IN THE UK COVID-19 INQUIRY
MODULE 3

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

"... [losing our baby Ziggy during Covid-19], it's obviously something that's completely impacted the rest of our lives, and I think we have just been left to deal with it ourselves. We're kind of away from the hospital now and that's all ... that matters to them, we're out the door, and we're the ones left with this for the rest of our lives, basically." - Catherine Todd[1]

"I think it's [having a baby] a magical time for parents and you need to allow them to be parents as soon as they can irrespective of the circumstances. So although we may have been doing it for [what] we thought were the right reasons, there's a price that they've paid that they'll never get back." - Baroness Eluned Morgan[2]

A. INTRODUCTION

1. This is the closing statement of the 13 Pregnancy, Parenting and Baby Organisations (the "**PBPOs**") who have come together to assist this Inquiry in fully investigating the impact of Covid-19 on women, pregnant people and new parents' experiences of healthcare during the relevant period of the pandemic.

2. Each of these 13 organisations - Aching Arms, Baby Lifeline, Bliss, The Ectopic Pregnancy Trust, Group B Strep Support, ICP Support, The Lullaby Trust, The Miscarriage Association, National Childbirth Trust, The Pelvic Partnership, Pregnancy Sickness Support, Tommy's and the Twins Trust – witnessed first-hand the deleterious impact of Covid-19 on the experiences of women, pregnant people, new parents, the newly bereaved and their families. Each of the PBPO's experiences was that, although some positive efforts were made particularly by individual staff members, too often the goal of preventing the spread of Covid-19 was prioritised at the cost of adequate healthcare for women, pregnant people, and newborn babies. After participating in ten weeks of hearings and reviewing the evidence provided to this Inquiry, the PBPOs' experiences have sadly been borne out as entirely representative of a wider picture.

3. This statement accordingly addresses (i) the impact of Covid-19 visitor restrictions on women, pregnant people, new families, and their partners; (ii) the impact of Covid-19 on access to maternity and maternity-related care; and (iii) the need to value pregnancy-related healthcare now and in the future.

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[1] Transcript of evidence of Catherine Todd, 11 September 2024, p 28.
[2] Transcript of evidence of Baroness Eluned Morgan, 20 November 2024, p 183.

4. The PBPOs are grateful for attention the Inquiry has given to pregnancy and maternity-related care and urge it to ensure that these experiences are properly highlighted in its report, so that the experiences of pregnant women and people, and their families, during the pandemic are appropriately reflected to the public and key decision-makers. The PBPOs further urge the Inquiry to make meaningful, forward-looking recommendations to ensure that women, pregnant people, and new babies' healthcare is properly protected in the future. As Gill Walton from the Royal College of Midwives ("**RCM**") explained, women's health services are often overlooked:

> *"I think it has been seen for a long time as women having babies. Actually, if women having babies -- if we don't get it right, it can very quickly go wrong. And the outcomes which I know you will have heard of are absolutely devastating for the families. So I absolutely believe that getting it right at the start of life, having maternity services prioritised in the NHS, is the right thing to do, and it actually is an investment in the future health of the population."*[3]

5. The PBPOs wholeheartedly agree. The Inquiry has the ability to contribute to a future in which all forms of maternity-related and neonatal care are properly prioritised and supported in the case of a major emergency such as the pandemic. It should seize this opportunity through its recommendations.

6. Finally, the PBPOs repeat the important point set out in their opening statement: although some CPs, witnesses, and the Inquiry have used the umbrella term of 'pregnant women' the experiences of pregnant women during the relevant period were shared by all pregnant people. References to pregnant women (in the Inquiry and where used in this closing statement) must be understood inclusively to include pregnant people.

B. VISITING AND IPC RESTRICTIONS

7. One near-immediate response to the outbreak of Covid-19 was the introduction of visiting restrictions to hospitals including in maternity-related and neonatal care. The PBPOs do not set out a complete timeline of those restrictions here, given the number of iterations of different guidance across the four nations of the United Kingdom. In short, however, total visitor bans were implemented on around the 25th and 26th of March 2020 in England, Wales and Northern Ireland and similar bans were implemented in Scotland.[4] Exceptions were allowed for a birthing partner for a woman in labour or for a parent visiting their child. No visitors were allowed in early pregnancy units or antenatal or postnatal wards, and neonatal visiting was limited to one parent only, often with additional time restrictions.

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[3] Transcript of evidence of Gill Walton, 7 October 2024, p 141.

[4] See NHS Visitor guidance (25 March 2020) [INQ000399381]; Email from Department of Health (Northern Ireland) official to colleagues, attaching a letter and document on Covid-19 visitors advice from Professor Charlotte McArdle (Chief Nursing Officer) to HSC (27 March 2020) [INQ000438142].

8. The impact of these restrictions was immediately felt by women, pregnant people, and new parents. Indeed, Bliss issued its first position statement on access to neonatal units as early as 8 April 2020.[5] The universal experience of those affected by the restrictions and dealing with front-line decision-makers was that the exceptions were limited and, in any event, interpreted narrowly.

9. Despite the impact, and corresponding public attention, it took significant time for the guidance to be adjusted and for maternity-specific guidance to be issued. The suspension on visiting was lifted in England on 5 June 2020 and replaced with a direction for visiting to be the subject of "local discretion" by Trusts and other NHS bodies.[6] In respect of maternity-related care, the most that guidance did was to link to the Royal College of Midwives ("RCM") website. Wales, Scotland and Northern Ireland each issued national guidance on maternity and neonatal visiting, though not until early to mid-July 2020;[7] NHSE endorsed RCM guidance in September 2020 and finally published its own guidance addressing maternity and neonatal care in December 2020 (see further below).[8]

10. The PBPOs address below the effects of this guidance and why it has been shown in the course of this Inquiry to be neither necessary or proportionate, and the failure of the healthcare system to adapt and modify the guidance over the course of the pandemic. It is important to stress at the outset, for the reasons detailed further below, that issuing the national guidance on maternity and neonatal visiting was in no way a panacea. In some cases, the guidance continued to treat partners and new parents as mere "visitors" and not as essential partners in care; in all cases, it delegated decisions on visiting to local decision-making and risk assessments.

11. It is equally important to recognise at the outset that the PBPOs work in the context of healthcare for women and pregnant people and with many diligent healthcare professionals. The PBPOs consider it was crucial that those professionals were and are supported to provide the best quality care and, clearly, that includes ensuring that those professionals themselves are safe in the workplace. For that reason, the PBPOs acknowledged in their opening statement that they appreciated the need for infection prevention and control ("**IPC**") measures.[9] However, as the PBPOs explain below, it is far from clear that visiting restrictions in the manner enforced were necessary for IPC; nor, in respect of local restrictions, whether they were appropriate or proportionate. These failures mean, the PBPOs submit, the Inquiry

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[5] Bliss Position Statement, 'Covid-19 and parental involvement on neonatal units (8 April 2020) [INQ000399377].
[6] NHS, 'Visiting healthcare inpatient settings during the COVID-19 pandemic' (5 June 2020) [INQ000330865]
[7] COVID-19 National Incident Response Board, 'Meeting minutes re: National guidance on the reintroduction of visitors and accompanying adults to inpatient and outpatient maternity services' (17 August 2020) [INQ000421230_0006].
[8] NHS Guidance, 'Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers' (14 December 2020), [INQ000330895].
[9] Opening Statement on behalf of the 13 PBPOs, §25 [INQ000502153_0008] ("**PBPO Opening Statement**").

must not merely accept that just because visiting restrictions were aimed at supporting and protecting staff they were therefore justified. When carefully examined, it is clear that visiting restrictions were used as a blunt tool by worried staff, in the absence of proper IPC protections and, at times, in the absence of common sense.

Impacts of "visiting" restrictions must not be forgotten or overlooked

12. This Inquiry has spent significant time in the Module 3 hearings investigating the impact of "visiting" restrictions on maternity-related care. The PBPOs are grateful for this focus. They still receive reports about the detrimental impacts, fear and anxiety suffered by pregnant people and their partners when one person was left alone to hear devastating news about a pregnancy; was induced alone; or when families had to ration time with newborn, vulnerable babies. For the PBPOs, it is these women and their families who must be kept at the heart of the Inquiry; the PBPOs urge the Inquiry to bear in mind the evidence they have provided and collated through various reports, including Every Story Matters,[10] when analysing the visitor restrictions and their implementation and making recommendations for the future.

Antenatal and early pregnancy care

13. Antenatal and early pregnancy care is ideally associated with positive news. Even then, it is important that women and pregnant people can share the early stages of pregnancy with their partners, not least to encourage bonding. But where there is negative news about a pregnancy, particularly those experiencing miscarriage or ectopic pregnancy, or a pregnant person requires hospital care, an accompanying partner or support person becomes essential.

14. Support partners and co-parents provide emotional support. They can help to interpret information where a pregnant person speaks English as a second language, or to explain (and where necessary, question) medical advice for a partner, who may be experiencing severe distress and emotional impact from receiving negative news about their baby,[11] or who may themselves be extremely ill and require help. These are crucial functions. For many pregnant people and their partners, the effects of being separated during these periods of crisis were serious and long-lasting. For one partner who was denied access to an antenatal scan, it meant never seeing his baby alive because she later passed away at 20 weeks' gestation.[12] As Sarah Jones, an impact witness to the Inquiry said in her witness statement: "*I think that the long-term impact that my experience of having an ectopic pregnancy during the pandemic has made me lose faith a bit in the NHS and has really knocked my confidence in them. I really needed my husband with me when I was waiting for that surgery, and I really needed a little bit of compassion from the nursing staff. ... I just would have liked for them to have been*

[10] UK Covid-19 Inquiry Legal Team, Every Story Matters: Healthcare, (June 2024) [INQ000474233_0203].
[11] Witness statement of Jenny Ward on behalf of the PBPOs, §65, [INQ000408656_0050] ("**PBPO Statement**").
[12] PBPO Statement, Quote 62 [INQ000408656_0048].

more compassionate given that they knew my husband couldn't be with me and so I was very much alone."[13]

Impact on birth and labour, and postnatal care

15. Despite officials repeatedly referring to the visiting restrictions having an exception for women "*in labour*" to be accompanied by a partner, the evidence is clear that this was widely understood as requiring a woman to be in *active labour* before she could be supported by a partner. Records in England indicated around half of women and pregnant people who gave birth during the pandemic only had their partners with them during active labour.[14] As the PBPOs set out in their opening statement and oral evidence, the result was demeaning and frightening for many women, who were often forced to wait on their own until they were sufficiently dilated to be able to have their partner with them for moral and practical support.[15] As the Inquiry heard, some women felt obliged to consent to medically unnecessary checks in order to hurry up the process of being able to see their partner;[16] in one survey of 15,000 women, 17.4 per cent reported feeling forced to have a vaginal examination.[17] This was intrusive and degrading. It was also demeaning for partners and co-parents, many of whom travelled in from their homes with their partners, dropped them off and were forced to wait in the car not knowing what was happening inside. Some of those co-parents missed the birth of their own children,[18] likely with serious lasting consequences.

16. The Inquiry heard evidence from Chief Nursing Officer Dame Ruth May, who stated that the guidance was not intended to draw such a distinction and that the dividing line between active and non-active labour had been drawn by those in charge of trying to manage visitors. Dame Ruth accepted that women should have had their partners present during the entirety of labour. It was, she said, a "*learning point*" for a future pandemic to be more specific, earlier.[19] Other evidence attributed the division to the fact that women and pregnant people would initially be on a shared labour ward and only later were moved to an individual room.[20] Gill Walton of the RCM said that, although the RCM raised this issue and it was discussed with decision-makers, there were no changes to the guidance.[21] The PBPOs note that the guidance was not written to distinguish between shared and private rooms: it was intended, as Ruth May noted, to allow a woman to have a support person with them as a proportionate and reasonable exception to the IPC rules. If the full impact of the rule had been understood, the

[13] Statement of Sarah Jones, §24 [INQ000485283_0006]
[14] Witness Statement of Dame Ruth May, §354 [INQ000479043_0076].
[15] Transcript of evidence of Jenny Ward, 7 October 2024, pp44-45; PBPO Opening Statement, §28 [INQ000502153_0009].
[16] Transcript of evidence of Jenny Ward, 7 October 2024, pp 42-43.
[17] Aydin et al, 'Giving birth in a pandemic: women's birth experiences in England during COVID-19' BMC Pregnancy and Childbirth (2022) [INQ000308968_0003]
[18] Sanders et al, 'Anxious and traumatised' *Midwifery Journal* (8 June 2021), p 4 INQ000308999_0005.
[19] Transcript of evidence of Dame Ruth May, 17 September 2024, p 73.
[20] Transcript of evidence of Jean White, 19 September 2024, p 134; Transcript of evidence of Gill Walton, 7 October 2024, pp 116-117.
[21] Transcript of evidence of Gill Walton, 7 October 2024, pp 116-117.

PBPOs do not consider it would have been thought proportionate, for example, for a woman in labour to wait in a room alone post induction for many hours.

