

2 **BEFORE THE OREGON HEALTH LICENSING AGENCY**  
4 **BOARD OF DIRECT ENTRY MIDWIFERY**

6 *In the Matter of:* )  
7 **Jennifer Gallardo,** ) **Settlement Agreement**  
8 ) **and**  
9 *License No.* ) **Stipulated Final Order**  
10 *DEM-LD-1000044* )  
11 Respondent, ) Agency File No. 10-5963  
12 )

14 1.

16 Under ORS 687.420, 687.445, and 687.485, the Board of Direct Entry Midwifery (“Board”),  
17 with the assistance of and in consultation with the Health Licensing Office<sup>1</sup> is the State board  
18 charged with licensing and disciplining licensed direct entry midwives. Pursuant to ORS  
19 687.445, 676.612(1), and 676.992(2), the Board, hereby finds the following facts and  
20 conclusions of law.

22 2.

- 24 1. At all relevant times, Jennifer Gallardo (Respondent) held Direct Entry Midwifery license  
25 DEM-LD-1000044 issued by the OHLA.  
26  
27 2. At all relevant times, Respondent was the primary midwife for Client. Client was attempting  
28 to have a vaginal birth after a prior cesarean (VBAC).  
29  
30 3. On January 8, 2010, Client was at 42 weeks and 1 day of gestation. Client was not given a  
31 biophysical profile (BPP). While Respondent noted that Client previously declined the BPP  
32 and AFI, the record for the visit does not contain documentation of education, discussion of  
33 why the test or procedure is required or recommended, or refusal of the test in conjunction  
34 with the Client’s signature. The BPP would have included an amniotic fluid index, which is  
35 required at 42 weeks. The record does not contain any documentation of education,  
36 discussion of why the amniotic fluid index is required, informed consent or refusal of the  
37 amniotic fluid index with the Client’s signature.  
38  
39 4. On January 11, 2010, at 2:15 p.m.,<sup>2</sup> Respondent arrived at Client’s residence.  
40  
41 5. On January 11, 2010, at 3:20 p.m., in the labor records, a variable deceleration was  
42 documented by Respondent. On 1/11/10, at 8:15 p.m., in the labor records, a variable

<sup>1</sup> As of July 1, 2014, the “Oregon Health Licensing Agency” (OHLA or Agency) became the “Health Licensing Office” (HLO or Office).

<sup>2</sup> Dates and times are from the Client’s records.

2 deceleration was documented by Respondent. On 1/12/10, at 4:10 a.m., in an addendum to  
the labor records, a variable deceleration was documented by Respondent.

4 6. On January 12, 2010, at 4:15 a.m., according to the labor records, Respondent discussed with  
the variable decelerations with Client, that the baby had recovered each time but that it  
6 sounded like a cord issue and the Client might need to be transported to the hospital.  
Respondent did not have client sign the refusal to transport.

8 7. On January 12, 2010, at 5:10 a.m., according to the labor records, Respondent discussed the  
10 need to transport with the Client again, noting that the baby could be fine, need resuscitation  
or worse. Respondent did not have client sign the refusal to transport.

12 8. There is no documentation that Respondent informed the Client that the decelerations could  
14 be an indication of uterine rupture, for which Client would have already been at higher risk  
as this was a VBAC.

16 9. On January 12, 2010, at 7:00 a.m., Respondent did not find fetal heart tones. Respondent did  
18 not call 911 to transfer to care to EMS, did not document discussion of need to transport with  
Client, nor is there a signature from Client refusing transport to the hospital.

20 10. On January 12, 2010, between 7:00 a.m. at 9:00 a.m., fetal heart tones are charted in the labor  
22 record by Respondent's apprentice. These appear to not have been fetal heart tones but  
rather the Client's pulse. Respondent admitted that she questioned whether these were fetal  
24 heart tones at the time, and thought the baby was either fine or dead. Respondent did not  
call 911 to transfer to care to EMS, did not document discussion of need to transport with  
26 Client, nor is there a signature from Client refusing transport to the hospital during this time.

28 11. On January 12, 2010, at 9:13 a.m., in an addendum to the labor records, Respondent  
30 documented baby being born dead.

