BEFORE THE HEALTH LICENSING OFFICE
BOARD OF DIRECT ENTRY MIDWIFERY

In the Matter of:	)	**Notice of Intent to Suspend License Impose**
Eleanor Legare,	)	**Additional Discipline Right to Request a Hearing**
	)	
License No.	)	
DEM-LD-269194	)	
	)	
Respondent,	)	Office File No. 12-6962

Notice of Proposed Action

Under ORS 676.606, 676.607, 687.445, and 687.485, and OAR 332-030-0000, the Board of Direct Entry Midwifery (Board), in consultation with the Health Licensing Office (*formerly* Oregon Health Licensing Agency (HLO or Agency)), is charged with disciplining licensed direct entry midwives. Pursuant to ORS 676.992(1)(d) and (m), (2) and (4), the Board, in consultation with HLO, hereby proposes to:

1) Suspend Respondent's license for a minimum period of two years with reinstatement contingent on the following:

1.1. Satisfying any general requirements for reinstatement under the applicable statutes and rules and the following specific requirements.

1.2. Respondent must successfully complete a Board approved course related to identification and management of prolonged labor. Respondent is responsible for identifying the course and submitting the course for approval by the Board. This course will not count toward any continuing education requirements for renewal of the Respondent's license.

1.3. Respondent violates no laws or Oregon Administrative Rules during suspension period.

2) Respondent is responsible for any fees or costs associated with these requirements, including any fees or costs associated required classes.

3) Assess the cost of any disciplinary proceeding against Respondent, up to a maximum of $5,000.

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FINDINGS OF FACT

1) At all relevant times, Respondent held Oregon Direct Entry Midwifery license DEM-LD-269194 issued by the Office.

2) At all relevant times, Respondent was the midwife responsible for the primary care of the client including the client's records, prenatal and intrapartum care.

3) In September of 2011 the client began her prenatal care with Respondent, at the time the client was 26 years old and 14 weeks into with her first pregnancy.

4) In Respondent's client records for the client, under section "exposures during pregnancy", the client indicated Marijuana as one of those exposures. Respondent did not counsel the client regarding that drug use and there is no indication of drug testing in the records.

5) According to the client's prenatal record, the client indicated that she had a history of excessive alcohol and IV drug use. Respondent did not counsel the client regarding that drug use and there is no indication of drug testing in the records.

6) Respondent stated in her interview that she missed that exposure to marijuana and history of excessive alcohol and IV drug use and did not counsel the client regarding that drug use and did not request drug testing.

7) On or about March 31, 2012 at 2:30 a.m., the client began labor at 40.4 weeks. At 5:45 a.m. she was having contractions every 5 minutes lasting 40 seconds and called Respondent.

8) At 7:30 a.m. the apprentice arrived and assessed the client to be 4 cm dilated, at 0 station and 80% affected, FHT as 130s to 140 and were recorded as having good beat to beat variability. According to the apprentice, she took the client's vital signs, blood pressure, pulse, and temperature but failed to chart them.

9) Respondent arrived at the client's home at 8:45 a.m. and the assistant arrived at 9:00 a.m. The client was assessed at 6 cm dilated, 0 station and 90% affected.

10) At 2:00 p.m., the client vomited three times.

11) At 5:48 p.m. Respondent found that the client had a cervical lip. Respondent attempted to resolve the cervical lip by having the client bear down while she tried push the lip over with her fingers.

12) Between 5:45 p.m. and 10:45 p.m., the client was changing positions and moving between the bedroom and the living room. The client vomited at least four times. Fetal heart tones were taken using a hand held Doppler, which were recorded as in the 120s to 130s and

described as having "beat to beat good variability." On at least two occasions at 7:55 p.m. and 9:45 p.m., the client was pushing to some degree in the McRoberts position while Respondent attempted resolve the cervical lip by having the client bear down while she tried push the lip over with her fingers.

13) At 10:45 p.m. According to records, Respondent discussed, and the client declined, transporting to the hospital. Respondent did not chart any details about that conversation as the only notation in the chart is "the client declines transfer to the hospital".

