



Case story

Communication within the multidisciplinary team when clinical urgency changes

Early Notification

Case story guidance

Background

In '[Resolution through collaboration](#)', [NHS Resolution's 2025-28 strategy](#), our second strategic priority is to contribute our unique data and insights to learn from harm and our third is to support maternity and neonatal safety improvements. Aligned with these aims we have gathered together learning from our Early Notification Scheme and produced a number of case stories to help support learning from harm identified through claims.

These resources

Our case stories are illustrative and based on recurring themes from real life events. These experiences have been highlighted and shared with you, to help identify potential risks in your clinical area, promote learning and prevent fewer incidents/claims like these occurring in the future.

How to use the case stories

There are various ways you may use the case stories, from individual self-directed learning to support continuous professional development to using them in a team environment. We have had feedback that some Trusts use the case stories as part of multidisciplinary mandatory training such as Drills and Skills/In situ simulation and also use them to support teaching for student midwives/medical students. The idea is that by learning from the experience of others, maternity unit staff will be able to change their approach to care. As you read or discuss the examples of incidents that we are sharing we ask you to consider the following:

- Could this happen in my organisation?
- What changes within my organisation or team might I consider after reading the material, including individual practice?
- What information should I share with the team?
- How can I share the learning from this case story?
- Who else needs to know?

Practical applications

1. Consider the key elements of the case story and through reflection apply the learning to influence your practice in the future.
2. Use this case study as a point of discussion at appropriate multi-disciplinary team meetings, safety huddles, and/or human factor's training.
3. Use this case study to create a multi-disciplinary simulation in the clinical area or on mandatory training.
4. Review your claims scorecard to identify whether there are any themes which relate to this case story and identify where improvements could be made.

Case story

This case story is illustrative and based on a range of litigation cases. NHS Resolution is sharing the experience of those involved to help prevent a similar occurrence happening to pregnant women and pregnant people, families, and staff.

As you read about this incident, please ask yourself:

- Could this happen in my organisation?
- Who could I share this with?
- What can we learn from this?

Topic

Communication within the multidisciplinary team (MDT) when clinical urgency changes

Key points

- Clinical urgency can rapidly change during obstetric emergencies and requires ongoing communication, reassessment and escalation by the multidisciplinary team. Structured communication tools, such as SBAR (Situation, Background, Assessment, Recommendation), can help ensure the current situation, what has changed, why it matters and what action is being recommended are clearly understood.
- Maintaining shared situational awareness supports a common understanding of risk, priorities, roles and next steps when the clinical picture evolves. This includes recognising when an initial plan is not progressing as expected and agreeing a clear contingency plan.
- A culture where staff feel able to speak up, challenge respectfully, seek senior support and request a second opinion when concerns persist supports timely escalation, additional clinical review and safer decision-making.

Maternity story

Antenatal features

Amara is a 30-year-old woman in her first ongoing pregnancy. She attends her booking appointment at eight weeks' gestation¹. During this consultation, it is established that she has a history of scoliosis, which has not affected her in adult life. She is otherwise fit and well and takes no regular medication.

A plan is made for ongoing antenatal care under the midwifery team, with review by both the obstetric and anaesthetic teams to prepare for delivery. Her pregnancy progresses without complication.

At 28 weeks, she is reviewed by the obstetric team. No issues are raised and a plan is made to follow the recommendations from the anaesthetic team. At this point

Amara is keen to birth in the midwifery-led unit. A plan is made for further review after she has been seen by the anaesthetic team.

At 32 weeks, she is seen by the anaesthetic consultant. Following examination and review of her medical history, a plan is made for an early epidural in labour if she chooses to have one. It is felt that her history of scoliosis is unlikely to affect epidural placement or effectiveness.

At 39 weeks, she is reviewed by her community midwife, and a plan is made for induction of labour at 41 weeks' gestation. Information regarding the induction process is discussed and provided to Amara and her partner. She is aware that she may have to birth on the obstetric-led unit in the process of the induction of labour.

At 41 weeks, Amara is admitted for an induction of labour at 12:00. The process is explained and consent is confirmed. The fetal wellbeing is assessed with a cardiotocograph (CTG). The CTG is normal. Following this, a vaginal examination is carried out and a prostaglandin pessary is inserted at 14:00 with a plan for review after 24 hours. The following day she is re-examined and requires a further induction agent and the prostaglandin gel is inserted at 14:30 and left in situ for six hours. Following this, Amara is examined and the cervix is found to be 2 cm dilated and a plan is made to transfer her to the labour ward for artificial rupture of membranes.

