DISCIPLINE COMMITTEE
OF THE COLLEGE OF MIDWIVES OF ONTARIO

PANEL:		Lilly Martin, Chairperson Deirdre Brett John Stasiw
BETWEEN:		
COLLEGE OF MIDWIVES OF ONTARIO	)	ERICA RICHLER for College of Midwives of Ontario
- and -	)	KATE HUGHES for Nasrin Bandari Vali
NASRIN BANDARI VALI	)	Heard: November 27, 2019

DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee on November 27, 2019 at the College of Midwives of Ontario ("the College") in Toronto, Ontario.

Publication Ban

At the request of the College and with the consent of the Member, the Panel made an order that no person shall publish, broadcast or in any manner disclose the name of any patients, or any facts or information that could identify any patients referred to orally at the hearing or in the exhibits filed at the hearing.

The Allegations

The allegations against Nasrin Bandari Vali (the "Member) as stated in the Notice of Hearing dated July 24, 2019 (Exhibit #1) are as follows:

IT IS ALLEGED THAT:

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).

Member's Plea

The Member admitted the allegations as set out in the Notice of Hearing. With respect to the allegation set out in paragraph 13(b) of the Notice of Hearing, the Member acknowledged that her conduct would reasonably be regarded by other members of the profession as unprofessional.

The Panel conducted a plea inquiry and was satisfied that the Member's admissions were voluntary, informed and unequivocal.

Agreed Statement of Facts

Counsel for the College advised the panel that agreement had been reached on the facts and introduced an Agreed Statement of Facts (Exhibit #2) which provided as follows.

The Registrant

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

2. The Member was initially registered with the College in the supervised class on August 11, 2005. The Member obtained a general certificate from the College on January 9, 2006 and she has held a general certificate since that time.

Agreed Facts regarding Midwifery Care Provided to the Client

3. The Member provided midwifery care to Client CK ("the Client") from April 26, 2017 to August 28, 2017.

4. The Client agreed to have a midwifery student, KB, involved in her care (the "Student"). The Member acknowledges that she was accountable for the care provided by the Student.

5. Ultrasound results from the Client's family physician dated April 17, 2017 (15 weeks by dates, 12 weeks by last ultrasound) and June 8, 2017 (23 weeks by dates, 19 weeks by last ultrasound) were forwarded to the Member and reviewed by her. These ultrasound reports did not raise issues relating to the estimated fetal size. The June 8, 2017 ultrasound report indicated the baby was in the 28th percentile for estimated fetal weight.

6. On July 26, 2017 the Client had her third midwifery clinic visit. The client was assessed as well with no concerns.

7. On August 11, 2017 (which was before the next scheduled clinic visit), when the Client was 28 weeks and 6 days gestational age, the Client paged with concerns of lack of fetal movement. The Member, with the Student, did an in-person assessment of the Client at the Clinic that same day. The assessment indicated a fetal heart rate of 145 and good fetal movement was noted.

8. At that assessment on August 11, 2017, the Member referred the Client for an ultrasound. The Member followed up later that same day and booked the ultrasound for the Client when the Client forgot to book her ultrasound. The Student was instructed to follow up and make sure the Client attended the ultrasound and that the ultrasound clinic sent them the results as soon as possible.

9. The ultrasound was conducted on August 11, 2017. The ultrasound results were sent to the Clinic on Monday, August 15, 2017. When the results came to the Clinic, the Student texted the Member with the results that the fetal weight was in the 5th percentile for gestational age.

10. The Member immediately advised the Student on August 15 that they needed to repeat the ultrasound two weeks after the August 11th ultrasound and instructed the Student to call the Client to let her know and to book an appointment for the Client the next week. The Member advised the Student that if the ultrasound results were the same, then a consultation should be arranged. A requisition was sent to the ultrasound clinic that day with the notation that the ultrasound was for growth. They obtained an ultrasound appointment for the Client for August 24, 2017.

11. The Client paged the Clinic and reported concerns on August 17, 2017, August 23, 2017 and August 26, 2017 as follows:

    a. On August 17, 2017, the Client reported spotting when wiping, mild and intermittent low back pain, and front pelvic pain. The Client spoke with the Student at the Clinic who advised the Client to hydrate, rest, take a bath, take Tylenol, use a hot water bottle, and re-page if there was an increase in bleeding, a gush of fluid, the low back pain becomes intense/rhythmic/painful, or if there were concerns with fetal movement. The Member signed off on this plan.

    b. On August 23, 2017, the Client reported ongoing pelvic pain, dizziness, blurry/double vision, dull pain in her right side, nausea, mild headache and irregular bowel movements. The Client spoke with the Student at the Clinic who advised the Client to rest, hydrate, and to take Tylenol and Gravol. The Member signed off on this plan.