14) At 11:45 p.m., the assistant gave the client an IV of 1000 ml lactated ringers. In her statement, Respondent said they wanted to try every tool that they had to make the client feel like she tried everything. Fetal heart tones were recorded as 140-150's.

15) On or about April 1, 2012, at 1:28 a.m., the client was pushing or bearing down in McRoberts position while Respondent attempted resolve the cervical lip. The client reported she was vomiting black bile.

16) At 3:09 a.m., according to records, Respondent discussed transporting to the hospital with the client but the client declined. Respondent did not chart any details about this conversation and the only notion in the chart is: "Discuss hospital transfer again the client declines."

17) At 2:14 a.m. the client was given oxygen 8ml/min.

18) At 4:00 a.m. the anterior lip was resolved and baby was at 0 station. The client's vagina, vulva and labia were swollen. Respondent stated in an interview with an office investigator that she was concerned that the client was too swollen and exhausted to have the baby at home.

19) At 4:20 a.m., According to records Respondent discussed transporting to the hospital with the client, but the client declined. Respondent did not chart any details about this conversion the only notation in the chart is: "Discuss hospital transfer again the client declines."

20) Between 4:00 a.m. and 6:30 a.m., the client pushed on and off, with no progress. The client was vomiting with every contraction. Fetal heart tones during this time frame were recorded as 120s to 160s.

21) At 6:22 a.m., according to records Respondent discussed transport to the hospital with the client. The client agreed and Respondent began making the arrangements.

22) At 7:15 a.m., the client's blood pressure was 110/70, pulse 72, temp 98.2, FHT's 160's-170's. the client was transported to Emanuel by private car sometime between 7:15 and 8 a.m.

23) The client gave birth by cesarean section at 9:14 a.m. with an APGAR scores were 1 at 1 minute, 2 at 5 minutes, 3 at 10 minutes, and 6 at 15 minutes.

24) The baby suffered severe and fatal neurologic insult as a result of severe hypoxic ischemic encephalopathy. The attending physician at Emanuel wrote she suspected this likely was caused by cord compression during the prolonged second stage of labor. The baby was taken off life support and died the next day at 3:58 p.m. on April 2, 2012.

25) A surgical pathology report noted a trivascular umbilical cord showing marked funisitis, subamnionic pigment-laden macrophages, chorioamnionitis, The placental disk showed patchy intervillous fibrin deposition calcifications.

APPLICABLE LAW

Pursuant to **OAR 332-025-0021** Risk Assessment Practice Standards
Licensees must assess the appropriateness of an out-of-hospital birth taking into account the health and condition of the mother and baby according to the following absolute and non-absolute risk criteria:
(1) "Absolute risk" as used in this rule means conditions or clinical situations of obstetrical or neonatal risk that cannot be resolved and that preclude out-of-hospital care. If the mother or baby presents with any absolute risk factors, the LDM must:
(a) During the antepartum period, plan for transfer of care and an in-hospital birth;
(b) During the intrapartum period, arrange transportation to the hospital and transfer of care unless the birth is imminent;
(c) When the birth is imminent, take the health and condition of the mother and baby and conditions for transport into consideration in determining whether to proceed with out-of-hospital birth or to arrange for transportation to a hospital and transfer of care;
(d) During the postpartum period, arrange for transportation of mother or baby to a hospital and transfer of care;
(2) The following constitute absolute risk factors:
(b) INTRAPARTUM ABSOLUTE RISK CRITERIA:
(J) Excessive vomiting, dehydration, acidosis or exhaustion unresponsive to treatment;
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(3) "Non-absolute" means a condition or clinical situation that places a mother or baby at increased obstetric or neonatal risk, but does not automatically exclude a mother and baby from an out-of-hospital birth.
(4) When a mother or baby presents with one or more non-absolute risk factors, the LDM must:
(a) Arrange for the transfer of care of the mother or baby; or
(b) Comply with all of the following:
(A) Consult with at least one Oregon licensed health care provider regarding the non-absolute risk factors present.
(B) Discuss the non-absolute risk(s) with the mother, including:
(i) Possible adverse outcomes;
(ii) Whether an out-of-hospital birth is a reasonably safe option based upon the risk(s) present;
(iii) The anticipated risk(s) and the likelihood of reducing or eliminating said risks;
(iv) The midwife's experience with said risk(s);