32 12. The Client's GBS status was unknown, the Client was attempting a vaginal birth after  
cesarean, had a history of macrosomia with her last delivery, the last growth ultrasound put the  
34 baby in the 87<sup>th</sup> percentile, and the bag of waters had been ruptured approximately 30 hours  
at delivery. Despite the signs that the Client could be at higher risk for infection, maternal  
36 vital signs were not regularly documented during the labor aside from vitals at admission and  
two maternal pulses noted during the labor.

38 13. The Client's pulse was elevated to 120 and remained elevated over 12 hours post-delivery.  
Her blood pressure was decreased, with a low of 80/60 at 9:30 a.m. on January 13, 2010. At  
40 approximately 6:30 pm on January 12, 2010, Client became dizzy was standing at which  
point her fundus was above the umbilicus 4 finger breadths. She was given Pitocin at 11:19  
42 a.m. and 5:00 pm on January 12, 2010. The total blood loss listed on the birth summary is  
1250cc. Client's temperature was not taken until 7:30 p.m. on January 13, 2010, despite the  
44 signs that Client was at a higher risk for infection and had an elevated pulse.

3.

1. By failing to document a discussion with the Client of client education regarding the BPP, where Respondent states that the Client refused the BPP on January 8, 2010, Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0022(10).
2. By failing to document a discussion with the Client of why the BPP is required, where Respondent states that the Client refused the BPP on January 8, 2010, Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0022(10).
3. By failing to include the Client's signature in the Chart, when the Client refused the BPP on January 8, 2010, Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0022(10).
4. By failing to provide the Client with an amniotic fluid index on January 8, 2010, Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0022(4)(a).
5. By failing to document refusal of the amniotic fluid index, education regarding the amniotic fluid index, why an amniotic fluid index is required at 42 weeks or obtain the Client's signature refusing the amniotic fluid index, Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0022(10).
6. By failing to arrange for the Client to be transported to the hospital at 4:15 a.m. on January 12, 2010, when presented with an intrapartum absolute risk of OAR 332-025-0021(2)(b), evidence of fetal distress, the Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0021(1)(b).
7. By failing to arrange for the Client to be transported to the hospital at 4:15 a.m. on January 12, 2010, when presented with an intrapartum absolute risk of OAR 332-025-0021(2)(b), abnormal fetal heart rate pattern unresponsive to treatment, the Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0021(1)(b).
8. By failing to document the Client's signature where Respondent discussed the need to transport to the hospital with the Client at 4:15 a.m. on January 12, 2010, Respondent violated ORS 676.612(2)(j),(n) and 332-025-0021(5)(a).
9. By failing to document the Client's signature where Respondent discussed the need to transport to the hospital with the Client at 5:10 a.m. on January 12, 2010, Respondent violated ORS 676.612(2)(j),(n) and 332-025-0021(5)(a).

- 2 10. By failing to document that Client was informed about the decelerations indicating that  
4 Client was at risk of uterine rupture before Client refused transport, Respondent violated  
6 ORS 676.612(2)(j),(n) and 332-025-0021(5)(a).
- 8 11. By failing to arrange for the Client to be transported to the hospital at 7:00 a.m. on  
10 January 12, 2010, when presented with an intrapartum absolute risk of OAR 332-025-  
12 0021(2)(b), evidence of fetal distress, the Respondent violated ORS 676.612(2)(j),(n) and  
14 OAR 332-025-0021(1)(b).
- 16 12. By failing to arrange for the Client to be transported to the hospital at 7:00 a.m. on  
18 January 12, 2010, when presented with an intrapartum absolute risk of OAR 332-025-  
20 0021(2)(b), inability to auscultate fetal heart tones, the Respondent violated ORS  
22 676.612(2)(j),(n) and OAR 332-025-0021(1)(b).
- 24 13. By failing to call 911 at 7 a.m. on January 12, 2010 when presented with an immediately  
26 life threatening situation for the infant (no fetal heart tones detected), the Respondent  
28 violated ORS 676.612(2)(j),(n) and OAR 332-025-0021(5)(b).
- 30 14. By failing to document the client's refusal to transport, with client's signature in the  
32 chart; 7:00 a.m. on January 12, 2010, Respondent violated ORS 676.612(2)(j),(n) and  
34 332-025-0021(5)(a).
- 36 15. By failing to obtain the Client's signature refusing transport at 7:00 a.m. on January 12,  
38 2010, Respondent violated ORS 676.612(2)(j),(n) and 332-025-0021(5)(a).
- 40 16. By failing to ensure that her apprentice was properly discerning the difference between  
fetal heart tones and maternal pulse between 7 a.m and 9 a.m on January 12, 2010,  
Respondent was negligent and failed meet the standards of care in OAR 332-025-  
0022(7)(a), in violation of ORS 676.612(2)(j),(n).
17. By failing to arrange for the Client to be transported to the hospital between 7:00 a.m.  
and 9 a.m. on January 12, 2010, when presented with an intrapartum absolute risk of  
OAR 332-025-0021(2)(b), evidence of fetal distress, the Respondent violated ORS  
676.612(2)(j),(n) and OAR 332-025-0021(1)(b).
18. By failing to arrange for the Client to be transported to the hospital between 7:00 a.m.  
and 9 a.m. on January 12, 2010, when presented with an intrapartum absolute risk of  
OAR 332-025-0021(2)(b), inability to auscultate fetal heart tones, the Respondent  
violated ORS 676.612(2)(j),(n) and OAR 332-025-0021(1)(b).

