	REPORT TO PREVENT FUTURE DEATHS REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013 Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).
1.	**CORONER** I am Hannah Berry, Assistant Coroner for the coroner area of South Yorkshire West
2.	**DATE OF REPORT** **30 June 2026**
3.	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigation) Regulations 2013
4.	**THIS REPORT IS BEING SENT TO** 1. Chief Executive, National Institute for Health and Care Excellence 2. Chief Executive Officer, Royal College of Obstetricians and Gynaecologists Y**ou are under a duty to respond to this report with 56 days of the date of this report, namely by 25 August 2026. I, the coroner, may extend the period if an appropriate application is made**
5.	**YOUR RESPONSE** Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed. I have a duty to send a copy of your response to the Chief Coroner In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representation received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PDF reports are regularly published on the Chief Coroners webpages.

6.	**SUMMARY OF CORONER'S CONCERNS** There are no national guidelines regarding the assessment and management of a non-cephalic lie during pregnancy, including an oblique lie. The absence of such guidance contributed to a junior doctor not appreciating the significance of identifying an oblique lie at 38+2 weeks' gestation.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION and INQUEST** On 19 December 2024 I commenced an investigation into the death of Ted Oliver STEWART, aged 8 days. The investigation concluded at the end of the inquest on 30 June 2026. The conclusion of the inquest was a narrative conclusion as follows; On 11 December 2024, whilst Ted Oliver Stewart was still in utero, his mother, who was 38 weeks and 2 days pregnant, attended the Jessop Wing with abdominal pain and vaginal bleeding. Clinical assessment raised the possibility that Ted was in an oblique lie rather than a head-down presentation. This should have prompted an ultrasound scan to confirm presentation and as Ted was lying obliquely admission to hospital for ongoing management. Ted's mother was assessed by a junior doctor early in her obstetric training and she did not appreciate the significance of an oblique lie. There was no national or local guidance available to assist her. She consulted with a senior colleague but the possible oblique lie was not effectively conveyed, understood or acted upon and Ted's mother was discharged home. Shortly after returning home, Ted's mother went into active labour and Ted began to be born feet first. Paramedics attended but were unable to complete the delivery and transported Ted and his mother to the Jessop Wing. Ted was born in the ambulance whilst on his way to hospital. He was not breathing and required neonatal life support. Ted died on the 19 December 2024 at the Jessop Wing Sheffield as a result of a severe hypoxic and ischemic brain injury caused by head entrapment during the breech delivery. Had his mother been admitted to hospital, she would have had the opportunity either to undergo an emergency caesarean section or if vaginal delivery was unavoidable, to deliver in a hospital setting with appropriate obstetric and neonatal support and on the balance of probabilities, Ted would not have sustained the injury from which he died. The medical case of death was 1a Hypoxic Ischemic Encephalopathy 1b Term Breech Vaginal Delivery With Head Entrapment

9.	**CIRCUMSTANCES OF THE DEATH** On the 11 December Ted's mother attended Jessop wing at 38+2 gestation with back pain and bleeding. She was examined by an ST1 and on examination noted that Ted may be at an oblique lie. This was annotated in the medical notes. The ST1 was early in their obstetrics career and did not understand the significance of this find. The ST1 searched for both national and local guidance on presentation of an oblique lie; none was found as it did not exist. The ST1 consulted with an ST7 but the oblique lie was not effectively communicated and Ted's mother was discharged home. Ted's mother went into labour later that day at home and assisted by paramedics Ted was delivered whilst en route to hospital. Due to head entrapment it was estimated that Ted's umbilical cord was not perfused for approximately 15 minutes. On delivery Ted was not breathing and had no heart rate and neonatal life support was commenced. An MRI showed extensive damage to his brain and on the 19 December Ted died. Ted's mother should have been admitted to Hospital on identification of Ted's oblique lie. Had she been then on the balance of probabilities Ted would not have died.

10.	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed maters giving rise to concern. In my opinion there is risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report you. The **MATTERS OF CONCERN** are as follows. - (1) There is no national guidance regarding the assessment and management of women presenting during pregnancy with an oblique lie or other non-cephalic lie. In Ted's care the junior doctor searched for guidelines to assist in the management plan of Ted. Had such guidance existed, it may have alerted the doctor to the clinical significance of the finding and informed appropriate management.

11.

COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

I can confirm I have sent the report to:

1.The family of Ted Oliver Stewart
2. Sheffield Teaching Hospitals NHS Trust
3. Yorkshire Ambulance Service

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 5 above for additional information relating to the publication of reports and responses.

SIGNATURE

30 June 2026

Signature [redacted]

Hannah Berry H.M Assistant Coroner for South Yorkshire (West)