    c. On August 26, 2017, the Client reported increased discharge and increased pelvic pressure. The Client spoke with the Student at the Clinic who advised the Client that she wanted to confirm the plan with the Member. The Student and the Member then developed a plan for the Client to wear a pad or panty liner, hydrate, rest, eat normally and re-page if the Client had concerns with fetal movement, experienced a gush of fluid or soaked a pad with fluid within two to three hours, if any bleeding occurs, or if cramping/contraction pattern develops. The Member and the Student followed up with the Client two hours later and were told by the Client that there was a "small amount" of thin white-yellow fluid on the pad, that she felt 22 distinct fetal movements, and no contractions.

12. The Member did not conduct an in-person assessment of the Client in response to these calls.

13. The Member did not chart a plan or discussion of monitoring fetal movements.

14. On August 24, 2017 the Client attended her ultrasound appointment. The ultrasound results were sent to the Clinic on August 28. 2017.

15. On August 27, 2017, the Client and the baby's father attended at the hospital but did not page the Member or the Clinic to say there was a problem. The hospital paged the Member and the Member attended at the hospital and met with the Client. There was a reassuring EFM strip. At the suggestion of the baby's father, who had not been previously involved in the midwifery visits, the Client requested a transfer of care to an obstetrician. This was arranged by the Member without delay.

16. On August 28, 2017, the Client's care was transferred to an obstetrician and the ultrasound result from the August 24 ultrasound, received August 28, was forwarded to the obstetrician's office.

Expert Reports

17. Both the College and the Member retained experts in midwifery to provide their opinions on whether the Member met the standards of practice of the profession in relation to her care of the Client. The College's expert report dated November 19, 2018 is attached as **Exhibit "A"**. The Member's expert report dated January 30, 2019 is attached as **Exhibit "B"**. The College's supplementary expert report dated March 18, 2019 is attached as **Exhibit "C"**.

18. While there is disagreement on a number of issues, it is agreed by the experts that the Member failed to meet the standards of practice of the profession on the issues as outlined below.

Management of Fetal Movement and Fetal Growth

19. It is agreed that the Member failed to maintain the standard of midwifery practice with respect to the management of fetal movement and fetal growth in 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 appropriately counsel the Client to monitor fetal movement counts in:

        i. the period between the August 11, 2017 Clinic appointment and the receipt on August 15 of the August 11, 2017 ultrasound results; and

        ii. immediately following the receipt of the August 11, 2017 ultrasound results on August 15, 2017, which indicated that the fetal weight was in the 5th percentile;

    c. The Member failed to conduct an in person maternal assessment of the Client after receiving the August 11, 2017 ultrasound results on August 15, 2017 and before they received the follow up ultrasound scheduled for August 24, 2017;

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

    e. The Member failed to ensure that the 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 was documented, other than writing it in a text to the Student.

Management of Potential Preterm Labour or Preterm Prelabour Rupture of Membranes

20. It is agreed 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 the Client following the Client's reported concerns on August 17, 2017, August 23, 2017, and August 26, 2017.

Record Keeping

21. It is agreed that the Member failed to adequately document the Client's midwifery care, or ensure the Student did so, in the following ways:

    a. The antenatal records were incomplete;

    b. The Member did not adequately document all discussions with the Client or ensure that the Student did so;

    c. The Member did not adequately document care plans or ensure that the Student did so; and

    d. The Member did not adequately document the Client's medications.

Admission of Professional Misconduct

22. It is agreed 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 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

    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 unprofessional).

23. By this document, the Member admits to the truth of the facts referred to in paragraphs 1 to 21 above (the "Agreed Facts").

24. By this document, the Member states that:

    a. She understands fully the nature of the allegations made against her;

    b. She has no questions with respect to the allegations against her;

    c. She admits to the truth of the facts contained in this Agreed Statement of Facts and Admission of Professional Misconduct and that the admitted facts constitute professional misconduct;

    d. She understands that by signing this document she is consenting to the evidence as set out in the Agreed Statement of Facts and Admission of Professional Misconduct being presented to the Discipline Committee;

    e. She understands that by admitting the allegations, she is waiving her right to require the College to prove the allegations against her at a contested hearing;

    f. She understands that the decision of the Committee and a summary of its reasons, including reference to her name, will be published in the College's annual report and any other publication or website of the College;

g. She understands that any agreement between her and the College with respect to the penalty proposed does not bind the Discipline Committee; and

h. She understands and acknowledges that she is executing this document voluntarily, unequivocally, free of duress, free of bribe, and that she has been advised of her right to seek legal advice.

