DISCIPLINE COMMITTEE
OF THE COLLEGE OF MIDWIVES OF ONTARIO

PANEL:	Judith Murray, Chair Jan Teevan Donald Strickland

BETWEEN:

COLLEGE OF MIDWIVES OF ONTARIO	)	ERICA RICHLER for College of Midwives of Ontario
- and -	)	MICHAEL MANDARINO for Natasha Singleton-Bassaragh
NATASHA SINGLETON-BASSARAGH	)	
	)	LUISA RITACCA Independent Legal Counsel
	)	Heard: March 5, 2021

Amended DECISION AND REASONS

This matter came on for hearing before a panel of the Discipline Committee of the College of Midwives of Ontario ("the College") on March 5, 2021. This matter was heard via video conference.

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 the Client or the baby referred to during the hearing or in documents filed at the hearing, held March 5, 2021, or any information that would disclose the identity of the Client or the baby. The publication ban applies to the exhibits filed and to these decision and reasons.

The Allegations

The allegations against (the "Member) as stated in the Notice of Hearing dated July 28, 2020 (Exhibit #1) are as follows:

IT IS ALLEGED THAT:

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 [redacted], 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 [redacted], 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 [redacted], 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 [redacted], 2018, the Client paged the Practice to report contractions.

8. At approximately 1:21 a.m. on May [redacted], 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 [redacted], 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 [redacted], 2018 related to concerns regarding reduced fetal movement.

12. The Member met the Client at [redacted] (the "Hospital") at approximately 3:00 a.m. on May [redacted], 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).

Member's Plea

The Member admitted the allegations as set out in the Notice of Hearing at paragraphs 15(a) and (b), as described more fully in the Agreed Statement of Facts, described below. With resepct to the allegation at paragraph 15(b), the Member admitted that her conduct would reasonably be regarded by other members 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 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.

3. On May [redacted], 2018, the Client's primary midwife was off-call and the Member was the back-up midwife. The Member provided care to the Client in her role as back-up midwife on May [redacted] and [redacted], 2018. The Member had not been previously involved in the Client's pre-natal care.

4. On May [redacted], 2018, at 40 weeks and 3 days gestation, the Client delivered a baby girl who was stillborn.

Midwifery Care provided by the Member to the Client

5. At approximately 7:23 p.m. and approximately 7:54 p.m. on May [redacted], 2018, the Client paged the Practice because of a concern about fetal movement.

6. The Client's primary midwife was off-call and the Member received the Client's page at approximately 7:59 p.m.

7. At approximately 8:00 p.m. on May [redacted], 2018, the Member spoke with the Client. The Client advised the Member that she was concerned about reduced fetal movement. The Client indicated to the Member that the reason for her call was that she had not really been feeling fetal movements. When asked when the last time she felt the baby move was, the Client responded that she believed it was last night. She then said she thought she felt something earlier so she started checking again now. The Client indicated that she had tried a kick count for two hours and did not feel movement. The Client indicated that she was lying on her side when she did the kick count. The Member advised the Client to do a second kick count for two hours and that she should do it sitting up. The Member advised the Client to page if she felt six counts and otherwise the Member would follow up in two hours. A copy of the Member's narrative notes is attached as Exhibit A.

8. If the Member were to testify, she would state that she understood that the Client had reported that she was unsure about what she was feeling during this call but was concerned about what she had felt. As a result, the Member advised the Client to perform a "proper" kick count over a 2-hour period to confirm fetal movements.

9. At approximately 9:13 p.m. on May [redacted], 2018, the Client paged the Practice and reported that she was having contractions. The Member documented that the fetal movement was "as before" and that the Client was mostly feeling contractions. If the Member were to testify she would state that she understood this to mean that there were fetal movements similar to those she felt earlier per her last report. If the Member were to testify she would state that she thought that the reason the Client felt reduced movements was likely due to the contractions. The Member further documented that she measured the Client's contractions over the phone and that she determined the Client was in early labour. A copy of the Member's narrative note can be found in Exhibit A.

10. At approximately 11:13 p.m. on May [redacted], 2018, the Client paged the Practice to report contractions. Due to an error at the paging service company, the page went to another midwife, and the Member did not receive this page. The paging service, however, instructs clients to page back within 10 minutes if they do not receive a response.