Labour

Amara is admitted to the labour ward at 00:00, and the artificial rupture of membranes takes place. Amara is encouraged to mobilise for two hours. Following this, there is a plan for the obstetric resident doctor to review her and decide on next steps. As regular contractions do not establish, an oxytocin infusion is commenced in accordance with local guidance. Continuous CTG monitoring is established, and the fetal heart rate remains normal². The oxytocin infusion is adjusted appropriately as labour progresses.

Amara subsequently requests an epidural for pain relief. The epidural is sited by the anaesthetic resident doctor at 02:00 and initially provides effective analgesia. After two hours, Amara reports significant pain on one side of the abdomen. This is reviewed and additional top-ups are administered. The epidural subsequently provides sufficient pain relief as the labour continues.

On the same day at 18:00, Amara is examined and her cervix is found to be 8 cm dilated. The CTG becomes suspicious, demonstrating a rising baseline with maintained variability and recurrent variable decelerations with no concerning characteristics. Maternal observations are within range and notably the temperature is 37.3 °C and heart rate is 99 beats per minute. Conservative measures are undertaken, including maternal repositioning and discontinuation of the oxytocin infusion. Despite these interventions, the CTG does not improve.

The obstetric resident doctor reviews Amara again and discusses the need for urgent delivery as the CTG deteriorates and is now pathological². They counsel her for reassessment in theatre and urgent delivery either by an assisted vaginal delivery or caesarean birth. Amara accepts this plan. The midwife is informed and asked to get them ready for transfer to theatre, she mentions she requires assistance. This is

escalated to the labour ward co-ordinator who is dealing with another clinical situation on the busy labour ward. The obstetric doctor is also called away to review another patient. After a while they send a maternity care assistant to aid with the transfer. Amara arrives in the theatre 15 minutes after the decision for delivery is made.

On arrival in theatre, the epidural is assessed and found to not be providing sufficient analgesia for a caesarean birth and Amara would require an alternative. The obstetric resident doctor re-examines Amara at this point and confirms that delivery should proceed by a category 1 caesarean birth. This is communicated to the team. At this stage, the CTG has deteriorated further, with reduced variability, a persistently raised baseline and ongoing decelerations with concerning features.

The anaesthetic team suggests that a spinal anaesthesia can be performed quickly and would avoid the risks associated with general anaesthesia. The obstetric team expresses concern that there has already been some delay in transfer to the theatre, and that the CTG has continued to deteriorate. However, there is shared agreement to complete the spinal anaesthetic quickly and safely.

A spinal anaesthetic is attempted but is unsuccessful. A second attempt is made, and a discussion takes place between the obstetric and anaesthetic teams regarding whether to proceed directly to general anaesthesia. The anaesthetist advises that a further attempt is likely to be successful and may still be quicker overall than conversion to general anaesthesia. However, no further structured discussion takes place to summarise the evolving clinical situation, the deterioration in the fetal condition, the impact of any further delay, and the safest next step. Additional senior input is not sought despite ongoing concerns.

A third attempt at spinal anaesthesia is successful. By this stage, approximately 35 minutes have passed since the decision to transfer to theatre. During this period, the CTG remains pathological with an increased baseline, reduced variability and recurrent decelerations with concerning features.

The baby is delivered by caesarean birth five minutes later and they are in poor condition. The cord is clamped and cut, and they are passed to the awaiting neonatal team.

Neonatal outcome

The baby requires resuscitation at birth. The baby's Apgars are 1, 2, and 6 at one minute, five minutes and 10 minutes respectively. The umbilical cord gases demonstrate significant metabolic acidosis. The baby is transferred to the neonatal unit and subsequently meets criteria for therapeutic hypothermia⁴. MRI later demonstrates changes consistent with moderate hypoxic-ischaemic encephalopathy.

Learning points

This case highlights the importance of:

- The multidisciplinary team during the antenatal period¹. At the booking appointment it was correctly identified that Amara's previous medical history

can affect her pain relief options in labour and was acted upon. Review by the obstetric and anaesthetic teams⁵ enabled appropriate birth planning taking into consideration her medical history and preferences around birth.