25. In light of the Agreed Facts and Admission of Professional Misconduct, the College and the Member submit that the Discipline Committee should find that the Member has committed professional misconduct.

Decision

The panel considered the Agreed Statement of Facts and finds that the facts support a finding of professional misconduct and, in particular, finds that the Member committed an act of professional misconduct as set out in the Notice of Hearing.

The Agreed Statement of facts laid out clearly the areas of Ms. Bandari Vali's care that failed to meet the standard, in particular with regard to the management of fetal movement and fetal growth (Admission #19); management of potential preterm labour or preterm prelabour rupture of membranes (admission #20); and record keeping (admission #21). The submissions made during the hearing by both the College and the Member provided the panel with the necessary information and context to understand the Agreed Statement of Facts adequately and therefore make an informed decision to accept the facts as presented.

The panel is satisfied that the experts engaged by the College and Member were suffiently qualified to provide opinion on the matter. We are also satisfied that the experts provided impartial and independent opinions. Although there was some disagreement between the experts in certain areas, both experts and the Member herself agreed that aspects of her care fell below the reasonable standard of midwifery practice, and thus constituted professional misconduct.

The panel is also satisfied that the Member's conduct would reasonably be regarded by other members of this profession as unprofessional.

Ms. Bandari Vali herself has admitted that her conduct failed to meet the standard in the discrete and specific areas as set out clearly in the Agreed Statement of Facts. As set out above, having conducted a plea inquiry, the panel is satisfied that Ms. Bandari Vali understands the allegations, and has made her admission voluntarily, unequivocally, and free of duress.

For the reasons stated above, the panel supports the finding of professional misconduct and accepts the decision reached by the parties.

Penalty

Counsel for the College advised the panel that a Joint Submission as to Penalty had been agreed upon. The Joint Submission as to Penalty provides as follows:

> The College of Midwives of Ontario (the "College") and Nasrin Bandari Vali agree and jointly submit that the Discipline Committee should make the following order as to penalty and costs:
>
> 1. Ms. Bandari Vali is required to appear before a panel of the Discipline Committee to be reprimanded, with the fact of the reprimand to appear on the public register of the College;
>
> 2. The Registrar is directed to suspend Ms. Bandari Vali's certificate of registration for one (1) month commencing on December 18, 2019 to January 18, 2020;
>
> 3. The Registrar is directed to impose the following terms, conditions and limitations on Ms. Bandari Vali's certificate of registration:
>
>   a. Within six (6) months of the date of the Discipline Committee's Order, Ms. Bandari Vali is required to successfully complete, at her own expense and to the Registrar's satisfaction, a course, pre-approved by the Registrar, relating to the management of preterm labour, preterm pre-labour rupture of membranes (PPROM) and pre-labour rupture of membranes (PROM) to be offered by the International Midwifery Pre-Registration Program;
>
>   b. Within three (3) months of the date of the Discipline Committee's Order, Ms. Bandari Vali is required to prepare and submit a 1,500-word reflective paper, to the satisfaction of the Registrar, on the diagnosis and management of intrauterine growth restriction and small-for-gestational-age fetuses, including a discussion on screening for risk factors;
>
>   c. Ms. Bandari Vali is required to practise under the indirect supervision of one or more members in the general class of registration, pre-approved by the Registrar, subject to the following terms:
>
>   i. The period of supervision shall be six (6) months commencing on the date of the Discipline Committee's Order, not including any time in which Ms. Bandari Vali's certificate of registration is suspended;
>
>   ii. Ms. Bandari Vali must consult with an approved supervisor (either by phone or in person) regarding any clients who report signs or symptoms of PPROM, PROM, preterm labour, or decreased fetal movement;
>
>   iii. Ms. Bandari Vali must participate in chart reviews with an approved supervisor (who must be a midwife that practises at a different clinic than Ms. Bandari Vali) once every two weeks for the duration of the supervision term;
>
>   iv. In order to be approved, the supervisor(s) must agree to provide reports to the Registrar in the form and manner requested by the Registrar and at such intervals as requested by the Registrar;
>
>   v. Ms. Bandari Vali is responsible for any costs or expenses associated with the supervision; and
>
> 4. Ms. Bandari Vali is required to pay to the College costs in the amount of $3,500.00 within 12 months of the date of the Discipline Committee's Order.