17. The PBPOs submit that the implementation of the labour and active labour division was unreasonable and harmful to pregnant women and their partners, and importantly, failed to understand the role and importance of a partner in care as more than just a visitor. As with antenatal and early pregnancy care, Jenny Ward's evidence to the Inquiry carefully explained that a birth partner can be essential in advocating for women during birth and actually assisting healthcare staff in flagging (for example) when a woman's condition was deteriorating.[22] The PBPOs have highlighted to the Inquiry the evidence of the serious consequences that arose from women not having access to interpreters or for disabled women left without support.[23] Birthing partners were also required to leave very quickly after birth. In some cases, hospitals required partners to leave within one or two hours. For women who had suffered traumatic births, this again left them reliant on overworked and overstretched staff. The presence of a partner could have relieved the impact on staff by allowing the partner to act as a carer; to help the new mother to the bathroom, to eat, and to hold their baby; as well as facilitating crucial bonding as a family with their new baby in their first hours of life.

18. Having a partner present to support a woman or pregnant person actually served to reduce the pressure on staff and increased the prospect of good outcomes for the person giving birth. These crucial roles were undervalued or not understood in the restrictive visiting guidance.

Neonatal care

19. Some of the PBPOs, for example Bliss, led work during the relevant period to try and regularise neonatal visiting restrictions. It was notable in evidence that many key decision-makers, from Matt Hancock to Chief Nursing Officer for Wales Jean White, specifically recalled Bliss' advocacy on this issue. The PBPOs submit that the importance of parents being able to be with their child in neonatal care cannot be understated. Again, Jenny Ward explained that these are babies who are necessarily at risk and whose parents are already deeply concerned about them and want to be as involved as they possibly can be. She explained that parents would be thinking: "*will I still be able to recognise my baby? They may have masks on them, they may have breathing equipment. If you are only able to see them for one or two hours a day that is exacerbating the trauma that neonatal parents go through anyway*"[24].

20. The Inquiry also heard powerful evidence from Tamsin Mullen about the practical unreality of the visitor restrictions on neonatal care: rushing herself to be discharged from hospital so

[22] Transcript of evidence of Jenny Ward, 7 October 2024, pp 43-44.
[23] Disability Equality Forum 'Report on the impact of COVID-19 on disabled people in Wales', (March 2021) [INQ000350302]; PBPO opening statement at §29.
[24] Transcript of evidence of Jenny Ward, 7 October 2024, pp 53-54.

she could be with her partner; travelling from her home with her husband each day to see her newborn babies, only for each of them to be required to sit in a waiting room while the other cared for their children; being told she could not sit inside to express milk and offered only a toilet to sit in to do so; and of course, the impacts on her wider family while she and her husband tried to navigate these rules.[25]

21. All of these examples are only snapshots of the impacts of visiting restrictions provided to the Inquiry in evidence; but they demonstrate the very real, and in many cases, long-lasting impacts on women and pregnant people, new parents, and their families and their ability to access adequate healthcare and support.

Visiting restriction decisions were not proportionate or necessary

> *"I felt that all they cared about during that time was Covid. I felt that the balance between what I was going through physically and emotionally and the risk of Covid were not fully realised. I think my husband should have been allowed with me if he had worn appropriate PPE, a mask, even a protective suit and had tested negative for Covid. In terms of any recommendations that the Inquiry may make, they need to ensure that a partner can be there in the event of another pandemic like this so that women like me are not made to feel so alone."* - Sarah Jones, impact witness.[26]

Strictness of visiting regimes was not based on robust IPC science

22. The strict visitor restrictions were nominally understood to be necessary to control the spread of Covid-19 in hospitals. This was based on a simple premise: that more footfall in hospitals meant more risk. But the regimes and the rules as enforced lacked basic common-sense. For example, there was no good reason why parents who lived in the same household should not be allowed to be together in the hospital; particularly when there was no consistent approach taken to PPE being offered or enforced to "visitors" on the wards. There was also no logic in making women like Tamsin Mullen sit in a shared waiting room instead of visiting her newborn babies with her husband, particularly once her babies were given a private room.

23. It became apparent during the oral hearings that robust IPC expert evidence was not sought or utilised when setting or updating the visiting restrictions. None of the public health agency heads who were asked were aware that they had provided advice on these measures: Lisa Ritchie, head of the UK IPC Cell, said that the IPC Cell had no input on visiting restrictions;[27] Professor Fu-Meng Khaw, head of Public Health Wales, did not recall Public Health Wales being involved in visiting guidance or providing any IPC assessment about the relative benefit of imposing visiting restrictions on pregnant women and their families;[28] and Aidan Dawson of the Northern Ireland Public Health Agency ("**PHA**") did not think that his

[25] Transcript of evidence of Tamsin Mullen, 7 October 2024, pp 19-20.
[26] Witness Statement of Sarah Jones (12 June 2024) [INQ000485283].
[27] Transcript of evidence of Lisa Ritchie, 16 September 2024.
[28] Transcript of evidence of Fu Meng Khaw, 5 November 2024, pp 33-34.

organisation provided any analysis about the impact or effect of visiting restrictions and was clear that there was no process of feeding back local risk assessments to show what worked and what did not.[29] At its highest, evidence before the Inquiry indicated that advice was sought from the Covid-19 Nosocomial Review Group in Scotland in March 2021 about visiting restrictions (not maternity-specific). Their advice was:

> *There is an absence of evidence about the role of visitors in hospital transmission, however there is evidence that closed settings, which are close contact and crowded are high risk for COVID-19 outbreaks, so the more visitors the higher the risk in hospitals.*[30]

24. Aside from the basic proposition, that more people created more risk, there was therefore no real information available against which the role of visitors in nosocomial spread was being robustly assessed, and certainly none about the role of partners from the same household. That reflects the evidence of Sir Stephen Powis of NHSE who, despite being responsible for the NHS visiting guidance which governed these decisions, did not know whether there was specific data on visitor-to-staff or visitor-to-visitor transmission of Covid-19.[31]

25. That lack of an evidence base was reflected in the evidence of the IPC experts, Dr Shin and Dr Warne. They confirmed in oral evidence that no work was done to ascertain whether visitors were actually complying with PPE and IPC measures when visiting.[32] That is particularly relevant given that one, often-cited, modelling study indicated that sustained visiting restrictions were likely to have reduced nosocomial transmission, but its implementation was likely of less impact than other IPC measures such as universal mask wearing and isolation of infected healthcare workers.[33] The Chief Medical Officer's Technical Report into Covid-19 endorsed the same research.[34] If that was the case, it is difficult to understand why PPE for visitors was not promoted more vigorously (aside from supply issues).

26. The IPC experts' report is carefully balanced in its analysis of the benefits and harms of visiting restrictions. The report sets out research showing the mental health impacts of restrictions and the impact on bonding for neonatal babies and their parents, as well as the impacts of extra burdens on healthcare staff where patients were without supporters. The experts' tentative conclusion that the visiting restrictions struck a reasonable balance was heavily caveated with comments that "*variation in local practice that contributed to differing experience*" and that their conclusion took into account "*the exceptions made for special*

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[29] Transcript of evidence of Aidan Dawson, 5 November 2024, pp 87-88.
[30] Covid-19 Nosocomial Review Group, CNRG advice on the reinstatement of visiting guidance, (19 March 2021) [INQ000323771]
[31] Transcript of evidence of Sir Stephen Powis, 7 November 24, pp 121-122.
[32] Transcript of evidence of Dr Shin, Dr Gould and Dr Warne, 19 September 24, p 209.
[33] Expert report of Dr Shin, Dr Gould and Dr Warne, §8.16 [INQ000474282_0085].
[34] CMO Technical report, p 363 [INQ000177534_0363].

circumstances like ... maternity services ... and the fact that visiting guidance evolved to be more flexible over time".[35] In oral evidence, the experts continued to emphasise that the restrictions had been sufficiently flexible, for example remarking that *"... for neonatal intensive care units, it was quite common to have a more flexible approach*".[36]

27. The PBPOs submit that, from the evidence heard by the Inquiry, the reality was that there was limited flexibility and limited exceptions built into the system and certainly very limited evidence of any assessment of whether the risks of infection were in fact outweighed by the benefit of having family with a patient. For example, as the Inquiry has heard, in Wales it took until May 2022 until rules were modified to allow both parents to be together on the neonatal ward. This is addressed further below, but to the extent the IPC experts' conclusion was based on a misunderstanding of how the system worked in practice, it cannot be relied on as anything more than equivocal and caveated support for visiting restrictions. To the contrary, the absence of flexibility belied a system which was not working.

28. Further, the IPC experts explicitly recognised the logic of having different rules for "visitors" where the person lived with the patient: there was a difference where "*the carer is somebody who is already living with the patient ... they already had the same exposures and risks already*"[37] In those circumstances, Dr Shin said that he thought it was reasonable for a carer to be let in to the hospital. This is a seemingly obvious, but overlooked point. As Vaughan Gething pointed out, when balancing risk, "*if a couple live together and one part of that couple goes in for the scan there's a fair argument about whether actually you're reducing the risk significantly of only having that person in when they have direct contact with the person they live with so there is something about that whether it's a scan and whether it's the ability to go into a neonatal ward if babies are particularly ill*."[38]

29. Mr Gething, and more pertinently the expert analysis, reflected the view that many women and pregnant people reached applying common-sense. Unfortunately, at no point did this principle become part of the logic of visitor restrictions or exceptions (even during the period Mr Gething had oversight of the Welsh Health Department). It is disappointing that, in

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[35] Expert report of Dr Shin, Dr Gould and Dr Warne, §8.22 [INQ000474282_0086]

[36] Transcript of evidence of Dr Shin, Dr Gould and Dr Warne, 19 September 2024, pp 202-203. See also pp 120-121 where the experts said: *"... I think everyone working in the NHS understands the reasons why [visiting restrictions] caused so much controversy and upset, but the decision-making to restrict visiting in that manner and to only allow those specific circumstances, especially end-of-life care and paediatric -- neonates, newborn babies and in labour, that was done really to protect members of the public and visitors. So a balance had to be struck somewhere and where the balance lay was -- in those particular circumstances it was felt that the risks of infection were outweighed by the benefit of having -- you know, allowing the family, for example, to be there when a patient – end of life, obviously that is a very major life event, obviously, and the other examples. So that was where the line was drawn."*

[37] Transcript of evidence of Dr Shin, Dr Gould and Dr Warne, 19 September 2024, p 122.

[38] Transcript of evidence of Vaughan Gething, 20 November 2024, pp 81-82.

reality, even the IPC experts in essence agree that there may have been no need for some of the harshest policies applied to pregnant women and people and their families.

Visiting restrictions were not sufficiently responsive to changing circumstances of pandemic

30. Attempts to remedy the issues caused by the visitor restrictions were extremely slow across the UK and particularly in England and Wales. As set out above, Wales, Scotland and Northern Ireland did not issue national guidance on maternity visiting until early to mid-July 2020 (and May 2022 for neonatal visiting in Wales),[39] and in England, until September 2020 (and December 2020 to address neonatal visiting).[40] In all four nations, the national guidance did not resolve the concerns raised by women, pregnant people, and new parents, as there was a large emphasis on local risk assessments. At the close of Module 3, the PBPOs submit that it remains unclear why there were not more efforts, more promptly, to adapt and adjust these restrictions across the course of the pandemic.

31. In respect of access to neonatal care, particularly ensuring that both parents could have unrestricted access to their own children, there were serious delays. The initial restrictions across all four nations meant that only one parent at a time could visit a child in hospital.[41] The experience of the PBPOs, and particularly Bliss, was that the lack of guidance particularly in England meant that there was considerable variation among units in the implementation of this rule and it was often subject to strict time restrictions. The PBPOs further found that, even after national guidance was implemented, policies which allowed both parents access but only on a "taking turns" basis were persistent even into 2022. National data reporting in England on visiting restrictions in neonatal care did not commence until June 2021;[42] that was therefore the first real opportunity for monitoring of the guidance. It is not clear that any monitoring at all took place in the other three nations.

32. In Wales, although national maternity guidance around visiting restrictions was implemented in July 2020, that did not address neonatal visiting. Updated guidance which allowed "*up to two parents, carers or guardians*" at a time to be with a neonatal baby, "*subject to local determination and following a risk assessment*" was not implemented until July 2021.[43] It

[39] COVID-19 National Incident Response Board, 'Meeting minutes re: National guidance on the reintroduction of visitors and accompanying adults to inpatient and outpatient maternity services' (17 August 2020) [INQ000421230_0006].

[40] NHS Guidance, 'Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers' (14 December 2020), [INQ000330895].

