Overview of the scenario	Decreased GCS post seizure on postnatal ward following PDPH
Learners	All staff working on postnatal ward Multi-disciplinary obstetric team; obstetricians, midwives, anaesthetists Peri-arrest response team including medical registrar Radiology team Neurosurgical team
Suggested clinical learning outcomes	Knowledge of differential diagnosis of a seizure Knowledge of assessment of GCS Knowledge of differential diagnosis of decreased GCS Call appropriate help Initial assessment and management of decreased GCS Identification and exclusion of reversible causes Communication with diagnostic and treatment teams
Suggested non-clinical learning outcomes	Software: Ensure up to date SOP for all aspects of management of collapsed obstetric patient Ensure referral pathway in place for rapid assessment and treatment of neurosurgical emergencies Hardware: Cardiac arrest trolley stocked and easily available Full monitoring is available in the location that the patient is being treated in Functioning emergency buzzer and bleep systems Transfer equipment with full monitoring is available Environment: Consider where it is best to manage this case? Teamworking: Management of a maternal collapse needs a cohesive MDT. Ensure there is clear leadership at all times Ensure clear communication across the whole team who need to be involved with the care including obstetric MDT, theatre team, radiology, neurosurgery, ICU 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 Scribe Regular situational report to share mental model with team and encourage suggests from team Following the stabilisation of the patient a team debrief should ensue.
Scenario	32 year old, P1, 8 days postnatal has been admitted to the postnatal

	ward with worsening of headache. Observations were normal; HR 70bpm, saturations 98% on air, BP 110/65. She is otherwise fit and well. She had an epidural for analgesia in labour. A dural puncture was suspected when the test dose caused instant pain relief with lower limb motor block. The epidural catheter was removed and re-sited; the second epidural worked well in labour. Day 1 postnatal she complained of a postural headache. She was prescribed analgesia and recommended to increase her oral fluid intake. Her headache resolved to a level that she was happy to go home on day 2. She was lost to follow up as she did not answer her phone on a number of occasions. She self-presented to triage with worsening of headache. She was admitted to the postnatal ward and was awaiting review by the anaesthetic team when she falls to the floor and has a grand mal seizure. It lasts 5 minutes. Following the seizure her GCS remains at best 10/15 E-2 Opens eyes to pain V-3 Inappropriate words M-5 Moves to localised pain
Debrief topics **Following your simulation, consider how you will disseminate crucial learning points with the wider MDT.**	What differential diagnosis were considered / excluded? Was it easy to contact the people you needed? Were there any drugs / equipment that you wanted that was not available? Discussion re treatment of seizures Would communication with radiology and neurosurgery be easy to facilitate? If you had this case again, is there anything that you would do differently? A useful article to support the debrief is: **Association Between Post-Dural Puncture Headache After Neuraxial Anesthesia in Childbirth and Intracranial Subdural Hematoma** JAMA Neurol 2020 Jan 1;77(1):65-72. doi: 10.1001/jamaneurol.2019.2995.