(v) The ease and time involved in accomplishing transport or transfer of care;
(vi) Recommendation(s) given by the consulting Oregon licensed health care provider(s); and
(vii) Recommendation(s) given by the LDM to the mother.
(C) Document discussion of information listed in subsection (B).
(D) To the extent the LDM acts contrary to the recommendations given by the consulting Oregon licensed health care provider, the LDM must document the justification.
(E) Informed consent must be obtained and documented in records.
(5) The following are non-absolute risk factors:
(b) INTRAPARTUM NON-ABSOLUTE RISK CRITERIA:
(B) History of substance abuse during this pregnancy;
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(F) Lack of adequate progress in second stage:
(i) Lack of adequate progress in vertex presentation is when there is no progress after a maximum of three hours in cases with full dilation, ruptured membranes, strong contractions and sufficient maternal effort; * * *.

Pursuant to **OAR 332-025-0022** Mother and Baby Care Practice Standards
(3) In addition to and not in lieu of the MANA core competencies, an LDM must adhere to the following mother and baby care practice standards:
(a) Care During Pregnancy (Antepartum) - The LDM must:
(B) Determine the need for consultation or referral as appropriate;
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(b) Care During Labor, Birth and Immediately Thereafter (Intrapartum) — the LDM must:
(B) Determine the need for consultation or referral as appropriate;
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(D) Make appropriate and ongoing risk assessment and document maternal and fetal status and response throughout labor;
Pursuant to 332-025-0110 Records of Care Practice Standards
(1) The LDM must maintain complete and accurate records of each mother and baby.
(2) Records mean written documentation, including but not limited to:
(a) Midwifery care provided to mother and baby;
(b) Demographic information;
(c) Medical history;
(d) Diagnostic studies and laboratory findings;
(e) Emergency transport plan defined under OAR 332-025-0020;
(f) Informed consent and risk information documentation under OAR 332-025-0120;
(g) Health Insurance Portability and Accountability Act (HIPAA) releases;
(h) Description of the reasoning for transfer of care defined under OAR 332-025-0021 of the mother and baby;
(i) Documentation of all consultations and recommendations from health care providers as defined under OAR 332-015-0000;
(j) Documentation of all consultations and recommendations regarding non-absolute risk factors from Oregon licensed health care providers as defined under OAR 332-025-0021;
(k) Documentation of any declined procedures under OAR 332-025-0022;
(l) Documentation of termination of care under OAR 332-025-0130; and

(m) Documentation that the patient Recommended disclosure form has been received by the mother under OAR 332-025-0020.
(3) Records must be maintained for no less than seven years. All records are subject to review by the agency.
(4) All records must be legibly written or typed, dated and signed.
(5) All records must include a signature or initial of the LDM.

Pursuant to **OAR 331-020-0070** Discipline
(1) The Oregon Health Licensing Agency may discipline authorization holders for violations of laws and rules, in accordance with ORS 676.612 and 676.992.
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(5) As used in ORS 676.612(2)(j) negligence means engaging in conduct detrimental to the client.

Pursuant to **ORS 676.612(2)(J)** A person subject to the authority of a board, council or program listed in ORS 676.606 commits a prohibited act if the person engages in unprofessional conduct, negligence, incompetence, repeated violations or any departure from or failure to conform to standards of practice in performing services or practicing in a regulated occupation or profession subject to the authority of the boards, councils and programs listed under ORS 676.606.

CONCLUSIONS OF LAW

1) By failing to properly document labor records and failing to adequately document the mother's refusal to transport, including the mother's signature in the chart, Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0110(1),(2)(a),(k).

2) By failing to determine the need for consultation or referral as appropriate or perform risk assessment by not addressing Marijuana use, and the client's past history of excessive alcohol and IV drug use, Respondent violated ORS 676.612(2)(j),(n); OAR 332-025-0021(1)(2)(a)(J)(3)(5)(b)(B) and OAR 332-025-0022 (3)(a)(B).