[41] PBPO Statement, §144 [INQ000408656_0044]

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

[43] Letter from Gareth Howells, Interim Chief Nursing Officer to NHS Wales Executive Nurse Directors, NHS DoTHS, NHS Clinical Directors, Heads of Midwifery Services, Heads of Sonography/ Radiography Services, Hospices in Wales, Wales Maternity & Neonatal Network Board and RCPCH re update to Hospital Visiting during the COVID outbreak (18 June 2021) [INQ000271668].

took until May 2022 for visiting guidance to be updated to fully address neonatal visiting and to provide for both parents to be allowed to have unrestricted access as primary caregivers.[44]

33. The Inquiry has heard no adequate explanation given for this exceptional delay, in the written or oral evidence. Judith Paget said that she was surprised to hear the delay had been so substantial;[45] she had understood that the system had moved to a more supportive approach by November 2020 and specifically identified neonatal services as an area where she felt there should have been some consistency across Welsh hospitals as to what was "*essential visiting*".[46] Baroness Eluned Morgan recalled and accepted Bliss' advocacy in the summer and autumn of 2021, as did Chief Nursing Officer Jean White: "*I certainly was affected by the Bliss report that described what the impact on was having not the two parents seen as a unit if you like ... Neonatal care is very fraught and often the child may not survive, so it is a very difficult area, and I think on reflection I would have said they always should be as a pair*".[47] Baroness Morgan did not consider the failure to act more quickly was due to a lack of priority being given to neonatal visiting as a women and maternity-related issue and attributed it simply to the pressure of having to make a hundred decisions just on a Sunday.[48] The PBPOs are grateful for her frankness but, unfortunately, her description still discloses that the improvement of neonatal visiting restrictions was insufficiently prioritised. There is no good explanation for that de-prioritisation, given the consensus view that the rules ought to be loosened.

34. In terms of antenatal, intrapartum and postnatal settings, although Wales, Scotland and Northern Ireland issued setting-specific guidance by July 2020, that guidance still set out principles to enable visiting rather than directive guidance. For example, the guidance continued to distinguish between labour and active labour. In response to letters of concern from Senedd members on behalf of their constituents, the then-Minister for Health Vaughan Gething continued to advise in October 2020 that women could only be accompanied by a partner during "*active labour*" and "*for some time*" after birth.[49] The PBPOs submit, in agreement with the NGO Birthrights, that between the four nations Scotland's guidance was the clearest at setting not just overall expectations but also providing specific pathways for services to follow to allow "visitors" (particularly in neonatal settings).[50] By contrast, Birthrights had to issue legal challenges against two health boards in Wales which offered

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[44] Welsh Government, 'Hospital visiting during the coronavirus outbreak guidance: July 2021' (updated 9 May 2022). [INQ000082810]
[45] Transcript of evidence of Judith Paget, 13 November 2024, p 170.
[46] Transcript of evidence of Judith Paget, 13 November 2024, p 149.
[47] Transcript of evidence of Jean White, 17 September 2024, p 136.
[48] Transcript of evidence of Dame Eluned Morgan, 20 November 2024, p 184.
[49] Letter from Vaughan Gething (Minister for Health and Social Services) to Dai Lloyd MS (Member of the Senedd for South Wales West) regarding the provision of maternity services during the COVID-19 epidemic, dated October 2020 [INQ000412562].
[50] PBPO Statement, §145 [INQ000408656_0044] and §157 [INQ000408656_0047].

less than two hours visiting on maternity wards, many months after guidance from the Welsh Government was issued requiring local risk assessments; and in Northern Ireland new mothers and babies were for months limited to having "visitors" once a week on postnatal wards.[51]

35. In England, there was no national guidance on how visiting restrictions should be applied in maternity and neonatal settings for almost the entire first year of the pandemic. While the NHS endorsed guidance co-produced by the RCM in September 2020, that was maternity specific. It is also relevant that the RCM are a trade union. Their position was (understandably, but importantly) taken from the perspective of protecting their members and advocating for their concerns.[52] They had no direct role in advocating for patients, although the RCM (along with the Royal College of Obstetricians and Gynaecologists, "**RCOG**") spent a significant amount of time chasing the NHS to request national guidance because of the difficulties they were having dealing with concerned and upset women and families without centralised rules.[53]

36. The delay in issuing modified nationwide maternity and neonatal care visiting guidance in England has not been adequately explained despite the attention given to this issue in Module 3. In August 2020, a report by Chief Nursing Officer Ruth May was provided to the COVID-19 National Incident Response Board.[54] The report recognised the need for national visiting guidance due to "*significant clinical and reputational risks associated with a delay in publishing national guidance*" and recognising both a significant detrimental impact on "*women's experiences and outcomes in maternity services; and on the reputation and credibility of the Maternity Programme's and wider NHS England and NHS Improvement's commitments to world-class evidence-based safe and personalised maternity care*". Tellingly, the report identified that there were unwarranted variations across England in lifting blanket restrictions; that there was a risk this led to perceptions of a postcode lottery; that being assisted by a supportive partner or other person was important for many women but "*essential for some*", including women for whom English was not a first language, with a risk that the rules would exacerbate health inequalities; and that each of the other four nations had already issued national guidance.

37. Following this, the NHS finally released guidance in September 2020 alongside the RCM, RCOG and the Society and College of Radiographers. It did not address neonatal visiting; nor did it identify that women and pregnant people's partners were essential visitors/care

[51] Statement of Shanthi Gunesekera and Janaki Mahadevan (Birthrights), §§6.1-6.3 [INQ000239418_0010].
[52] Transcript of Gill Walton, 7 October 2024, p 144.
[53] Statement of Gill Walton, §§35-42 [INQ000347411_0015, 17]
[54] COVID-19 National Incident Response Board, Meeting minutes re the publication of guidance on the reintroduction of visitors and accompanying adults to inpatient and outpatient maternity services (17 August 2020) [INQ000421230].

givers and that they should not be considered under a wider visiting framework; and continued to stress the need for social distancing, including suggesting that partners wait outside the hospital or in their car if it was not possible for them to be in a waiting room with their partner. That only exacerbated problems many pregnant people the PBPOs worked with identified. One of the women cited in the PBPOs' statement recalled:[55]

> *"It was one thing being completely alone in hospital when having my miscarriage confirmed and having to decide how to manage things. But knowing that the government were having parties at the same time is disgusting and fills me with so much anger. I remember meeting my husband at the entrance to the hospital to decide on how to manage things, I'll never forget the group of men standing there waiting for their partners come out from appointments and scans. It was so inhumane and a memory I'll never forget."*

38. Updated and more detailed NHSE guidance was finally approved in December 2020. For the first time it recognised that a support person should be seen as "*an integral part of both the woman and baby's care throughout and not as a visitor*"; and that parents of babies in neonatal care were "*partners in care*" and not visitors.[56] However, despite the original draft guidance directing Trusts to ensure partners were allowed to accompany pregnant women and people to hospital appointments "*at all times during her maternity journey*",[57] revisions substantially watered this down. The final guidance "*encouraged*" Trusts to facilitate women and pregnant people having support during the pregnancy journey, to use testing and to adapt spaces, but still left specific decisions to Trusts based on localised risk assessments.

39. The evidence the Inquiry has before it indicates that changes to tone down the guidance were in major part the result of lobbying by the RCM and RCOG,[58] in particular, and an intervention by Dame Jenny Harries.[59] Gill Walton was clear when giving evidence that the RCM saw their role as a membership organisation and were particularly focused on safety at work so that professionals could deliver safe care.[60] There was particular concern about some maternity environments which had insufficient space for social distancing. Ms Walton recognised that this created discrepancies between women's experiences across the NHS, and therefore caused distress and upset, and said: "*I'm not sure what the answer is to that other than make sure that women's services are the best, that the environment is perfect for now and for the next pandemic. Because I do believe that women and their partners should have had equal access to maternity services together but it just wasn't safe to do so in every*

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[55] PBPO Statement, Quote 61 [INQ000408656_0048].
[56] NHS, 'Supporting pregnant women using maternity services during the coronavirus pandemic: Actions for NHS providers' (14 December 2020) [INQ000330895_0002,0003].
[57] For example, as originally drafted: "*A woman therefore must have access to support from at least one person of her choosing at all times during her maternity journey (including all antenatal scans and throughout the totality of labour). All trusts must facilitate this with immediate effect.*" [INQ000071973_0001].
[58] See statement of Gill Walton at §§41-42 and the emails contained therein [INQ000347411_0017].
[59] See Jenny Harries' comments on the guidance and covering email [INQ000071973] [INQ000071972_0001].
[60] Transcript of evidence of Gill Walton, 7 October 2024, p141-144.

single service across the UK".[61] In addition to these lobbying impacts, by December 2020, sufficient time had passed that the UK was experiencing the second wave of Covid-19. That was necessarily a poor time for many hospitals to take any steps which could increase the risk of infection. However, it was the NHS' own delays which created this poor timing for the arrival of the December 2020 guidance.

40. The PBPOs are also well aware of, and share the RCM's concerns over, the variations in maternity services, infrastructure, and staffing across the country. However, the lack of work done between the first and second wave to address the factors which led to visiting restrictions being seen as necessary, particularly maternity staff's lack of confidence in other IPC protections in hospital settings, reflects a lack of prioritisation and response to this issue.

41. The Inquiry has heard extensive evidence that there was widespread concern amongst maternity staff (like other healthcare professionals) that the PPE they received, and the IPC guidance they were given, was insufficient.[62] Dr Morris considered that the shortages of PPE, alongside other concerns about the maternity estate, meant that for many healthcare providers limiting attendance for maternity-related appointments and scans "*likely felt the only feasible measure they could take to protect staff against contracting COVID-19*".[63] Gill Walton of the RCM described the anxiety levels as "*huge*" amongst the midwives her union represented. The feeling was that the Public Health England guidance was insufficient: "*I have said earlier that maternity services often gets forgotten, it is not seen as an essential service, and our members told us that access to PPE was really difficult. That guidance did not protect them.*"[64] These concerns were not specific to maternity care but there was clearly a widespread level of discontent amongst this segment of staff. This also must have influenced the approach taken by the RCM and RCOG.

42. The PBPOs emphasise, as the IPC experts highlighted, that restrictions and rules around visiting needed to be focused on balancing the risks against the benefits of particular types of 'visitors'. In the PBPO's submission, simple steps could have been taken to recognise the role of a partner in pregnancy, birth, neonatal care, and maternity-related support (and comparable lack of risk if from the same household). In particular, testing and adequate provision of PPE were obvious solutions to staff concerns about the risks of infection.

43. It was particularly disappointing that Matt Hancock gave evidence to the Inquiry that he was aware of the guidance being prepared in December 2020 and had tasked a private secretary

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[61] Transcript of evidence of Gill Walton, 7 October 2024, p148.
[62] See e.g. email from Jon Skewes to recipients re Midwives concern (24 March 2020) [INQ000410936]; Email chain between Birte Harlev-Lam and Sean O'Sullivan and others re PPE Concern (25 March 2020) [INQ000410937]; Witness Statement of Gerry Murphy for the Irish Congress of Trade Unions (23 Jan 2024) at §36 [INQ000409079_0013].
[63] Statement of Dr Morris, §69 [INQ000470853_0026].
[64] Transcript of evidence of Gill Walton, 7 November 2024, pp 126. See also p 85.

to work on it due to its importance as an issue but, despite being made aware that the guidance was being "*toned down*", took no specific steps to address the fears of NHS midwives and maternity staff which resulted in those groups pushing back on the guidance. That was despite Mr Hancock having said, in evidence to the Health and Social Care Committee on 8 September 2020, that he had "*heard loud and clear*" the call for better access to maternity and neonatal services and that he had "*taken it up with the NHS*".[65]

44. In respect of testing, the evidence before the Inquiry was of limited efforts to focus testing resources to allow visiting restrictions to be removed. Many witnesses, including the Chief Nursing Officers of England, Wales, and Scotland, considered better access to testing would have changed the nature of visiting restrictions.[66] Dame Ruth May said access to lateral flow tests earlier "*without doubt ... would have relieved a lot of anxiety and tension between staff and women and families and provided better outcomes or experiences*". Gill Walton of the RCM agreed that testing "*absolutely, definitely would*" have facilitated lifting visiting restrictions (alongside more PPE for midwives). She commented: "*I mean, it is interesting, isn't it, that -- I'm not sure now whether the testing was available elsewhere in the NHS before it reached maternity, but I think there was an issue there, again, maternity not being seen as a key part of NHS care, an essential service.*" There was no evidence to the Inquiry of specific efforts to prioritise access to testing in maternity-related care.

45. To the contrary, the PHA consulted with NHSE officials in January 2021 to discuss changes to testing regimes to enable visiting, including in maternity settings, but no changes were made until September 2021. Aidan Dawson accepted that this could be seen as a "*lack of timeliness*" on PHA's part.[67] He committed to reflecting on this issue further with his team but the PBPOs submit that the Inquiry should find that there was a lack of priority given to using testing to lift visiting restrictions.

46. There was also some evidence of misguided approaches to the impact which testing could have on visiting restrictions. Jenny Harries' evidence was that she edited NHSE visiting advice in December 2020 to remove the emphasis on using testing where social distancing was not available because she wanted to emphasise that testing would not "*remove all risk of Covid*".[68] This was too narrow an approach. The question should not have been whether the risk of any Covid-19 transmission could be eliminated (which was impossible), but whether the risks could be reduced sufficiently. Her approach was in contrast to approaches in other parts of society. For example, testing was used to enter nightclubs and even care homes, but not to decide whether you could accompany your partner while in early labour or

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[65] Oral evidence given by Matt Hancock for the Health and Social Care Committee (8 September 2020) [INQ000218365_0028]

[66] See e.g. transcript of evidence of Fiona McQueen, 17 September 2024, p 175; transcript of evidence of Jean White, 19 September 2024, p 134.