- 2 19. By failing to call 911 between 7:00 a.m. and 9 a.m. on January 12, 2010 when presented  
4 with an immediately life threatening situation for the infant (no fetal heart tones  
6 detected), the Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0021(5)(b).
- 8 20. By failing to document the client's refusal to transport, with client's signature in the  
10 chart; between 7:00 a.m. and 9 a.m. on January 12, 2010, Respondent violated ORS  
12 676.612(2)(j),(n) and 332-025-0021(5)(a).
- 14 21. By failing to properly monitor maternal vital signs during the, where Client was at risk  
16 for maternal infection, Respondent was negligent and violated the standard of care of  
18 providing appropriate on-going assessment of mother during labor in OAR 332-025-  
20 0022(7), in violation of ORS 676.612(j),(n).
- 22 22. By failing to arrange for the Client to be transported to the hospital, when presented with  
24 an postpartum absolute risk of OAR 332-025-0021(2)(c), uncontrolled postpartum  
26 bleeding, the Respondent violated ORS 676.612(2)(j),(n) and OAR 332-025-0021(1)(b).
- 28 23. By failing to properly monitor maternal vital signs, where Client was at risk for maternal  
infection, was showing signs of hypotension and tachycardia, Respondent was negligent  
and violated the standard of care of providing appropriate on-going assessment of mother  
during labor in OAR 332-025-0022(7), in violation of ORS 676.612(j),(n).
- 30 24. By failing to either arrange for transport or comply with requirements of OAR 332-025-  
0021(3)(a)-(d), when presented with the non-absolute risk of a condition requiring more  
than 12 hours of postpartum observation (postpartum hemorrhaging, signs of  
hypotension, signs of tachycardia), Respondent violated OAR 332-025-0021(3), ORS  
676.612(j)(n).

4.

32 Respondent and the Board desire to fully and finally resolve this matter and, pursuant to ORS  
34 183.417(3)(a), agree as follows in full, final, and complete settlement of this matter as follows:

- 36 (a) The Final Order below may be issued and entered, incorporating the findings of fact  
and conclusions of law in sections (2) and (3) of this settlement agreement.
- 38 (b) Respondent will participate in the Oregon Midwifery Council's peer review and  
full chart review process for Client #1, Client #2, Client #3.<sup>3</sup> The OMC peer and

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<sup>3</sup> These clients are listed in the confidential key that will be supplied to Respondent with this Settlement Agreement and Stipulated Final Order.

chart review process can be found at:  
<http://oregonmidwiferycouncil.org/wp/member-resources-2/>.

