Overview of the scenario	Maternal collapse during induction of labour as a result of amniotic fluid embolism (AFE)
Learners	All members of the obstetric MDT: obstetricians, midwives, anaesthetists, theatre staff, neonatal team. Cardiac arrest team members
Suggested clinical learning outcomes	Recognition of maternal collapse Call appropriate emergency response teams Initial assessment and management of maternal cardiac arrest (including manual uterine displacement) Timely performance of resuscitative hysterotomy Identification and exclusion of reversible causes Consideration of escalation of care including ECMO Diagnostic criteria for AFE Supportive treatment for AFE Laboratory tests in the context of AFE
Suggested non-clinical learning outcomes	Software: Ensure up to date SOP for all aspects of management of collapsed obstetric patient. Ensure there is clarity of who to call and how to call them; this should include all required members of a maternal emergency response team (for both maternal and neonatal resuscitation) Cardiac arrest algorithms present on the cardiac arrest trolley Hardware: Emergency buzzer system working. Bed able to lie in rapid supine position. Cardiac arrest trolley stocked and easily available; this should also include a scalpel for resuscitative hysterotomy. Other equipment available including ultrasound machine to aid with identification and exclusion of reversible causes. PPE available and considered (Covid-19 unknown cases). Environment: Is there enough space around the bed space for the whole MDT team and the resuscitation equipment. Is there adequate access to perform a resuscitative hysterotomy? Where will the neonate be resuscitated? Teamworking: Management of cardiac arrest needs a cohesive MDT. Ensure there is clear leadership at all times. Leader to avoid task fixation but needs to keep overview. Clear concise delegation of tasks. Closed loop communication by all the team members. Good handover on arrival of new team members. Early allocation of a scribe to aid documentation and time lines. Use of checklists where available. Regular situational reports to share mental model with team and encourage suggests from team.

	Following the stabilisation of the patient a team debrief should ensue. Pro-active communication between all teams regarding Covid status of women.
Scenario	A multiparous mother was admitted to delivery suite post term with spontaneous rupture of membranes and meconium stained liquor. A syntocinon infusion was started as she was in early labour. Within an hour she was contracting strongly and began involuntary pushing. The fetal heart rate dropped, she became distressed and breathless, then cyanosed and unresponsive with no respiratory effort and no palpable central pulse. Once resuscitated, the mother is obviously coagulopathic. Management of obstetric cardiac arrest as per advanced life support algorithm, identification / treatment of reversible causes and resuscitative hysterotomy are required.
Debrief topics **Following your simulation, consider how you will disseminate crucial learning points with the wider MDT.**	Were all the right team members present? Was it easy to contact the people you needed? Was there any equipment that you wanted that was not available? Discussion re differential diagnosis considered. Discussion re AFE identification, management and pathogenesis. Was the resuscitative hysterotomy performed in a timely manner? If you had this case again, is there anything that you would do differently?