**Statement of Allegations**
**Natasha Singleton-**
**Bassaragh (COIN 305C)**

**The Member**

1. At the material times, Natasha Singleton-Bassaragh (the "Member") was a duly registered member of the College of Midwives of Ontario practising midwifery at AMMA Midwives (the "Practice").

**The Client**

2. The "Client" was a client of the Practice.

**Midwifery Care provided by the Member to the Client**

3. At approximately 7:23 p.m. and approximately 7:54 p.m. on May 28, 2018, the Client paged the Practice because of a concern about fetal movement.
4. The Client's primary midwife was off-call and the Member received the Client's page at approximately 7:59 p.m.
5. At approximately 8:00 p.m. on May 28, 2018, the Member spoke with the Client. The Client advised the Member that she was concerned about reduced fetal movement. The Member advised the Client to do a second kick count for two hours. The Member advised the Client to page if she felt six counts and otherwise the Member would follow up in two hours.
6. At approximately 9:13 p.m. on May 28, 2018, the Client paged the Practice and reported that she was in labour. The Member spoke with the Client at approximately 9:26 p.m. The Member documented that the fetal movement was "as before".
7. At approximately 11:13 p.m. on May 28, 2018, the Client paged the Practice to report contractions.
8. At approximately 1:21 a.m. on May 29, 2018, the Client paged the Practice and reported contractions and that she was still waiting for a call back from a midwife.
9. The Member spoke with the Client at approximately 1:22 a.m. The Client advised the Member that she was having contractions. The Member documented that the Client's labour seemed more active. The Member advised the Client that she would find out if the Client's primary midwife was back on call. The Member advised the Client not to go to the hospital at this time. The Member advised the Client that she would call the Client back.
10. At approximately 2:29 a.m. on May 29, 2018, the Client paged the Practice and reported contractions and that she was going to the hospital. The Member spoke with the Client at approximately 2:30 a.m. The Client advised the Member that she was approximately five

minutes away from the hospital. The Member advised the Client that the primary midwife was on her way to the Client's house but that both the Member and the primary midwife would now meet the Client at the hospital. The Member documented that the Client was not aware that the primary midwife had been on her way to the Client's house.

11. It is alleged that the Member failed to appropriately manage the above-noted aspects of the Client's care, including in one or more of the following ways:

    a. The Member failed to conduct an in-person assessment of the Client when the Client reported concerns relating to fetal movement; and/or

    b. The Member failed to clearly communicate to the Client and document a plan for an in-person assessment following the call at approximately 9:13 p.m. on May 28, 2018 related to concerns regarding reduced fetal movement.

12. The Member met the Client at Etobicoke General Hospital (the "Hospital") at approximately 3:00 a.m. on May 29, 2018.

13. The Member performed an assessment of the Client. The Member did not auscultate the fetal heart rate at the initial assessment.

14. It is alleged that the Member failed to appropriately monitor fetal well-being and the fetal heart rate upon the Client's admission to hospital and prior to the primary midwife assuming primary care for the Client, including in one or more of the following ways:

    a. The Member failed to conduct a non-stress test upon the Client's admission to the Hospital;

    b. The Member failed to auscultate the fetal heart rate in a timely manner;

    c. The Member failed to adequately document the fetal heart rate assessments and/or failed to describe the interpretation of the fetal heart rate;

**Professional Misconduct Alleged**

15. 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).