Penalty Decision

The panel accepts the Joint Submission as to Penalty and accordingly orders:

1. Ms. Bandari Vali is required to appear before a panel of the Discipline Committee to be reprimanded, with the fact of the reprimand to appear on the public register of the College;

2. The Registrar is directed to suspend Ms. Bandari Vali's certificate of registration for one (1) month commencing on December 18, 2019 to January 18, 2020;

3. The Registrar is directed to impose the following terms, conditions and limitations on Ms. Bandari Vali's certificate of registration:

    a. Within six (6) months of the date of the Discipline Committee's Order, Ms. Bandari Vali is required to successfully complete, at her own expense and to the Registrar's satisfaction, a course, pre-approved by the Registrar, relating to the management of preterm labour, preterm pre-labour rupture of membranes (PPROM) and pre-labour rupture of membranes (PROM) to be offered by the International Midwifery Pre-Registration Program;

    b. Within three (3) months of the date of the Discipline Committee's Order, Ms. Bandari Vali is required to prepare and submit a 1,500-word reflective paper, to the satisfaction of the Registrar, on the diagnosis and management of intrauterine growth restriction and small-for-gestational-age fetuses, including a discussion on screening for risk factors;

    c. Ms. Bandari Vali is required to practise under the indirect supervision of one or more members in the general class of registration, pre-approved by the Registrar, subject to the following terms:

        i. The period of supervision shall be six (6) months commencing on the date of the Discipline Committee's Order, not including any time in which Ms. Bandari Vali's certificate of registration is suspended;

        ii. Ms. Bandari Vali must consult with an approved supervisor (either by phone or in person) regarding any clients who report signs or symptoms of PPROM, PROM, preterm labour, or decreased fetal movement;

        iii. Ms. Bandari Vali must participate in chart reviews with an approved supervisor (who must be a midwife that practises at a different clinic than Ms. Bandari Vali) once every two weeks for the duration of the supervision term;

        iv. In order to be approved, the supervisor(s) must agree to provide reports to the Registrar in the form and manner requested by the Registrar and at such intervals as requested by the Registrar;

        v. Ms. Bandari Vali is responsible for any costs or expenses associated with the supervision; and

4. Ms. Bandari Vali is required to pay to the College costs in the amount of $3,500.00 within 12 months of the date of the Discipline Committee's Order.

Reasons for Penalty Decision

The panel concluded that the proposed penalty is reasonable and in the public interest. The Member has co-operated with the College and, by agreeing to the facts and a proposed penalty, has accepted responsibility for her actions.

In accepting the Joint Submission, the panel was mindful of its obligations when reviewing a joint proposal. The case law makes clear that the panel should not depart from a joint submission on penalty unless it finds that accepting the submission would bring the administration of justice into disrepute or otherwise be contrary to the public interest.

The panel found that the agreed upon is appropriate, for the following reasons:

1. It meets the objective of the protection of the public. The terms, conditions and limitations as set out in the Joint Submission will contribute toward the goal of rehabilitation and remediation. The education, self reflection and period of supervision will contribute toward improvement in the Member's skills and understanding, with the expectation that she will meet the standards of the profession in the future.

2. It meets the objective of general deterrence. The suspension of the member's registration, the delivery of an oral reprimand, and publication on the College website of the decision and summary of reasons demonstrate to the profession and the public that the Discipline Committee is fulfilling its mandate and that acts of professional misconduct are taken seriously and addressed appropriately.

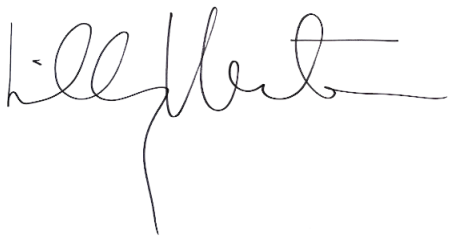
3. It meets the objective of specific deterrence. The panel is satisfied, after reviewing the Agreed Statement of Facts, conducting a plea inquiry, and delivering the oral reprimand, that the Member fully appreciates the seriousness of her conduct and the urgency of addressing her shortcomings in terms of knowledge, skills and judgement.

4. The awarding of costs to the College, while not part of the penalty *per se*, demonstrates to the Member the considerable financial burden to the profession for having to address issues of professional misconduct. The award of costs is not meant to be punitive, but it is an acknowledgment that the membership of the College should not bear the entire burden of these proceedings.

5. During the oral reprimand it was made clear that should the member ever appear before a panel of the Discipline committee in the future and be found guilty of professional misconduct, the consequences and penalty will be more severe.

The panel is satisfied that the Member has taken responsibility for her actions, and will do better in the future. Despite the difficulty in finding comparable or similar cases from previous discipline cases, the panel is satisfied that the proposed penalty in the Joint Submission is reasonable. Given that the Joint submission meets the objectives of general and specific deterrence, as well as protection of the public, we accept it as submitted.

I, Lilly Martin, sign this decision and reasons for the decision as Chairperson of this Discipline panel and on behalf of the members of the Discipline panel as listed below:



December 10, 2019

Lilly Martin, Chairperson
Deirdre Brett
John Stasiw

Date