11. At approximately 1:21 a.m. on May [redacted], 2018, the Client next paged the Practice, and reported contractions and that she was still waiting for a call back from a midwife.

12. The Member called the Client at approximately 1:22 a.m. The Member documented that she had not received the first page (from 11:13 p.m.). The Client advised the Member that she was having contractions. The Member documented that the Client's labour seemed more active. During this call, the Client reported that she felt a bulge and thought the baby dropped a lot. If the Member were to testify, she would state that at this time she understood the Client's report to be related to contractions and labour, and that the baby was moving down the birth canal into delivery position.

13. The Member advised the Client that she would find out if the Client's primary midwife was back on call and update her regarding the Client's status. The Member advised the Client not to go to the hospital at this time as she was still not in active labour. The Member advised the Client that she would call the Client back. A copy of the Member's narrative note can be found in Exhibit A.

14. If the Member were to testify she would state that following this call, she texted and then spoke with the primary midwife. The Member asked the primary midwife to attend to the Client so that the Member could attend to another client in labour at the hospital. If the Member were to testify she would say that she understood that the primary midwife was going to call the Client and tell her she was going to attend her home to assess her.

15. At approximately 2:29 a.m. on May [redacted], 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 Member asked the Client if she had heard from the primary midwife. The Client indicated that she had not heard from the primary midwife. 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. A copy of the Member's narrative note can be found in Exhibit A.

16. The Member acknowledges that she should have offered the Client an in-person assessment following their discussions regarding reduced fetal movements. The Member understood at the time that the Client was advising that there was some movement and she did not understand the Client to be advising that there was no fetal movement. The Member acknowledges that she should have ensured that communications regarding this issue were clear and unequivocal. She also acknowledges that she should have responded with an in-person or hospital assessment in order to assess fetal well-being.

17. It is agreed that the Member failed to appropriately manage the above-noted aspects of the Client's care, including in 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

    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 [redacted], 2018 related to concerns regarding reduced fetal movement.

Treatment at Hospital on May [redacted], 2018

18. The Member met the Client at [redacted] (the "Hospital") at approximately 3:00 a.m. on May [redacted], 2018.

19. The Member performed a vaginal examination of the Client which determined the Client's membranes were intact, and that dilation was at 1-2 cm. The Member documented at 3:00 a.m. that she "will go for mobile Doppler to check FHR as client is ambulating." A copy of the Member's note is attached as Exhibit B.

20. If the Member were to testify, she would state that upon arrival to the Hospital, the Client appeared to be in active labour and the Client believed that the birth was imminent. The Member would also testify that she would normally perform a fetal heart rate (FHR) reading first, but in the circumstances, the Member prioritized performing a vaginal examination to determine labour progress. The Member was able to conclude that the Client was only 1-2 cm dilated and her membranes were still intact. As such, while the Client was in labour, birth was not imminent.

21. The Member would also testify that once she had assessed the Client, the Member then took steps to perform a FHR reading but found the Hospital's Doppler was inoperable.

22. Because the Client was ambulating and labouring well, the Member decided to perform intermittent auscultation. If the Member were to testify, she would state that she understood that the Hospital discouraged midwives from using electronic fetal monitoring to auscultate heart rate for intermittent auscultation.

23. It is agreed that the Doppler at the Hospital was not operable and so the Member was unable to auscultate the fetal heart rate with a Doppler at that time. It is agreed that the Member texted the primary midwife at approximately 3:40 a.m. to bring up her own Doppler. It is agreed that the primary midwife had already arrived at the Hospital when the primary midwife received this text though she was not yet on the Labour and Delivery Unit. At 3:44 a.m., the Member also advised the primary midwife via text message that she had assessed the Client, as well as another client. At this point, the primary midwife walked on to the unit.

24. If the Member were to testify she would state that she was providing care to two of the practice's clients (that is, the Client and another practice client) upon her arrival at the Hospital and that she had been back and forth between the two rooms during the period of 3:00 am and 3:45 am. She would further state that she was not able to perform the FHR reading on the Client because she believed she had to first conduct a vaginal examination upon her arrival to the Hospital to confirm or rule out the Client's report of an imminent delivery. In addition, the Member was also managing another client at the same time who was also in active labour and close to delivery. She was providing care to two clients during the approximately 40-minute period that she was at the Hospital prior to the primary midwife's arrival which was a factor in the delayed FHR reading for the Client. When the primary midwife arrived on the unit, care of the Client was transferred back to the primary midwife so that the Member could attend to the other client.