3) By failing to properly assess the need for transport, consultation or referral as appropriate when the client presented with non-absolute risks and absolute risks during labor, Respondent violated ORS 676.612(2)(j),(n); OAR 332-025-0021 and OAR 332-025-0022(3)(b)(B)and (D).

4) By allowing the client to labor with no progress for 13 to 14 hours, full dilation, except a cervical lip, with ruptured membranes, strong contractions and sufficient maternal effort, Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0021(5)(b)(F)(i).

5) By failing to recognize or acknowledge and transport when the client presented with the absolute risks of excessive vomiting and exhaustion, Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0021(2)(b)(J).

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6) The Respondent acted with negligence, as defined in OAR 331-020-0070(5), by failing to properly act in addressing the client's abnormal labor pattern, violating ORS 676.612(2)(j)(n) and OAR 332-025-0022.

PROPOSED ORDER

Pursuant to ORS 676.612(1) and ORS 676.992(2), the office may take any disciplinary action it finds proper, including revocation of Respondent's license, for any violation.

Pursuant to OAR 332-030-0000, the Board of Direct Entry Midwives, in consultation with the Health Licensing Office, finds and hereby proposes to ORDER:

1) Suspend Respondent's license for a minimum period of two years with reinstatement contingent on the following:

1.1. Satisfying any general requirements for reinstatement under the applicable statutes and rules and the following specific requirements.

1.2. Respondent must successfully complete a Board approved course related to identification and management of prolonged labor. Respondent is responsible for identifying the course and submitting the course for approval by the Board. This course will not count toward any continuing education requirements for renewal of the Respondent's license.

1.3. Respondent violates no laws or Oregon Administrative Rules

2) Assess the cost of any disciplinary proceeding against Respondent, up to a maximum of $5,000.

3) Respondent is responsible for any fees or costs associated with these requirements, including any fees or costs associated required classes.

DATED 12-11-14

Colleen Forbes, LDM
President, Board of Direct Entry Midwifery

Enclosures: Option form, Notice of Contested Case Rights and Procedures
CERTIFIED MAIL: 7010 3090 0000 6746 4838

NOTICE OF RIGHTS TO REQUEST A HEARING

You have the right to a hearing to contest this order. The hearing, if requested, will be conducted according to the Administrative Procedures Act, ORS chapter 183. A **request for hearing** must be in writing and **must be received** by the Health Licensing Office **within 30 days** from the date this Notice was mailed to you. The written request for a hearing must be sent to the Health Licensing Office, 700 Summer St. NE, Suite 320, Salem, Oregon 97301-1287.

If you request a hearing, you **may be required to provide, with your request, an answer** to each factual matter alleged in the Notice and a short and plain statement of any **affirmative defense** you will raise at the hearing. Please see OAR 331-020-0020. If a specific response is required, factual matters alleged in the notice and not denied in the answer shall be presumed admitted; failure to raise a particular defense in the answer will be considered a waiver of such defense; new matters alleged in the answer (affirmative defenses) shall be presumed to be denied by the office; and evidence shall not be taken on any issue not raised in the notice and the answer. You may be represented by an attorney. If you cannot afford an attorney, you may contact Oregon's Legal Aid providers to attempt to obtain free or low-cost representation.

If you are an active duty service member you have the right to request a stay of proceedings under the federal Servicemembers Civil Relief Act and may contact the Oregon State Bar toll-free at (800) 452-8260, or the Oregon Military Department toll-free at (800)452-7500, or the United States Armed Forces Legal Assistance (AFLA) locator at http://www.militaryonesource.mil or http://legalassistance.law.af.mil.

You will be notified of the date, time and place of the hearing. If you request a hearing you may be represented by an attorney at hearing and you may subpoena and cross-examine witnesses. If you cannot afford an attorney, you may contact an Oregon legal aid office to apply for assistance. If you request a hearing, you will also be given information on the procedures, right of representation and other rights relating to the conduct of the hearing before the commencement of the hearing.