Black and Brown women and birthing people and those with additional and specific needs such as those living with trauma, a disability, and/or neurodiversity.

10.3.8. Communication must be clear, consistent and minimise any anxiety for women and pregnant people.

10.3.9. The NHS must uphold rights-respecting and person-centred care - this means that individual exceptions to policies must be considered on a case-by-case basis and informed decisions made by women and birthing people about their care must be respected, even if these decisions are out of guidelines

10.3.10. Rights-respecting care cannot be delivered without sufficient and **meaningful investment in maternity services**. It is vital that the Government listens to the voices of those on the frontline.

10.4. There are also clear learnings from the specific policies that were developed to Covid-19 that must not be repeated in any response to future pandemics and crises:

10.4.1. Partners must not be treated as visitors - partners must be permitted to attend scans, antenatal appointments, labour, induction, birth, theatre, postnatal wards

10.4.2. Women and birthing people should **not be required to wear face masks during any stage of labour**

10.4.3. Core maternity services, including home birth and midwifery-led birth centres must be resourced - not suspended - so that women and birthing people's legal **right to make informed decisions about their place of birth is upheld**

10.4.4. Women and birthing people's **right to make informed decisions about their care, including requests for elective c-sections must be respected**

10.4.5. Women and birthing people should **never feel coerced into having a vaginal examination** in order to receive the care or support they need

10.4.6. Women and birthing people's **right to access pain relief must be upheld**

10.4.7. Interpreting services must be appropriately resourced so that women and birthing people have **access to the information they need to uphold their right to make informed decisions** about their care

10.4.8. Parents must not be separated from their babies unless there is a real genuine and compelling need

10.5. The lessons and recommendations outlined in section 9 must be applied to the response to any future pandemics, but are also of immediate relevance to maternity services today as we continue to see many Trusts and Hospital Boards developing concerning policies and processes in response to the current staffing and resourcing challenges in the NHS.

10.6. All **women and birthing people should feel safe and heard** throughout their pregnancy and birth. Women and birthing people must be confident they will be offered safe maternity care that fully respects their right to bodily autonomy, self-agency, and accepts their lived experience – **even in times of crisis.**