[67] Transcript of evidence of Aidan Dawson, 5 November 2024, p 108.

[68] Transcript, 6 November 2024, p 171-173.

to remain on the ward with her afterwards. The PBPOs submit that there was a failure to properly adapt visitor guidance from its initial restrictive approach as understanding about Covid-19 risks and technology to monitor those risks improved.

Under-appreciation of the impact of local, varied restrictions

47. A recurring theme in the evidence heard by the Inquiry, and in the emphasis of decision-makers during the pandemic, was that individual hospitals, Trusts and/or health boards were permitted to vary visiting restrictions depending on their particular IPC needs. On analysis, this was flawed reasoning. The PBPOs submit that the consistent emphasis of many senior decision-makers on the benefits of local flexibility[69] overlooked (a) the evidence of the PBPOs and others about the serious detriments from women and pregnant people's anxiety about what rules would apply to them and (b) the impact of staff anxiety over Covid-19 infection which may have encouraged visiting restrictions as a substitute for other forms of protection.

48. As to (a), Jenny Ward explained to the Inquiry that women and pregnant people were well aware of differences even locally and that created a real anxiety for them entering hospital: *"So families picked that up. They knew, well, I know somebody who is in here and they are allowed to do that, why am I not? And we didn't have the answers for them to be able to say that. Usually we would hope that we could reassure families and say, you should be allowed your partner at this point, and we simply couldn't do that."*[70] Gill Walton of the RCM also spoke about the anxiety and confusion midwives were witnessing firsthand, as women discussed different localised rules on social media.[71]

49. As to (b), the PBPOs have set out above the concerns of pregnancy and maternity, maternity-related, and neonatal staff about the poor levels and quality of PPE and overall discontent with the IPC measures that were being put in place in hospitals in particular (see [41]-[43]).

50. In those circumstances, it is little surprise that local decisions were often highly restrictive. As Dr Morris of RCOG identified (despite his organisation's own concerns about visiting rules), at times there was also simply an "*overly stringent*" application of discretionary rules in place.[72] The PBPOs invite the Inquiry to find that there is an obvious risk that staff who were scared and lacking basic PPE may have been influenced by their fear into endorsing or implementing stricter visiting rules than were actually necessary (particularly in light of the IPC evidence, or lack thereof).

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[69] See e.g. transcript of evidence of Sir Stephen Powis, 7 November 24, p 58; transcript of evidence of Humza Yousaf, 19 November 2024, p 140; transcript of evidence of Judith Paget, 13 November 2024, pp 148-149.
[70] Transcript of evidence of Jenny Ward, 7 October 2024, pp 39-40.
[71] Transcript of evidence of Gill Walton, 7 October 2024, pp 86-87.
[72] Statement of Dr Morris at §75 [INQ000470853_0029].

51. While the PBPOs often held different views to the staff unions about the extent of the visiting restrictions needed in maternity-related and neonatal settings, they appreciate the need to protect staff and to reassure them about the risk of infection. In that light, it was disappointing that the Inquiry did not receive any evidence about any efforts made by senior decision-makers or political leaders to address those concerns so as to facilitate lifting those restrictions. Indeed, Matt Hancock told the Inquiry that he was aware of the concerns from women, pregnant people, and new parents about the visiting restrictions and recalled meeting with Bliss in September 2020 to discuss this. As set out above, he had made specific commitments to address these issues to a Select Committee. Despite this, he could identify no specific steps he took to address maternity staff's concerns and fell back on the generic need for testing to increase for all groups rather than offering any specific solution to the issues facing women, pregnant people and new parents.[73] Similarly, the best other witnesses could say was that, if testing had been available, it would have allowed things to be different.[74] But testing was available and at no point was earmarked or prioritised for maternity-related care. These responses were disappointing and showed the relative lack of prioritisation given to maternity-related care and to women and pregnant people receiving proper support.

52. Looking forward, the PBPOs appreciate that, at times where infection levels were high, it may be difficult to enforce mandatory nation-wide guidance on visiting, although they continue to emphasise the need for better PPE and other protective measures for healthcare staff, to reduce the reliance on visiting restrictions as an emergency stop-gap. But, where staff were concerned and implemented local restrictions, the missing pieces of the puzzle were (a) guidance based on the key principle that early pregnancy, antenatal, maternity, and neonatal visitors provide essential care, (b) provision of a more explicit balancing of the benefits (and harms) of visiting restrictions as against their IPC benefits and (c) a robust system for monitoring those restrictions and ensuring they were and remained proportionate and necessary as the underlying factors changed.

53. As to (a) and (b), although many midwives knew how crucial supporters are during maternity-related care, senior decision-makers clearly did not have such a nuanced understanding. That was reflected in the initial decisions to lump partners and carers in with all other forms of visitors. Equally, there was a lack of evidence for visiting restrictions particularly on partners from the same household and limited appreciation of this fact. Ultimately, where decisions are left to local decision-makers' discretion, those decision-makers must have core guiding principles and evidence-based information as the foundation of their decisions. The RCM agrees with this approach. In questioning, Gill Walton agreed a national framework for visiting to ensure consistency, predictability and support for decision-

[73] Transcript of evidence of Matt Hancock, 22 November 2024, p 23-24.
[74] Transcript of evidence of Robin Swann, 18 November 2024, pp 178.

makers would have been helpful not just to assist with assessing what services they could or should provide, but also for clearly communicating to local populations.[75] The PBPOs would also support a centralised framework with key principles of access enshrined.

54. As to (c), to the PBPOs' knowledge, there was no systematic monitoring of the local systems (either across the four nations or within the four nations) to ensure any additional or different restrictions imposed were consistent and properly reflected local infection rates and/or that all alternatives had been tried (e.g. PPE, testing). In short, there was no way for the centralised decision-makers to track what was happening across local NHS Trusts and health boards. At its highest, Jeanne Freeman described that when the Scottish Government became aware of more restrictive practices in a particular area, they contacted the particular hospital or setting to remind them about national guidance and steps they could take to mitigate any concerns about IPC.[76] There was no equivalent evidence of scrutiny in England, Wales, or Northern Ireland. However, Ms Freeman's evidence is not altogether reassuring: it relied on women and charities like the PBPOs speaking up and drawing concerns to decision-makers' attention, particularly given that Scotland was not requiring any data to be collected about maternity services in the way that England was doing (see below at [92]).

55. From June 2020, England collected 'SitRep' data setting out the limitations on partners attending hospitals with pregnant women or people;[77] and from June 2021, began collecting equivalent data about neonatal visiting.[78] Undoubtedly, recording this information will have encouraged some monitoring, but there has been no evidence about any robust patterns of scrutiny to ensure IPC restrictions were warranted. It was, put simply, not enough to rely on local staff, who were themselves over-worked and scared, to implement such momentous decisions.

56. There needed to be greater understanding from the central decision-makers about what was actually happening across the UK. The PBPOs consider there was insufficient knowledge about what women, pregnant people, and new parents were really facing on the front lines. Indeed, it may surprise many of those who gave evidence to the Inquiry to learn that across the UK visiting restrictions continue to be implemented including in neonatal settings as an IPC measure.[79] The Inquiry should make clear that visiting restrictions should only be implemented as a last line of defence and that any restrictions on support in maternity-related services must be particularly carefully scrutinised for need and proportionality.

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[75] Transcript of evidence of Gill Walton, 7 October 2024, pp 90-91.
[76] Transcript of evidence of Jeanne Freeman, 19 November 2024, pp 76.
[77] Statement of Sir Stephen Powis, §1245 [INQ000485652_0343].
[78] 'Maternity transformation programme COVID-19 response and recovery SitRep summary slides' (7 Oct 2021) [INQ000421197_0010].
[79] See for example, the PBPO Statement at §195 [INQ000408656_0059]

Recognition of problems with visiting guidance for maternity-related care

57. The PBPOs have welcomed recognition by some officials of failures in the visiting guidance. The PBPOs submit that this reflects a relative consensus around this issue:

(a) In Wales, Vaughan Gething said, in hindsight, more might have been done to enable visits in maternity and particularly on how to review the evidence for the restrictions as against the harms done in practice over time.[80] He made the sensible point, set out above, about the need to view parents and households as a unit. He accepted that increasing the use of PPE could also have affected the balance of risk and that this would have required having more PPE in the stockpile to be used. Chief Nursing Officer Jean White and Baroness Eluned Morgan both specifically reflected on neonatal visiting. Ms White acknowledged Bliss' work on neonatal care, as noted above, and agreed that in the future, she would have liked to be more permissive earlier. Baroness Morgan agreed and said frankly that, if she had her time again, she would definitely have introduced guidance for birthing partners being recognised as "*partners in care*" and not visitors earlier,[81] and acknowledged that she "*took too long*" to make changes to neonatal restrictions to allow parents to be at their baby's cotside together.[82]

(b) In Scotland, Humza Yousaf acknowledged the Scottish Government had needed to make changes to address the "*considerable hurt, anxiety and anger*" about initial restrictions in maternity and neonatal settings, although this was partially caveated by his view that the changes they had made during the pandemic had alleviated this problem. Jeanne Freeman acknowledged that the issue was around operational delivery of the national guidance which was too strict, particularly as the virus became better understood and the pandemic evolved.[83] Caroline Lamb likewise identified that maternity and neonatal visiting guidance in July 2020 was intended to address concerns that the initial guidance, and particularly reference to 'essential visitors', was being interpreted overly strictly in maternity care. She said "*So we felt it was important that we clarify the expectations around ... women being able to be accompanied to antenatal appointments, to being able to have an essential visitor, a designated birth partner, but also someone else, and in certain circumstances more than one person, and ... in neonatal units, for example, parents not being defined as visitors but being able to access those units.*"[84] Her view was that it was a key learning for the Scottish Government that there was a need for service-specific guidance for maternity-related and neonatal care from the outset. She thought that would have helped with addressing issues around variation in restrictions and helping communicate with women about what they could expect in services.

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[80] Transcript of evidence of Vaughan Gething, 20 November, p 82.
[81] Transcript of evidence of Baroness Morgan, 20 November 2024, p 143.
[82] Transcript of evidence of Baroness Morgan, 20 November 2024, p 143.
[83] Transcript of evidence of Jeanne Freeman, 19 November 2024, p 76.
[84] Transcript of evidence of Caroline Lamb, 14 November 2024, pp 158-159.

(c) In England, Sir Stephen Powis similarly accepted that the NHSE "*could have been clearer*" earlier in defining birthing partners as partners in care rather than 'visitors', which did not occur until 14 December 2020. He considered it was a "*lesson for next time*" in ensuring that proper distinctions were drawn between the healthcare support team and visitors[85] When asked about what "*did not go well*" in the response, Chief Nursing Officer for England, Ruth May, specifically identified that maternity visiting guidance could have been more specific earlier about extending access for birthing women to their partners throughout the entirety of labour, which would have been better for women, for partners and for staff.[86] These reflections were a notable contrast to the evidence of former Secretary of State Matt Hancock, who despite being aware of concerns about visiting since June 2020, continued to insist in retrospect that the restrictions were appropriate. Mr Hancock did accept, in questions from the UK Covid Bereaved Groups, that such restrictions should be drafted and planned in advance rather than reactively made. The Inquiry may consider that this reflected a general lack of reflection from Mr Hancock; in the PBPOs' view, his view does not reflect the balance of evidence before this Inquiry.

58. On any view, and whatever the reason, it took too long for changes to occur to facilitate greater access once the issues had been identified. There was an ongoing failure to help midwives and nurses at the coalface feel that they could allow women and pregnant people to be accompanied by supporters throughout their maternity journey or for both parents to have access to their vulnerable neonatal babies. The PBPOs urge the Inquiry to reflect in its conclusions and recommendations the open recognition by senior decision-makers that there were delays in fixing the issues around visiting in maternity-related and neonatal care.

C. WOMEN AND PREGNANT PEOPLE'S HEALTHCARE DURING COVID-19

Stay at Home, Protect the NHS: unintended, but foreseeable effects

59. A repeated theme throughout the Inquiry, and across a number of different interest groups, has been the concerns about the effect of the 'Stay at Home, Protect the NHS' messaging used during the pandemic in deterring people from seeking healthcare. This had a serious impact in the case of pregnant people and their families, particularly in combination with the decision to deem pregnancy as creating clinical vulnerability to Covid-19, and put women off seeking medical assistance.