- Continuous fetal monitoring during labour^{1,8}. During an induction and with an oxytocin infusion, the use of continuous fetal monitoring is necessary to detect early signs of fetal compromise¹ and ensure the appropriate contractions are being achieved³. Where fetal compromise is suspected, all members of the multidisciplinary team should have a shared understanding of the next steps^{7,8}. Situational awareness is not static and requires ongoing communication, reassessment and escalation by the multidisciplinary team. This shared understanding should be regularly revisited as the clinical condition evolves.
- Communication during obstetric emergencies⁶. Differences in perspective between teams can arise during time-critical situations. Structured communication should clearly convey the current situation, what has changed, why it matters and what action is being recommended. This supports shared situational awareness, timely escalation and coordinated multidisciplinary decision-making as clinical urgency evolves⁸.
- The role of human factors in obstetric emergencies⁶. Team members may become understandably focused on their specific task or area of expertise during time-critical situations. Maintaining situational awareness and ensuring that all members of the MDT retain a shared understanding of the evolving clinical picture is essential to safe care⁸.
- Team members should feel empowered to raise concerns, seek senior support and obtain a second opinion when concerns persist. These principles are consistent with Martha's Rule and support timely escalation and additional clinical review.
- Theatre readiness^{5,7}. This extends beyond physical transfer to theatre and includes coordinated preparation, clear leadership, effective communication and a shared understanding of the urgency of the situation. Regular multidisciplinary training and simulation can support teams in managing complex obstetric emergencies⁶.

Considerations for your hospital

The learning from this case is particularly relevant as maternity services continue to strengthen processes for the escalation of concerns, access to additional clinical review, and support for staff to speak up when concerns persist.

These principles align with Martha's Rule⁹, which has recently been introduced in maternity services. It aims to support the early recognition of deterioration and provides mechanisms for patients, families and staff to escalate concerns and request additional clinical review when concerns are not being responded to⁹.

These considerations focus on communication, escalation, situational awareness and organisational processes that support safe multidisciplinary decision-making during evolving clinical situations^{6,8}.

- How is changing clinical urgency communicated and acknowledged across the multidisciplinary team?
- How do teams maintain shared situational awareness when the clinical situation evolves? Are contingency plans routinely discussed?
- Do staff feel able to speak up, challenge respectfully and seek senior support or a second opinion when concerns persist?
- Is there a clear process for obtaining additional clinical review when there are ongoing concerns about patient safety?
- How are differences in perspective between team members or specialties managed during obstetric emergencies?
- Does multidisciplinary training include scenarios where clinical urgency changes and plans need to be reassessed?
- Do local reviews of adverse outcomes consider communication, escalation and human factors within the multidisciplinary team, alongside clinical decision-making?
- Are organisational processes aligned with the principles of Martha's Rule, supporting escalation of concerns by staff, women and families when they feel deterioration is not being recognised or acted upon?

What has happened as a result?

This case story is illustrative. If a similar case were to occur in real life, then it would be referred to NHS Resolution's Early Notification Scheme. NHS Resolution's in-house, specialist teams will review all available information about the care received, to decide whether there is any evidence of substandard care which could potentially result in compensation.

The expertise of NHS Resolution is used to proactively assess the legal risk and provide early support to families where liability is established.

NHS Resolution supports an open, transparent discussion between clinicians and families following adverse events¹⁰. The scheme is also designed to improve the experience for NHS staff by limiting the need for protracted involvement in the legal process and rapidly sharing learning.

It is very important to note that no amount of money is comparable with the loss of a child or a child living with lifelong neurological injuries. Where poor outcomes occur as a result of deficiencies in care, NHS Resolution aims to resolve all such claims or cases fairly and as quickly as possible.

In 2024/25, the average compensation cost for a baby who has long term severe brain injury is £11.2 million. The human costs to the babies, families and clinical teams involved are immeasurable.

Resources

1. National Institute for Health and Care Excellence (NICE). Antenatal care. NICE guideline NG201. Published 2021. <https://www.nice.org.uk/guidance/ng201/chapter/Recommendations>
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4. British Association of Perinatal Medicine. Therapeutic Hypothermia for Neonatal Encephalopathy Framework. Updated 2025. https://hubble-live-assets.s3.eu-west-1.amazonaws.com/bapm/file_asset/file/3269/THNE_Framework_2025.pdf
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7. National Institute for Health and Care Excellence. Caesarean birth. NICE guideline NG192. Updated January 2024. <https://www.nice.org.uk/guidance/ng192/chapter/Recommendations>
8. NHS England. Saving Babies' Lives Care Bundle Version 3.2: A care bundle for reducing perinatal mortality. 2025. <https://www.england.nhs.uk/long-read/saving-babies-lives-version-3-2/>
9. NHS England. Martha's Rule. Updated 2026. <https://www.england.nhs.uk/patient-safety/marthas-rule/>
10. NHS Resolution. Saying Sorry. June 2017. <https://resolution.nhs.uk/wp-content/uploads/2018/09/NHS-Resolution-Saying-Sorry.pdf>



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