25. It is agreed that when the primary midwife arrived on the Labour and Delivery Unit, she and the Member had a discussion that there were no working Dopplers available on the Labour and Delivery Unit. If the Member were to testify she would state that

she spoke to the primary midwife about the need to have a FHR assessment completed, and the Member understood that the primary midwife acknowledged this.

26. The Member transferred primary care to the primary midwife at approximately 3:45 a.m. when the primary midwife arrived at the Labour and Delivery Unit. The Member remained involved in the Client's care in a secondary role after that time. The Member did not document the transfer of care discussion in the Client's health record.

27. It is agreed that the Member did not conduct a non-stress test prior to transferring primary care to the primary midwife.

28. If the Member were to testify she would state that she understood the reason for admission at the Hospital to be increased contractions and onset of active labour, and not because of reduced or lack of fetal movements. She acknowledges that she should have conducted a non-stress test upon arrival given the Client's reports regarding fetal movements. She acknowledges that any issues regarding fetal movement should be treated seriously and responded to with an abundance of caution. She would state, however, that given her understanding and the Client's reporting of active labour and imminent birth, she believed that to be the priority and primary concern.

29. It is agreed 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 transferring primary care back to the primary midwife at approximately 3:41 a.m., including in the following ways:

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

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

30. Other aspects of the Member's care of the Client were addressed by the Inquiries, Complaints and Reports Committee (ICRC) of the College in a decision dated July 10, 2020 and the ICRC required the Member to complete a specified continuing education and remediation program as follows:

    a. The Member must review the HIROC Strategies for Improving Documentation: Lessons from Medical Legal Claims and complete the University of British Columbia's Midwifery Documentation and Communication Online Learning course and provide proof of successful completion to the Registrar. This component was completed on October 2, 2020.

    b. The Member must complete the Fundamentals of Fetal Health Surveillance Course offered by the University of British Columbia. This component was completed on January 8, 2021.

Admission of Professional Misconduct

31. By this document, the Member admits to the truth of the facts referred to in paragraphs 1 to 30 above (the "Agreed Facts").

32. It is agreed that the Agreed Facts constitute 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);

    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 unprofessional).

33. 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.

34. 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 and Reasons

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 and described more fully in the Agreed Statement of Facts.

The Agreed Statement of facts laid out clearly the areas of Ms. Singleton-Bassaragh's care that failed to meet the standard, in particular with regard to the management of fetal movement (see paragraph 29 of the Agreed Statement of Facts). 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 accepts the submissions of the College and the Member that aspects of the Member's care fell below the reasonable standard of midwifery practice in 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. Singleton-Bassaragh understands the allegations, 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. Singleton-Bassaragh 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 resolution reached by the parties.

Penalty

Counsel for the College advised the panel that a Joint Submission as to Penalty (Exhibit #3) had been agreed upon. The Joint Submission as to Penalty provides as follows:

> The College of Midwives of Ontario (the "College") and Ms. Singleton-Bassaragh agree and jointly submit that the Discipline Committee should make the following order as to penalty and costs:
>
> 1. Ms. Singleton-Bassaragh 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 impose the following terms, conditions and limitations on Ms. Singleton-Bassaragh's certificate of registration:
>
>   a. Within three months of the date of the Discipline Committee's Order, Ms. Singleton-Bassaragh is required to prepare and submit a 1,500-word reflective paper, to the satisfaction of the Registrar, regarding the management of decreased fetal movement and the assessment of fetal well-being in labour.

b. Within six months of Ms. Singleton-Bassaragh's return to practice, Ms. Singleton-Bassaragh must participate in a chart audit with a College appointed auditor, subject to the following terms:

i. Ms. Singleton-Bassaragh must notify the Registrar in writing one week before the date that she returns to practice;

ii. The auditor will review a minimum of five and a maximum of eight charts, with care provided by Ms. Singleton-Bassaragh after her return to practice referred to in paragraph (i) above, focusing on the documentation and care surrounding the assessment of fetal heart rate, including any charts with reported decreased fetal movement, if available;

iii. The auditor will provide a written report to the Registrar regarding the outcome of the chart audit in a form and manner approved by the Registrar;

iv. Ms. Singleton-Bassaragh is responsible for any costs or expenses associated with the chart audit to a maximum of $1,500.