60. The experience across the PBPOs was that some women delayed access to care because of fears of going to hospital. Jenny Ward described for the Inquiry frankly that the messages they received from women and pregnant people was of "*people pulling back, thinking, well, I have been told to stay at home. We have also been told that healthcare -- places like hospitals are overwhelmed. We are also worried about Covid. We have been told that in*

[85] Transcript of evidence of Ruth May, 7 Nov 2024, pp 119-120.
[86] Transcript of evidence of Ruth May, 17 September 2024, p 73 and 88-89.

pregnancy we are particularly vulnerable. ... So yes, people held back and yes, there were difficult situations as a result of that."[87]

61. The "*difficult situations*" which resulted included material impacts on the health of some women. The PBPOs set out some of these in their opening statement, such as the increase in free-birthing and the Healthcare Safety Investigation Branch ("**HSIB**") findings on the impact of delays on some women's care.[88] There was a long tail to these impacts: it is notable that concerns were still being raised in Northern Ireland about increases in free birthing in September 2021, indicating the long tail impact of dissuading women from engaging with hospital services.[89] The PBPOs also note the tragic reports from MBRRACE-UK[90] which found that three women between March and May 2020 died at home or presented to hospital late, either because of reluctance to attend hospital for fear of infection, or due to following advice to stay at home.[91] More generally, Ms Ward on behalf of the PBPOs also explained to the Inquiry that many conditions in pregnancy can only be picked up face-to-face and through specific testing,[92] leaving long-term impacts if such face-to-face interactions are skipped. Dr Morris of RCOG described that RCOG members were "*seriously concerned*" about the adverse impacts of women not attending and highlighted in his statement studies which indicated a rise in stillbirth and pre-term delivery for pregnant women not infected with Covid-19 during this period.[93]

62. The impacts of the blanket 'stay at home' messaging were felt by all the PBPOs. However, it is worth noting the particular concerns of groups like The Miscarriage Association and The Ectopic Pregnancy Trust and Pregnancy Sickness Support. There is an obvious importance in those experiencing miscarriage or ectopic pregnancy receiving prompt medical assistance; similarly, those experiencing severe pregnancy sickness can face very serious consequences including dehydration and require medical assistance.[94] The PBPOs' experiences was that these were the very same groups who were deterred by the 'stay at home' messaging. Sir Stephen Powis accepted in questioning that the 'Stay at Home' messaging could have been one reason for a decline in inpatient admissions for miscarriage during the pandemic, in the

[87] Transcript of evidence of Jenny Ward, 7 October 2024, p 26.
[88] PBPO Opening Statement, §22.
[89] See Chair's brief, Swansea Bay UHB IQPD meeting, regarding Unpublished waiting time performance position (15 November 2021) [INQ000412564].
[90] MBRRACE-UK: Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK.
[91] MBRRACE-UK, 'Saving Lives, Improving Mothers' Care, Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK' (March - May 2020). [INQ000221912_0004]
[92] Transcript of evidence of Jenny Ward, 7 October 2024, pp 24-25.
[93] Statement of Dr Morris, §50 [INQ000470853_0018].
[94] PBPO Statement, §§44-45.

context of studies showing that 40 per cent of women and pregnant people had not been able to access preferred management methods for their miscarriage.[95]

63. Remote care was a useful alternative option for many, and the PBPOs have been keen to note the advantages it had for some groups,[96] but it is not a complete substitute for in-person healthcare. Jenny Ward also explained that it shut out those experiencing digital poverty, and often aggravated issues of access for other groups with pre-existing inequalities.[97] The evidence was clear that there was particular reluctance to attend maternity services from Black, Asian, and ethnic minority groups. That should have been concerning in and of itself but took on more significance once it became known that a majority of the pregnant women admitted to hospital, or dying of Covid-19, were from ethnic minority backgrounds.[98] When asked in questioning by Counsel to the Inquiry about this, Dame Ruth May could not identify whether there was any evidence that the (limited) interventions to address this had been successful.[99] Indeed, the evidence that she pointed to consisted of (1) a letter from the CMO in June 2020 to local maternity services giving a generic direction to maternity units to begin "*reaching out and reassuring pregnant BAME women with tailored communications*" and (2) a follow up communications toolkit, not published until January 2021.[100]

64. Dame Ruth May accepted in questioning that in hindsight the message should have been "**stay at home but not if you're pregnant**".[101] Although some senior level decision-makers continued to defend the broad stay at home messaging (notably former Secretary of State for Health Matt Hancock),[102] the Inquiry may again consider that this reflected an overall defensive and non-reflective position adopted by Mr Hancock. The PBPOs are clear that a more nuanced approach in communications was needed from the outset.

65. In particular, the PBPOs submit that the inequities in maternity care experienced by women from Black, Asian, and other minority ethnic backgrounds were well-known and should have been able to be addressed from the very beginning of the pandemic. As Jenny Ward summarised, the PBPOs were "*shocked but sadly not surprised*" by the inequalities in

[95] Transcript of evidence of Sir Stephen Powis, 11 November 2024, pp 6-7.
[96] PBPO Statement, see inter alia §104, §202 and §239.
[97] Transcript of evidence of Jenny Ward, 7 October 2024, pp 24-25.
[98] MBRRACE-UK, 'Saving Lives, Improving Care: lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2019-2021' (October 2023) [INQ000399403_0010] and NHS, NHS boosts support for pregnant black and ethnic minority women (27 June 2020) [INQ000280429].
[99] Other than referring to a CQC study had showed that a majority of women (including BAME) felt they had enough information about their pregnancy (which, respectfully, did not indicate the interventions had been tested for efficacy and did not answer whether those same women felt safe to come into hospital or were properly or adequately accessing healthcare). See transcript of evidence of Dame Ruth May, 17 September 2024, pp 70.
[100] NHS, Communications toolkit for local maternity teams to improve communications with Black, Asian and minority ethnic women (13 January 2021). [INQ000421195]
[101] Transcript of evidence of Dame Ruth May, 17 September 2024, p. 69.
[102] Transcript of evidence of Matt Hancock, 21 November 2024, p 1.

maternal mortality rates and Covid-19 rates among minority ethnic groups: "*I would certainly hope that they should have been a high-risk group from the very beginning that everybody tried to focus on; ... I think with -- we would have hoped the communications around that would have recognised that in a bit more detail than possibly they did.*"[103] This was echoed by Gill Walton of the RCM, and her impression was that there was limited engagement by the Government and again a failure to recognise the importance of the impact this messaging had, and the need for attention to maternity services to redress that issue: "*We particularly wanted those women who were more likely to have a poor outcome to have a higher profile and for there to be a focus on them and clearer support and communication for staff to deliver different services to that group of women.*"[104] The PBPOs consider it was disappointing these obvious points were not picked up earlier by decision-makers.

66. The 'Stay at Home' tag line appeared to have been developed without the input of medical professionals, given Sir Stephen Powis' observation that the messaging had been developed by the Cabinet Office communications team.[105] There was an obvious, and appreciated, effort by medical professionals to counter that messaging and to try and encourage anyone needing healthcare treatment or advice, particularly women and pregnant people, to seek such assistance. However, the effect of the overarching wider messaging was widespread and much more prevalent. The PBPOs ask the Inquiry to recognise these impacts and to note the unintended consequences of this messaging. In the future, any communications strategy should account for facilitating essential care, that will necessarily not stop during a pandemic, and should pay specific attention to the groups who are already disadvantaged including Black and Asian women and other ethnic minorities.

Belated, and insufficient, recognition of maternity-related care as essential

67. It should be stating the obvious to observe that maternity, early pregnancy, antenatal and neonatal services cannot stop or be paused, even during a pandemic. This was eventually recognised across the NHS and all four nations' healthcare services identified that maternity-related care was an essential service. However, there was a significant impact on available maternity services during the pandemic and an initial redeployment of specialised maternity staff. This was compounded by the systemic problems around staffing, from doctors to nurses to midwives, in maternity-related care. As Dr Morris of RCOG said: "*The pandemic ... put additional pressure on a service that was already struggling with low staffing levels, which had no reduction in the demand for its services during the pandemic*".[106] Indeed, Dr Morris was of the view that pre-pandemic, the availability of staff in maternity services was "*inadequate to consistently deliver safe, quality, personalised care*", [107] which is a shocking

[103] Transcript of evidence of Jenny Ward, 7 October 2024, p 37.
[104] Transcript of Gill Walton, 7 October 2024, pp 134-135.
[105] Transcript of evidence of Sir Stephen Powis, 7 November 2024, pp 160-161.
[106] Statement of Dr Morris at §89 [INQ000470853_0034]
[107] Statement of Dr Morris at §89 [INQ000470853_0034]

indictment of a system providing such a crucial service and suggests any changes during the pandemic were likely to have an outsize impact.

68. A number of maternity staff were redeployed at the outset of the pandemic, which caused significant problems for maternity services. Dr Morris of RCOG identified that this, amongst doctors, particularly impacted on junior grade doctors and locally employed doctors. There was also redeployment of nurses and midwives who were dual qualified which affected staffing levels. There was also an impact on, for example, the availability of anaesthetists which was recognised very early on in the pandemic as having an impact on the availability of healthcare, including epidurals.[108] Gill Walton of the RCM explained why access to anaesthetists were crucial beyond simple pain relief: there is usually only one anaesthetist in a maternity unit, so that doctor is required for emergencies such as if a woman collapses or an emergency caesarean section is needed; in addition, the impact of not having an epidural and suffering extraordinary pain can, and has, left some women traumatised.[109] In wards which already had low staffing levels, and on top of the impact of Covid-19 infections, redeployment had a large impact on the care which could be provided.

69. The PBPOs are also conscious of the impacts on redeployment for staff, who were asked to work in entirely new areas outside of their specialisms. Midwives reported feeling isolated and detached from support networks and having a lack of consistency in inductions and orientations, i.e. their training. The midwives who remained felt that they were picking up the burden from the changes to GP services and in social work and so were being used to "*absorb the risks elsewhere in healthcare without taking into account the challenges faced in delivering a safe maternity service during that time*".[110] 85 per cent of doctors reported a significant change in ways of working and 82 per cent noted a reduction in training opportunities. The remaining consultants, specialty, and middle grade doctors were placed under "*increased and unsustainable stress*" trying to run an essential practice whose demand had not ceased with a missing part of their workforce.[111]

70. Both the RCM and RCOG called for the redeployment of maternity staff to end. The RCM were reassured by early April 2020 that this had been broadly accepted by the Chief Midwifery Officers. However, redeployment did not immediately end for staff who had already been shifted. RCOG issued formal recommendations to the NHS asking for maternity redeployment to cease in June 2020 by memorable analogy: "*in simplistic terms, if organisations are not removing doctors from the emergency department they should not*

[108] Memo from Chief Midwifery and National Maternity Safety Champion to CNO Ruth May (23 March 2020) [INQ000421159_0002]
[109] Transcript of evidence of Gill Walton, 7 October 2024, pp 115-116.
[110] RCM submission to the Scottish Covid Inquiry, 'Overview of Key Themes relating to the Impact on our Members Working in the Healthcare Sector' (5 July 2023) [INQ000376405 _ 0006].
[111] Report from RCOG, 'Summary: Survey response of RCOG members on experiences of staffing changes during the COVID-19 pandemic' (June 2020) [INQ000308988].

consider removing doctors providing maternity care until they have exhausted all other options."[112] The ringfencing was also inconsistent: Ms Walton recalled that staff were still contacting them about being redeployed much later into the pandemic, such that in the second wave of the pandemic, the RCM contacted NHS England to re-clarify that maternity staff were essential and staff should not be redeployed.[113] By December 2020, RCOG surveys indicated the majority of redeployed staff had been returned and Ms Walton also indicated the later warnings by the NHS to avoid redeployment were heeded. However, a report to the COVID-19 National Incident Response Board on 30 July 2021 again identified as an impact of the second wave the risk of obstetric anaesthetists being redeployed into ICUs.[114] This was clearly a risk which had to be continually managed.

71. There was also redeployment and the cessation of some services outside hospital, particularly in postnatal care. In particular, face-to-face health visitor and bereavement care work was stopped altogether.[115] Up to 63% of health visitors were redeployed in some areas and contact with new families was reduced from five contacts plus additional support as needed to being limited to only antenatal contact and the new baby visit.[116] Health visitors have a crucial safeguarding role for young babies, as Jenny Ward explained orally to the Inquiry, and as is set out in important detail by Alison Morton of the Institute of Health Visiting in her statement. Health visitors are specialist public health nurses and often focus on contact with the most vulnerable. They also play a safeguarding role in monitoring new parents and babies and also facilitate The Lullaby Trust's safe sleep programmes including Care of Next Infant ("**CONI**"). As Ms Ward explained, in-person visiting allows those nurses to pick up on new mothers' mental health, check where the baby is sleeping, and also provides a space for new families to open up and ask questions.[117] The collective PBPOs' experience was that new parents were left much more isolated without face-to-face support.

