Statement of Allegations

Nasrin Bandari Vali

The Registrant

1. At the material times, Nasrin Bandari Vali (the "Member") was a duly registered member of the College of Midwives of Ontario practising midwifery at Kitchener-Waterloo Midwifery Associates (the "Clinic").

Care Provided to Client #1

2. The Member provided midwifery care to Client #1 from on or about April 26, 2017 to on or about August 28, 2017.

3. On or about August 28, 2017, Client #1's care was transferred to an obstetrician.

Management of Fetal Movement and Fetal Growth

4. On or about August 11, 2017, when Client #1 was 28 weeks and 6 days gestational age, the Member assessed Client #1 at the Clinic due to Client #1's report of decreased fetal movement.

5. The Member referred Client #1 for an ultrasound, which was conducted on August 11, 2017.

6. The results of the August 11, 2017 ultrasound became available to the Member on or about August 15, 2017.

7. The results of the August 11, 2017 ultrasound indicated that the fetal weight was in the 5th percentile for gestational age.

8. The Member made a note to repeat the ultrasound in two weeks. The Member instructed a midwifery student to call Client #1. The Member advised the midwifery student that if the ultrasound results were the same, then a consultation should be arranged.

9. It is alleged that the Member failed to maintain the standard of midwifery practice with respect to the management of fetal movement and/or fetal growth in one or more of the following ways:

    a. The Member failed to appropriately document the August 11, 2017 Clinic appointment;

    b. The Member failed to institute increased surveillance of fetal well-being, including by failing to counsel Client #1 to monitor fetal movement counts:

i. in the period between the August 11, 2017 Clinic appointment and the receipt of the August 11, 2017 ultrasound results; and/or

ii. following the receipt of the August 11, 2017 ultrasound results on or about August 15, 2017;

c. The Member failed to conduct a maternal assessment of Client #1 after receiving the August 11, 2017 ultrasound results;

d. The Member failed to inform Client #1 about maternal contributors for small-for-gestational age fetus or intrauterine growth restriction after receiving the August 11, 2017 ultrasound results;

e. The Member failed to document a plan of care for the investigation and management of the maternal or fetal aspects of the potentially small for gestational age fetus after receiving the August 11, 2017 ultrasound results.

Management of Potential Preterm Labour or Preterm Prelabour Rupture of Membranes

10. Client #1 paged the Clinic and reported concerns on or about August 17, 2017, August 23, 2017 and August 26, 2017. A midwifery student spoke with Client #1 over the telephone in response to these pages.

11. It is alleged that the Member failed to maintain the standard of midwifery practice with respect to the management of potential preterm labour or preterm prelabour rupture of membranes when the Member failed to conduct an in-person assessment of Client #1 following Client #1's reported concerns on or about August 17, 2017 and/or August 23, 2017 and/or August 26, 2017.

Record Keeping

12. It is alleged that the Member failed to adequately document Client #1's midwifery care in one or more of the following ways:

a. The antenatal records were incomplete;

b. The Member did not adequately document discussions with Client #1;

c. The Member did not adequately document care plans;

d. The Member did not adequately document Client #1's medications and/or the implications of taking medications for Client #1's pregnancy;

e. The Member did not adequately document changes in Client #1's situation over the course of midwifery care.

Professional Misconduct Alleged

13. It is alleged that the above conduct constitutes professional misconduct pursuant to clause 51(1)(c) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, and as defined in one or more of the following paragraphs of section 1 of Ontario Regulation 388/09, made under the *Midwifery Act, 1991*:

    a. paragraph 2 (Failing to maintain a standard of practice of the profession); and/or

    b. paragraph 47 (Engaging in conduct or performing an act or omission relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as disgraceful, dishonourable or unprofessional).