3. Ms. Singleton-Bassaragh is required to pay to the College costs in the amount of $1,500, to be in paid in 15 monthly instalments of $100.00, beginning one month after the date of the Discipline Committee's Order and continuing every month until paid in full.

Penalty Decision

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

1. Ms. Singleton-Bassaragh 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 impose the following terms, conditions and limitations on Ms. Singleton-Bassaragh's certificate of registration:

a. Within three months of the date of the Discipline Committee's Order, Ms. Singleton-Bassaragh is required to prepare and submit a 1,500-word reflective paper, to the satisfaction of the Registrar, regarding the management of decreased fetal movement and the assessment of fetal well-being in labour.

b. Within six months of Ms. Singleton-Bassaragh's return to practice, Ms. Singleton-Bassaragh must participate in a chart audit with a College appointed auditor, subject to the following terms:

i. Ms. Singleton-Bassaragh must notify the Registrar in writing one week before the date that she returns to practice;

ii. The auditor will review a minimum of five and a maximum of eight charts, with care provided by Ms. Singleton-Bassaragh after her return to practice referred to in paragraph (i) above, focusing on the documentation and care surrounding the assessment of fetal heart rate, including any charts with reported decreased fetal movement, if available;

iii. The auditor will provide a written report to the Registrar regarding the outcome of the chart audit in a form and manner approved by the Registrar;

iv. Ms. Singleton-Bassaragh is responsible for any costs or expenses associated with the chart audit to a maximum of $1,500.

3. Ms. Singleton-Bassaragh is required to pay to the College costs in the amount of $1,500, to be in paid in 15 monthly instalments of $100.00, beginning one month after the date of the Discipline Committee's Order and continuing every month until paid in full.

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 remedial education, self reflection, reflective essay and chart audit exercise 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 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 order for costs to be paid 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.

At the conclusion of the hearing, the Member confirmed that she had waived her right of appeal and so the Panel administered the reprimand, a copy of which is set at Schedule A.

I, Judith Muray, 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:

J. Murray

Judith Murray, Chair

3/15/21

Date

Jan Teevan
Donald Strickland

Schedule A

REPRIMAND

As you know, Ms. Natasha Singleton-Bassaragh as part of its penalty order this Discipline Panel has ordered you that you be given an oral reprimand. You agreed to this term of order as part of your joint submission on penalty filed during the course of the hearing.

The fact that you have received this reprimand will be part of the public portion of the Register and, as such, part of your record with the College.

Although you will be given an opportunity to make a statement at the end of the reprimand, this is *not* an opportunity for you to review the decision made by the Discipline Panel, *nor* a time for you to debate the merits of our decision.

The Panel has found that you have engaged in professional misconduct in the following ways, including:

1. Failure to maintain the standards of practice of the profession; and

2. Engaging in conduct which would reasonably be regarded as unprofessional.

It is a matter of profound concern to this Panel that you have engaged in these forms of professional misconduct.

Moreover, the result of your misconduct is that you have let down the public, the profession, and yourself.

We need to make it clear to you that your conduct is unacceptable.

Of special concern to us is that fact that the professional misconduct in which you engaged has involved:

1. Failure to appropriately monitor Fetal Heart Rate (FHR) upon client admission and during the time that the client was under your care.

2. Not responding to client's concern of reduced fetal movement appropriately in particular you failed to conduct an in-person assessment of the Client when the Client reported concerns relating to reduced fetal movement.

This misconduct amounted to a breach of professional standards and is conduct that would reasonably regarded by others in the profession as unprofessional.

The panel recognizes your remedial efforts to date and appreciates your willingness to take these steps in advance of this hearing. Further, we acknowledge your remorse and we understand that this was a challenging professional event in your career. We recognize the work that you have committed to by coming to an agreement with counsel for the college on this matter.

We also want to make it clear to you that while the penalty that this Panel has imposed upon you is a fair penalty, a more significant penalty will be imposed by another Discipline Panel in the event that you are ever found to have engaged in professional misconduct again.