72. The 'stop' on health visitor work was lifted on 3 June 2020 with new guidelines on community services. Again, this did not mean that redeployment had ceased and the Institute of Health Visiting had to continue to campaign for their staff's return. In August 2023, the Institute reported that health visiting services had not been reinstated either to pre-pandemic or to optimum levels.[118] This appeared to be partially because the rebuilding of health visiting

[112] Report from RCOG, 'Summary: Survey response of RCOG members on experiences of staffing changes during the COVID-19 pandemic' (June 2020) [INQ000308988_0005]
[113] Transcript of Gill Walton, 7 October 2024, pp 107-108.
[114] INQ000421240_0003.
[115] Transcript of Jenny Ward, 7 October 2024, pp 61-63; PBPO Statement at §§86, 91-92, 110-113, 185; Witness Statement of Alison Morton, CEO of the Institute for Health Visiting (7 April 2024) [INQ000411557].
[116] Witness Statement of Alison Morton, CEO of the Institute for Health Visiting (7 April 2024) at §24 [INQ000411557_0010].
[117] Transcript of Jenny Ward, 7 October 2024, pp 64-65.
[118] Witness Statement of Alison Morton, CEO of the Institute for Health Visiting (7 April 2024) at §66 [INQ000411557_0036].

services was left to local decision-making without any additional funding or a national workforce plan.[119] Dame Ruth May acknowledged that she was made aware about the concerns about redeployment of health visitors. She said clearly to the Inquiry that in a "*future pandemic health visitors should stay being health visitors, they should not be redeployed, and then they would have more ability to do the face-to-face contact.*"[120]

73. There were other factors which impacted on staffing levels. Ms Walton explained that maternity care is a largely female workforce and there were a high proportion of midwives and maternity support workers who were pregnant, and therefore deemed clinically vulnerable;[121] and later in the pandemic, exhausted midwives chose not to continue.[122] This also affected the services that could be provided (see further below, at [91]-[95]).

74. In general, in hindsight and after lobbying by the RCM, RCOG and other groups during the pandemic, there was widespread consensus amongst senior decision-makers that maternity services were essential. As well as Dame Ruth May's specific recognition of health visitors, she also described both antenatal and postnatal care as essential and needing to be prioritised during a pandemic. Sir Stephen Powis also specifically agreed that maternity care should not be redeployed to other services during a pandemic, because maternity care is an essential service and because training in maternity care is highly specialised.[123] That recognition is to be welcomed. However, the PBPOs submit that recognition still needed to be reflected in emergency health crisis planning and in implementing urgent changes to the health system; and that there was a failure (particularly at the outset) to adequately consider the impact of Covid-19 related restrictions and changes on early pregnancy and maternity-related services. That failure was reflected in the initial redeployment decisions and the lack of any subsequent assistance or resource provided for maternity care to continue at a high level. Simply telling staff that services were essential did not solve the underlying lack of capacity in the system at various points in the pandemic.

75. There is often a misconception that pregnancy and maternity-related care is straightforward or that women will simply "get on" with being pregnant. That is far from the truth. Maternal health is complex: pregnancy can pose a risk to women and pregnant people's lives and many women, pregnant people, new parents, and their families will experience pregnancy or baby loss. The PBPOs emphasise to the Inquiry that the failures to provide sufficient or adequate care throughout pregnancy, giving birth and in early parenting were far from minor inconveniences, or denial of women's "preferred choice" in care, which could be sacrificed

[119] Witness Statement of Alison Morton, CEO of the Institute for Health Visiting (7 April 2024) at §59 [INQ000411557_0023].
[120] Transcript of evidence of Dame Ruth May, 17 September 2024, pp 76-77.
[121] Transcript of evidence of Gill Walton, 7 October 2024, pp 111-112.
[122] Transcript of evidence of Gill Walton, 7 October 2024, pp 111-112.
[123] Transcript of evidence of Sir Stephen Powis, 7 November 2024, p 151.

to the wider goal of preventing the spread of Covid-19. As Ziggy's Mum, Catherine Todd, powerfully explained to the Inquiry at the beginning of Module 3, the impact of losing Ziggy during Covid-19 will stay with her and her family for the rest of their lives.[124] Other women have also, repeatedly, explained to the Inquiry and in other surveys and reports, the long-term trauma they suffered from the care they received during Covid-19, including serious consequences arising from the failure to provide epidurals or those who suffered PTSD due to their poor experience in birth or miscarriage.[125] The impacts of these decisions were significant and long-lasting.

76. Like the RCM, and as Baroness Hallett herself identified as a potential issue during Gill Walton's evidence, the PBPOs submit it is reasonable to infer that the lack of prioritisation for women and pregnant people's healthcare was because maternity care-related services are often structurally overlooked as healthcare "*by women, for women*".[126] As the RCOG noted, if doctors and staff in the emergency department were not being redeployed because it was recognised that the emergency department needed to keep its doors open, why were maternity staff not protected early on? The Inquiry must address in its findings not just whether maternity-related care was called essential but whether it was in practice treated as essential care and whether the facility for ensuring women received adequate care was retained. On the evidence, it was not.

Early Pregnancy and Antenatal Care, including care for those experiencing Miscarriages and Ectopic Pregnancy

77. The nature and availability of care for those in the early stages of pregnancy and antenatal care changed significantly during the pandemic. While some changes were clearly required, the PBPOs were concerned that the adaptations were sometimes made without thought for the health trade-offs associated with them. This was particularly evident in the management of miscarriages and ectopic pregnancies.

78. In respect of antenatal care, the major shift was from in-person antenatal care to remote care. Moreover, some women were reluctant attend in person for antenatal care due to concerns about Covid-19, as addressed above. Antenatal care is clearly essential because it allows medical staff to address early potential clinical problems for the pregnant person and baby to allow safe birth. However, Dr Morris of RCOG identified instances where "*blanket changes to service provision to maximise capacity to manage Covid-19 patients were not based on evidence and did not recognise the importance of antenatal appointments as part of an essential service*".[127] RCOG and the RCM subsequently issued guidance on how best to

[124] As set out above.
[125] Statement of Jenny Ward on behalf of the PBPOs, §59, Quote 10 [INQ000408656_0017]; J Sanders and R Blaylock, 'Anxious and traumatised' Midwifery Journal (8 June 2021), p 4, [INQ000308999_0005].
[126] Transcript of evidence of Gill Walton, 7 October 2024, pp 139-141.
[127] Statement of Dr Morris, §48, [INQ000470853_0017].

manage the stepping down of antenatal appointments where necessary to try and manage this process and ensure that base minimum levels of safety were maintained.

79. One study found that in May to July 2020 70% of units reported a reduction in antenatal appointments; 89% were using remote consultation methods; over two-thirds had changed the screening pathways for gestational diabetes; and just over half of units had reduced the provision of foetal growth surveillance scans for babies at risk of being small for gestational age.[128] The modifications in most units consisted of a reduction in the number of antenatal contacts offered by any method. The study noted that RCM and RCOG guidance had not recommended any stop to emergency antenatal appointments and yet these had also reportedly reduced.

80. By any measure, the changes to antenatal care were significant and (as the above study concluded[129]) the PBPOs submit that further research is required to ascertain the impact on maternal or perinatal outcomes. Some groups the PBPOs worked with responded well to remote consultation. But these efforts inherently risked missing those who needed help the most. Other studies indicate very real impacts: stillbirths increased "*significantly*" during the pandemic period and it has been suggested that increase could be linked to reluctance to attend hospital settings given the evidence that women were missing antenatal care.[130]

81. Caroline Lamb was asked extensively about maternity care and Covid-19. She confirmed that there were no NHS Scotland national-level plans put in place for antenatal care, maternity services, and postpartum care between notice of Covid-19 first being received and 1 March 2020. By inference, there were no plans for early pregnancy care at this stage either. Further, no advice was sought about the negative health impacts of a reduction in face-to-face care.[131] Ms Lamb's evidence highlighted a consistent theme of concern from the PBPOs and others working in maternity-related care about the relative focus given to non-Covid healthcare when responding to the pandemic. As Dr Morris highlighted, through examples reported to RCOG and indeed in his own Trust, at times "*blanket changes to service provision [were made] to maximise capacity to manage COVID-19 patients*" which were not evidence-based.[132] The lack of understanding about the importance of pregnancy-related care, particularly in early pregnancy and antenatal care, clearly impacted the decision-making. Ms

[128] Jardine et al, Maternity services in the UK during the coronavirus disease 2019 pandemic, British Journal of Obstetrics and Gynaecology (20 August 2020) [INQ000176659].
[129] Jardine et al, Maternity services in the UK during the coronavirus disease 2019 pandemic, British Journal of Obstetrics and Gynaecology (20 August 2020) [INQ000176659_0008]
[130] Statement of Dr Morris, §50, [INQ000470853_0018], citing Khalil et al, Change in the Incidence of Stillbirth and Preterm Delivery During the COVID-19 Pandemic, *JAMA* (10 July 2020) [INQ000308958_002].
[131] Transcript of evidence of Caroline Lamb, 14 November 2024, §149 and §§156-158.
[132] Statement of Dr Morris, §48 [INQ000470853_0017].

Lamb's evidence also indicates that no analysis of the potential consequence of adaptations was ever undertaken.

82. Certainly, the PBPOs can also point to the effects of changes in care during early pregnancy. The impact of the 'Stay at Home' messaging, as highlighted above, was particularly acute for this group as were moves away from face-to-face care. As noted above, there were some women experiencing miscarriage or ectopic pregnancy who were put off from seeking medical advice. Those who did seek medical assistance were not always able to actually access any services: 10 per cent were unable to receive face-to-face appointments despite suffering miscarriage, and a quarter of that group received no care at all.[133] As detailed in the PBPOs' opening statement, in respect of ectopic pregnancies, the guidelines adopted by NHS England were that surgical management would only be considered if no other management option was feasible.[134]

83. One woman recounted taking three weeks to have a missed miscarriage diagnosed and a further week for her treatment to be booked, resulting in her miscarrying at home. She was told by hospital staff to take a paracetamol.[135] Her experience echoed that of many others who did not receive adequate advice on pain levels, amount of bleeding and how to manage it, and what to do with the baby or pregnancy remains.[136] These experiences were sufficiently traumatising that some women reported suffering PTSD.[137] The sense, as Jenny Ward explained in her evidence, was that women were being encouraged to take a "*managed wait*", i.e. to stay at home and let nature take its course, and that generally miscarriage was being downplayed as 'just something that happens'.

84. Sir Stephen Powis was asked about the recommendations of the All-Party Parliamentary Group ("**APPG**") on Baby Loss which, in August 2020, called on NHS England and the DHSC to swiftly reinstate treatment options for pregnancy loss in all NHS Trusts. It is submitted that he gave no adequate explanation as to why this recommendation was not followed. He said, somewhat generically, that although there was an intention to get services back to as near normal as possible after the first wave, balances had to be made.[138] This is an insufficient explanation. The PBPOs invite the Inquiry to find that there was a lack of attention and prioritisation not just to maternity-related services but particularly to early pregnancy services and the impact of Covid-19 decisions on this form of care.

[133] PBPO Statement, §54 [INQ000408656_0016].
[134] Statement of Sir Stephen Powis, §1180 [INQ000485652_0320]
[135] PBPO Statement, Quote 8, [INQ000408656_0016].
[136] PBPO Statement, §59 [INQ000408656_0017].
[137] PBPO Statement, Quote 10 and Quote 17 [INQ000408656_0017, 18].
[138] Transcript of evidence of Sir Stephen Powis, 11 November 2024, pp 8-9.

Bereavement Care

85. Unfortunately, bereavement care was not given adequate attention in Module 3, despite the PBPOs' call for it to be prioritised in its Opening Statement. The PBPOs understood the Inquiry's position, at times,[139] to be that bereavement care was not part of healthcare. Respectfully, that is an outdated understanding which fails to appreciate the significance of parents and families suffering from bereavement and the long-term health impacts which can arise if they are not adequately supported. The PBPOs consider that best efforts should have been made to provide bereavement support and to deal sensitively with women and new parents whose babies had died; even taking into account the pressures on staff, the evidence suggested women's experiences during Covid-19 were very poor.

86. Bereavement care in the UK was significantly affected by Covid-19 related restrictions or rearrangement of services. This was particularly relevant for those who miscarried or had ectopic pregnancies but also for those whose babies were stillborn or died in early infancy. The issues were exemplified by Catherine Todd's moving evidence about her experience after her baby Ziggy died in hospital and the difficulties she faced engaging with the system.[140] The PBPOs explained to the Inquiry that specialist bereavement midwives were moved to provide other forms of care and that bereavement facilities within neonatal units were closed or repurposed.[141] Some hospitals applied rigid policies to bereaved families, meaning parents were unable to take photographs of their deceased children or to spend time sitting and holding their child in the hospital;[142] each of these aggravated the losses already suffered by these families and in many cases, left long-lasting additional trauma.

87. The Department of Health and Social Care granted limited additional funding to charities in 2020, specifically Bliss, Tommy's, and Sands, including "to provide bereavement support and to share Covid-19 messaging to a wider audience".[143] That was welcome but in no means substituted for the bereavement care which would otherwise have been provided through the NHS or the inability of many organisations to follow the National Bereavement Care Pathway including through providing access to experienced midwives. After hearing from those engaged in the sector, the APPG on Baby Loss concluded Covid-19 restrictions had impacted on the ability for women to get information about what to do after a miscarriage and that a lack of time and space had impacted on staff providing opportunities for memory making after death or stillbirth. The APPG called for Trusts to sign up to and follow the National Bereavement Care Pathway and to enable women to have options after

[139] Notably, in response to some of the PBPOs' requests for pre-Rule 10 questions.
[140] Transcript of evidence of Catherine Todd, 11 September 2024.
[141] PBPO Statement, §§110-113, §185 [INQ000408656_0032, 55].
[142] Thomson et al, 'Companionship for women/birthing people using antenatal and intrapartum care in England during COVID-19: a mixed-methods analysis of national and organisational responses and perspectives' *British Medical Journal Open* (1 December 2021) [INQ000236184_0008].
[143] Witness statement of Matthew Style, §143 [INQ000469724_0033]

bereavement.[144] This recommendation was not acted on and bereavement care in maternity-related care once again took a backseat.

88. The PBPOs note that Chief Medical Officer for Northern Ireland, Professor McBride, acknowledged as one of his reflections post-pandemic the need to "*do better*" in health and social care around bereavement care and bereavement support. He had identified this issue as early as March 2020, when restrictions were put in place on funerals, and he subsequently commissioned a bereavement support network.[145] The PBPOs submit that more needs to be done in the healthcare system as a whole, and particularly in maternity care, to address and assist those suffering bereavement. They submit that more could have been done to find alternative methods of supporting bereaved parents and families and of ensuring the system responded sensitively to women like Ms Todd.

Maternity, including Intra-Partum, and Postnatal Care

89. The Inquiry has heard much evidence about the effects of Covid-19 on maternity-related and postnatal care. Consistently with the PBPOs' direct experience, these included impacts on women's choice of birth setting and control over their birth plans; their experiences during birth, particularly for women and pregnant people with disabilities; and serious impacts on women's mental health. The Inquiry has also heard devastating evidence about pregnant women who died with Covid-19 during the relevant period and the relatively poor care they received.

90. In respect of birth and experiences during birth, data shows that between May and June 2020 in England, 48% of Trusts reported removal of previously offered birth setting (either home births or midwife-led units), 26% reported changes in provision of water births, 9% reported additional resources (staff or space) had been requested from another local maternity unit, 14% reported suspension of some indications for induction of labour, and 4% reported that their service was unable to support caesarean sections without clinical indication.[146] In April 2020, 57% of homebirth services were closed in England.[147] In London, all 18 Trusts had suspended the support of home births.[148] The evidence before the Inquiry also indicates that issues with accessing home births and concern around the lack of available ambulances for pregnant people at home continued into the second wave.[149]

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[144] Briefing by the All-Party Parliamentary Group on Baby Loss, Covid-19 and its Impact on Pregnancy and Baby Loss [INQ000485254].

[145] Transcript of evidence of Michael McBride, 24 September 2024, pp 25-28.

[146] Statement of Dr Morris at §62 [INQ000470853_0024], citing Jardine et al, Maternity services in the UK during the coronavirus disease 2019 pandemic, British Journal of Obstetrics and Gynaecology (20 August 2020) [INQ000176659].

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

[148] Table containing figures of trusts, suspensions of home birthing services, closures of midwifery units, freestanding and obstetric services in England by region (8 April 2020) [INQ000500357].

[149] Minutes of the COVID-19 National Incident Response Board meeting, regarding the Immediate and Medium-Term response to Maternity and Neonatal Services, dated 30/07/2021 [INQ000421240_0010]

91. The PBPOs were disappointed, and submit that it hampered the Inquiry's investigation of the impact of these restrictions on the ground, that detailed data was not comparably available across the four nations. Scotland decided not to collect data (after one initial collation) on the impacts of Covid-19 on maternity-related healthcare. There was no mention in Northern Irish and Welsh evidence of any consideration of collecting such data. While accepting that the data returns were detailed and time consuming for Scottish hospital boards to complete, the PBPOs submit that efforts could and should have been made to ensure even basic records were kept on the impact of changes to maternity services, beyond anecdotes. Although Caroline Lamb asserted that there was a general understanding that maternity services were being delivered to the minimum standards set out in guidance, she realistically had to accept it was not now possible to assess how many women in Scotland were affected by restrictions on birth location or other changes in maternity services.[150] It follows that it is also not possible to assess whether the minimum standards in guidance were in fact being adhered.

92. Changes in access to birth location and available support had an important impact on women and pregnant people's health and wellbeing as well as their individual rights and autonomy. As to the latter, women, pregnant people and their partners were entitled to a choice of birth setting; many had made careful personal and evidence-based decisions to labour and birth at home or in a midwifery unit. These plans were then abruptly denied to them with the only - extremely worrying - option being a hospital, given the prevalence of Covid-19 nosocomial infections. Choices about the method and place of giving birth are not simply optional extras to give effect to if possible: these decisions engage Article 8 of the European Convention on Human Rights as they are fundamentally linked to women's private life.[151] The interference with these rights caused by the removal of available choices added profoundly to the fear, loss of dignity and disruption already experienced by women, with additional impact on partners and expectant parents.

93. Nor was the decision to limit these rights without consequence. It risked material impact on women and pregnant people's health. Studies show that negative childbirth experiences can result in PTSD, and are affected by matters documented as arising during the pandemic such as negative aspects in staff-mother contact, feelings of loss of control over the situation, and lack of partner support. It is the case that "*women's feelings and ability to exert choice and control during the birth, are more important in terms of longer wellbeing, than the objective*

[150] Transcript of evidence of Caroline Lamb, 14 November 2024, pp 153-154.
[151] *Dubska and Krejzova v. Czech Republic*, Appl. No. 28859/11 and 28473/12 (15 November 2016).

facts of the birth".[152] A lack of companionship in labour is also associated with increased need for pharmacological or other interventions during birth.[153]

94. The PBPOs understand that closures were at times justified due to staff shortages or other capacity constraints: in London, for example, the London Ambulance Service had insufficient ambulances to ensure that those who had home births could be transported to hospital if needed.[154] Sir Stephen Powis likewise gave evidence that some birth centre closures were necessary where they were smaller units, such that Covid-19 outbreaks or staff shortages had greater impact.[155] However, this reality underscores the point the PBPOs have emphasised throughout these submissions and in the course of the Inquiry, about the need to adequately resource and safeguard maternity services so that these impacts are not so heavily felt by pregnant people and their families. Any changes and limitations on women and pregnant people's choices needed to proportionate, carefully and properly justified, and subject to ongoing review.

95. There were also changes to care standards during birth. As noted, visiting restrictions impacted particularly on women and pregnant people who had additional needs. For four women who had stillbirths, did not speak English, and had no access to either a partner or supporter or an interpreter, HSIB concluded the lack of access to interpretation services affected the care they received.[156] Dame Ruth May accepted that some women were unable to receive epidurals promptly or at all.[157] Additionally, and worryingly, MBRRACE-UK's surveillance study identified pressure on the maternity system which had specific impact on some women's care. The report concluded:[158]

> *COVID-19 resulted in a loss of situational awareness in many units where all other risk factors, such as those that occur with high-order repeat caesarean deliveries, became secondary to the possibility of SARS-COV-2 infection. In many instances, ... it was also noted that elective procedures and category 4 caesarean births were prioritised over emergencies ..., complicated surgeries were postponed until later in the day when fewer staff were available and they were performed by staff with less experience. Assessors noted that system pressure left little space for reflective learning amongst the teams caring for these women.*

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[152] Aydin et al, 'Giving birth in a pandemic: women's birth experiences in England during COVID-19' BMC Pregnancy and Childbirth (2022) [INQ000308968_0009].

[153] Thomson et al, 'Companionship for women/birthing people using antenatal and intrapartum care in England during COVID-19: a mixed-methods analysis of national and organisational responses and perspectives' (British Medical Journal Open, 1 December 2021) [INQ000236184_0006]

[154] Memo from Jacqueline Dunkley to Ruth May re Emerging maternity safety concerns (23 March 2020) [INQ000421159_0001]

[155] Transcript of evidence of Sir Stephen Powis, 7 November 2024, pp 153.

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

[157] Transcript of evidence of Dame Ruth May, 17 September 2024, pp 67-68.

[158] MBRRACE-UK 2019-21 Report, p 46 [INQ000399403_0064].

96. As to the treatment of pregnant women with Covid-19, RCOG and RCM issued clear guidance on the treatment of Covid-19 in pregnancy. Tragically, MBRRACE-UK's surveillance study found that many women were not treated in accordance with the guidance.[159] The report concluded it was imperative that clinicians in all areas of the hospital were made aware that evidence-based guidance existed for the care of pregnant women with Covid-19 and to know where to seek advice if there was any uncertainty about treatment. It was notable in this context that the majority of women who died during or after pregnancy with Covid-19 were from ethnic minority groups and thus were potentially affected the most by this lack of knowledge.

97. The PBPOs have shared their concerns with the Inquiry about the precedence that was sometimes given to protection from Covid-19 above all else. MBRRACE-UK's reporting highlights the practical impact of those concerns. The PBPOs also wish to reiterate their concern for staff in maternity and maternity-related settings: these healthcare professionals were typically trying their best to diligently care for the women and young babies in their care. They must, however, be supported and given the time and resources to give the best available care. It is also clear from MBRRACE-UK's reporting that they were not always so supported. That cannot be allowed to continue.

98. After birth, system pressures and service reduction continued. Dr Morris' statement identified that women were discharged from postnatal settings more quickly than they ordinarily would, due to the impacted levels of staffing on wards alongside the impacts of visitor restrictions. He indicated that rapid discharge could reduce the care and support provided in particular around breastfeeding.[160]

99. The Inquiry has also been told that rates of perinatal depression and anxiety almost doubled during Covid and reached rates of up to 61 per cent among women who gave birth during Covid-19;[161] and indeed that two postnatal women who died by suicide were not seen face to face by perinatal mental health teams due to Covid-19 restrictions.[162] MBRRACE-UK concluded that "*it was evident that changes to service provision as a consequence of the pandemic meant that women were not able to access appropriate mental health care*" and that "*receipt of the specialist care they needed may have prevented their deaths*".[163] The serious impacts on perinatal mental health were not a hidden injury only uncovered after the

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[159] MBRRACE-UK 2019-21 Report, p 54 [INQ000399403_0072].
[160] Statement of Dr Morris at §57 [INQ000470853_0021].
[161] Flaherty et al, Maternity care during COVID-19: a qualitative evidence synthesis of women's and maternity care providers' views and experiences *BMC Pregnancy and Childbirth* (26 May 2022). [INQ000308962_0002].
[162] MBRRACE-UK, 'Saving Lives, Improving Mothers' Care, Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK, (March - May 2020), §5.3, [INQ000221912_0011].
[163] MBRRACE-UK, 'Saving Lives, Improving Mothers' Care, Rapid report: Learning from SARS-CoV-2-related and associated maternal deaths in the UK, (March - May 2020), §5.3, [INQ000221912_0016].

fact. MBRRACE-UK's report was published in May 2020 as part of a rapid review process. Again, action needed to be taken, and should have been prioritised, to ensure pregnant women and people could access to specialist mental health care.

100. There were other drivers of the deterioration on new mothers' mental health. Lockdown disrupted many forms of perinatal support including: "*limited access to in-person health and support services and reduced breastfeeding support from healthcare professionals; discontinued parenting support groups; and reduced access to support from maternal social networks*".[164] Women consequently reported in studies, and anecdotally to the PBPOs, feeling isolated and unsupported and finding that online and technologically-supported alternatives did not effectively address feelings of isolation. One study concluded, that although some healthcare professionals provided support "*above and beyond national restrictions*", women and pregnant people often felt they were receiving inadequate information and support, with virtual healthcare often feeling like a tick box exercise.[165] The same study concluded that "*re-establishment of face-to-face parenting support groups*" was imperative to postnatal emotional wellbeing and recommended the "*prioritisation of essential face-to-face healthcare visitation in the immediate postnatal period*".[166]

101. The PBPOs firmly agree that more emphasis needed to be given to the importance of face-to-face care and support for new families. It was telling that (as noted above at [81]) Caroline Lamb of NHS Scotland said no advice was sought about the negative health impacts of a reduction in face-to-face care, including, for example, on the mental health of new mothers or those who had experienced baby loss. She felt that concerns about the spread of the virus outweighed those risks and that women had been offered an equivalent level of support via online methods. When pressed on whether there had been any explicit balancing of those risks when making decisions, Ms Lamb said that they had tried to balance the risks wherever possible but that often, because of the nature of the virus and the rate at which it was spreading, the "*overwhelming concern*" was to put in place protections to stop the virus.[167]

102. Ms Lamb's logic is concerning. The PBPOs submit that decisions taken with the laudable aim of preventing the spread of Covid-19 needed to be properly tested and more weight needed to be given to impacts on women, babies and new parents from halting services. That would have allowed decision-makers to properly consider whether there were additional

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[164] Jackson et al, Postpartum women's experiences of social and healthcare professional support during the COVID-19 pandemic: a recurrent cross-sectional thematic analysis, (11 October 2021), p 3 [INQ000308967_0003].

[165] Jackson et al, Postpartum women's experiences of social and healthcare professional support during the COVID-19 pandemic: a recurrent cross-sectional thematic analysis, (11 October 2021) [INQ000308967].

[166] Jackson et al, Postpartum women's experiences of social and healthcare professional support during the COVID-19 pandemic: a recurrent cross-sectional thematic analysis, (11 October 2021), pp 8-9 [INQ000308967_0009]

[167] Transcript of evidence of Caroline Lamb, 14 November 2024, pp 157.

practical steps which might mitigate those risks; at the least, decision-makers could have demonstrated that they fully evaluated the relative risks and had deliberately chosen the "least bad" option. In her statement to the Inquiry, the Scottish Chief Nursing Officer Fiona McQueen stated:[168]

> *Whilst we recognised the impact the virus had on the more vulnerable in our society, I wonder if we could have done more during the pandemic to support such groups. With hindsight a number of measures may have been beneficial: ... improved access to healthcare - in particular to mental health services; ...changing restrictions to support new mothers to receive additional in person support from family and friends ...*

103. When asked about this in oral evidence, Ms McQueen explained that she thought in particular that new mothers should have been allowed visitors. She maintained that the balance might be different in hospitals due to the risks of nosocomial infection but that once new mothers were at home, or in the lead up to birth, "*then they can make their own decisions and take their own risks about the balance of having emotional support for their wellbeing versus the risk of Covid, and of course they could then talk to whoever was providing them with that support and know that their behaviour was keeping them safe without Covid*."[169] She thought that there was more that could have been done to bubble bigger groups together to provide emotional support or to provide, with social distancing, classes or supports: "*So I think, you know, [we can be] working with women to find out what was most distressing for them, and I think we know [what that was], but working to see what we could do I think would be important, so that we know for the next pandemic, and it needs to be rehearsed and looked over, at ways we can mitigate and prevent some of the tragedies that have happened as a consequence of this pandemic*."

104. In the PBPOs' view, these are sensible reflections. They ought to have been considered at the time but must be considered going forward. The evidence is clear that the blanket rules and restrictions put in place did not account for vulnerable people, particularly pregnant people and new parents, enough. There was a need for greater flexibility in the community but also for proper risk assessment in hospitals and by healthcare staff. The PBPOs invite the Inquiry to find that no proper balancing of the risks and benefits of Covid-19 restrictions took place and in decision-making generally, insufficient weight was given to the impact of restrictions and changes to non-Covid healthcare including all maternity-related services.

[168] Statement of Fiona McQueen, §208 [INQ000474225_0059].
[169] Transcript of evidence of Fiona McQueen, 17 September 2024, pp 210-212.

Impact of PPE

105. As with many other important issues, the wearing of PPE around babies and in bereavement care was explored only at a relatively high level in the course of the Module 3 hearings. However, even that limited evidence was stark. The Inquiry should weigh heavily the powerful evidence of Ziggy's Mum, Catherine Todd, whose only photos with her baby are of her in PPE, and the effect that has had on her.[170] In the PBPOs view, Ms Todd's evidence about the lack of flexibility in PPE rules demonstrated the overly rigid approach applied in many hospitals, again reflecting the prioritisation of IPC over a holistic and compassionate approach.

106. The PBPOs' experience was that PPE could also at times pose a barrier to communication between women and healthcare professionals, particularly when delivering bad news. Healthcare professionals who spoke with the PBPOs identified PPE and masks as aggravating language barriers and leaving patients more isolated and scared.[171]

107. The Inquiry received evidence from the PBPOs (alongside other healthcare organisations like the British Association of Perinatal Medicine and Royal College of Paediatrics and Child Health) about concerns about blanket approaches to wearing PPE and masks around young babies and in neonatal wards.[172] As Fiona McQueen explained to the Inquiry, skin-to-skin care between parents and new babies is an evidence-based intervention that supports physical wellbeing of a neonate as well as the emotional health of the parent.[173]

108. In Scotland, advice was given in November 2020 so that parents could remove face masks where it was safe to do so to encourage bonding and support skin-to-skin and kangaroo care;[174] to the PBPOs' knowledge, no similar change was made in England or Ireland. In Wales, a recommendation for parents to remove masks where possible was not reflected until the 9 May 2022 guidance.[175] Ms McQueen indicated that the exception could be implemented because by November 2020, there was an ability to take balanced, proportionate risks. The PBPOs submit that this proportionate approach could and should have been followed across the four nations. It remains unclear why more joined-up work did not occur. The PBPOs submit that the lack of co-ordinated action across the other nations on PPE and neonatal care reflected a lack of joined-up thinking across the four nations and, again, a failure in England, Wales, and Northern Ireland to balance and properly prioritise child and neonatal

[170] Transcript of evidence of Catherine Todd, 11 September 2024.
[171] PBPO statement, [INQ000408656_0039].
[172] See e.g. British Association of Perinatal Medicine, 'Covid-19 Pandemic, Frequently Asked Questions with Neonatal Services' (updated Jan 2022), p 18 [INQ000399378_00020]; Bliss Statement: Covid-19 and parental involvement on neonatal units (updated 7 January 2021) [INQ000399377_00019].
[173] Transcript of evidence of Fiona McQueen, 17 September 2024, pp 209-210.
[174] Scottish Government, 'Visiting in maternity and neonatal settings during Covid-19 pandemic from 2 November 2020 minimum standards' (2 November 2020) [INQ000468049_0005].
[175] Welsh Government, 'Hospital visiting during the coronavirus outbreak guidance: July 2021' (updated 9 May 2022). [INQ000082810].

development. The Inquiry should find that overall, the guidance on neonatal care and PPE wearing failed to adapt over time and to take into account expert evidence.

D. WORK OF THE PBPOS DURING RELEVANT PERIOD

109. An aspect of evidence that has received less attention during the oral hearings, but which is nevertheless important, is the work that charities and voluntary organisations like the PBPOs undertook to supplement healthcare services during the pandemic. It is important that the role of charities and community groups is recognised alongside the ongoing impact on these groups due to the pandemic.

110. The PBPOs set out in their witness statement to the Inquiry the many ways in which they had to provide extra support to women, pregnant people and new families: fielding more and more enquiries and trying to explain complex and ever-changing rules and regulations, and finding new ways to deliver essential support services. For example, and not comprehensively:[176]

(a) Aching Arms set up a telephone and text service offering support to families experiencing baby loss;

(b) The Miscarriage Association fielded 37 per cent more calls and direct contacts in the first three months of the pandemic and created a special Covid-19 information hub online;

(c) The Pelvic Partnership experienced 150 per cent increase in demand for its services and found that women were increasingly having to look online to access support, information and treatment;

(d) Pregnancy Sickness Support had quadruple the contacts as compared to 2018; by the end of August 2020, the total number of contacts from sufferers had exceeded the number of contacts for the whole of 2019;

(e) The National Childbirth Trust switched to providing online ante-natal and other courses and, between 22 March 2020 and 28 June 2022, offered 12,928 online courses. It also set up Walk and Talk groups for new parents to connect.

(f) The Lullaby Trust fielded 51 per cent more queries in 2020 as compared to 2019; 132% more during the second lockdown period in November – December 2020; and 59 per cent more in the third lockdown period in January to March 2021 than in 2020;

(g) The Ectopic Pregnancy Trust undertook extensive efforts to keep up to date on complex changes in early pregnancy care and created a dedicated website area with information and undertook to encourage women to seek medical assistance;

(h) Baby Lifeline set-up an online Covid-19 Advice Hub, with accompanying PDFs and social media assets, for pregnant women, families, and healthcare professionals. The Hub outlined in simple language what the restrictions meant for hospital visits, scans,

[176] PBPO Statement, §§171-191 [INQ000408656_0052-0057]

concerns during pregnancy, labour, and postnatally – whether at home or in hospital – and later, vaccination.

(i) Twins Trust moved all their antenatal sessions online, set up text information service to distribute their support and resources and extended their crisis service to support new mothers in hospital, just home from hospital and anyone else who had lost their support= network and gave them remote help; and

(j) Bliss undertook extensive advocacy and lobbying work on parents' access to babies in neonatal care, as the Inquiry has heard from numerous decision-makers. It also developed online support services and sent regular email updates to both parents and healthcare professionals.

111. The above is a mere snapshot of the work these groups did which, although set out more thoroughly in the PBPO witness statement, cannot entirely be captured in writing. For many women, pregnant people and new families, these services were a lifeline when the NHS and other healthcare providers had ceased to offer support or where they were uncertain about where to go.[177] The PBPOs also directly assisted the hard-working and overstretched NHS staff and clinicians.[178]

112. The Inquiry heard directly from Jenny Ward that, at the same time these services were stretched to their maximum, their income went "*off a cliff*" and has never recovered.[179] Some short-term funding to a few charities was provided by the Department of Health and Social Care, and later by the National Lottery and other trusts and organisations, but ultimately there has been a real impact on the services that these groups are able to provide.

113. Despite this strained position, and the many ways these groups already went above and beyond to help their constituencies, the PBPOs' call to the Inquiry is focused on what more they can do and how they can be of use. They are expert groups, with access to specialist researchers and advice. They are also grassroots groups, with particular access to the communities and people to whom healthcare advice needs to reach. The PBPOs urge the Inquiry to recognise the work done by the charitable and voluntary sector and to recommend that, in future health crises, Government and NHS officials should take into account these groups' roles in planning for the overall response. While this was done to some degree, greater engagement with charities and voluntary groups, and greater support for these groups' work, could have helped their work have a better and broader impact.

E. LESSONS LEARNED: REDRESSING THE PLACE OF WOMEN AND PREGNANT PEOPLE IN HEALTHCARE

114. The PBPOs have been grateful for the care and attention shown to women's health, maternity, early pregnancy, neonatal, postnatal and antenatal health during the Inquiry. What

[177] See PBPO Statement, Quote 72, by way of example [INQ000408656_0054].
[178] PBPO Statement, §187(e) - (f).
[179] Transcript of Jenny Ward, 7 October 2024, pp 66-67.

close scrutiny shows is what the PBPOs have been identifying from the outset: that the women's work of maternity-related healthcare is undervalued and was under-appreciated during the pandemic. The PBPOs do not repeat the findings which they have invited the Inquiry to consider making, above. Nor do they repeat the lessons learned findings set out in their witness statement at §§215-244, to which they refer the Inquiry in full.[180]

115. It is worth reiterating the extent to which women and people who were pregnant during the pandemic have felt validated by the recognition of their experiences in the Inquiry. Too many of them, and their partners, feel as if their experiences have been forgotten or the harms they have suffered were simply not known to the wider public. The PBPOs urge the Inquiry to include as much as possible the real experiences of the women and families they represent in their report to ensure that the Inquiry's report is a full record of these experiences.

116. Stepping back, the PBPOs repeat their call for appropriate attention to pregnancy-related healthcare and for the work that has been traditionally relegated as a "women's service". The PBPOs recognise that compromise and balance must be struck where systems are being asked to respond to new crises. But, in light of the wide consensus about the essential nature of maternity, early pregnancy, antenatal, postnatal and neonatal services, there is still a need to ensure that sufficient and appropriate attention is paid to women, pregnant people, new parents, new babies and their families and to ensure that compromises to their care are the minimum that can be justified. In summary, that means:

(a) Properly protecting, resourcing and prioritising pregnancy and maternity services so that high standards of care can be maintained, including care for those experiencing bereavement;

(b) Ensuring women and pregnant people feel empowered to seek healthcare while pregnant and afterwards, including for pregnancy sickness, pelvic girdle pain, miscarriage, ectopic pregnancies and crucially, their mental health; and that the healthcare, diagnostic services and range of treatments they can access remains unhindered or, if changes or restrictions are essential, they are evidence-based;

(c) Ensuring that any restrictions on visitors are only used as a last resort, based on evidence and fully justified, and are founded on the support partners provide, and the caring role parents of neonatal babies provide, being recognised as essential;

(d) Providing adequate PPE and support to ensure staff safety;

(e) Ensuring that women, pregnant people, partners and new parents are not left isolated and alone both in hospitals and in the community, and are allowed access to support networks and in-person healthcare where necessary;

(f) Ensuring that babies continue to be monitored and protected in the crucial stages of their development, including through face-to-face contact where needed;

[180] PBPO Statement, §§215-244 [INQ000408656_0070].

(g) Ensuring all clinicians across the hospital are aware of evidence-based guidance on the care of pregnant women and people and have the time and resources to engage with that guidance; and

(h) Ensuring better, clearer communication between the Government, NHS, and local Trusts and health boards and pregnant women and people including proactive strategies from the outset to reach out to minority groups.

117. The PBPOs have been eager to participate in Module 3 of this Inquiry and to share their stories and the stories of the people they worked with during the pandemic, and those they continue to work with. It is centrally important that these experiences of pregnancy, childbirth and new parenting during the pandemic is not forgotten and that the Inquiry issues firm recommendations to ensure these groups are properly prioritised in the future.

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