- (c) Respondent must be directly supervised by a Board approved supervisor for her first five midwifery clients following the issuance of this Settlement Agreement and Stipulated Final Order. Supervisor and Respondent must comply with the Board's Midwifery Supervision Guidelines.<sup>1</sup> The supervisor must also be physically present at the births for these clients.
- (d) Respondent must provide the name(s) of the potential supervisor to the Health Licensing Office by November 23, 2015 for Board approval of this supervisor at the Board's December 2, 2015 meeting. The person(s) on Respondent's list must not have any past or pending discipline with the Board, or if licensed by another Board, with the Board that regulates the person.
- (e) Respondent must fully comply with the Board's statute and rules. Respondent must fully cooperate with any requests for information from the Board.
- (f) Respondent must provide acceptable proof to the Board of her compliance with the conditions of this Settlement Agreement by January 2, 2017. Time is of the essence, and if Respondent does not provide sufficient proof to the Board of her compliance with the conditions of this settlement agreement by January 2, 2017, Respondent's license will be automatically suspended from that date for two years.
- (g) Respondent is responsible for any fees, costs and expenses necessary for compliance with the conditions of this Settlement Agreement.
- (h) Respondent and the Board agree that the Board will not pursue costs for this contested case process.
- (i) This Settlement Agreement and Final Order is a public document and must be disclosed, published, and reported in accordance with the requirements of ORS 671.010 to 671.220, OAR Chapter 806, and Oregon Public Records Law.
- (j) This Settlement Agreement and Final Order in no way limits or prevents further remedies, sanctions, or actions which may be available to the Board under Oregon law for conduct or actions of Respondent not covered by this Settlement Agreement and Final Order, or against a party not covered by this Settlement Agreement and Final Order, or for Respondent's failure to comply with the terms of this Settlement Agreement and Final Order.
- (k) Respondent has been fully advised of Respondent's rights to notice and a contested case hearing under the Oregon Administrative Procedures Act (ORS Chapter 183) and fully and finally waives any and all such rights and any rights to appeal or otherwise challenge this Settlement Agreement and Final Order.

2 (l) Respondent acknowledges by the signature below that Respondent has fully read  
3 this Settlement Agreement and Final Order and understands it completely.  
4 Respondent acknowledges that, without any force or duress, she enters into this  
5 Settlement Agreement and consents to issuance and entry of this Final Order below.  
6 Respondent states that no promises or representation has been made to induce her to  
7 sign this Settlement Agreement and agree to issuance and entry of the Final Order  
8 below.

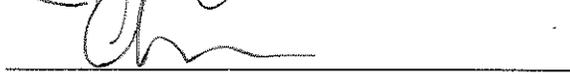
10 (m) Respondent has consulted with an attorney as to this settlement agreement or  
11 waives any and all rights to consult with an attorney prior to entering into this  
12 Settlement Agreement and the issuance and entry of the Final Order below.

14 (n) This Settlement Agreement constitutes the entire agreement between the Board and  
15 Respondent. No waiver, consent, modification or change of terms of this  
16 Settlement Agreement shall bind the Board and Respondent unless in writing and  
17 signed by Respondent and approved by Board. Such waiver, consent, modification  
18 or change, if made, shall be effective only in the specific instance and for the  
19 specific purpose given. There are no understandings, agreements or  
20 representations, oral or written, not specified herein regarding this Settlement  
21 Agreement.

22 **IT IS SO STIPULATED AND AGREED TO BY:**

24   
25 \_\_\_\_\_  
26 Jennifer Gallardo

Dated: 11/20/15

28   
29 \_\_\_\_\_  
30 Colleen Forbes, Chair  
Board of Direct Entry Midwifery

Dated: 12-2-15

2  
3  
4 **FINAL ORDER**

5 **NOW, THEREFORE**, based on the Settlement Agreement between Respondent and  
6 Board set forth above and pursuant to ORS 183.417(3)(b), it is hereby **ORDERED** that:

7  
8 The above Settlement Agreement is approved and incorporated herein by this reference; and as  
9 of the date below that this Final Order is issued, Respondent's license to practice direct entry  
10 midwifery in Oregon is subject to her compliance with the conditions in the Settlement  
11 Agreement. If Respondent does not provide acceptable proof of her compliance with the  
12 conditions in the Settlement Agreement by January 2, 2017, her license will be immediately  
suspended for two years.

13  
14 **ISSUED** and **EFFECTIVE** this 2 day of Dec 2015.

15  
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17 \_\_\_\_\_  
18 Colleen Forbes, Chair  
19 Board of Direct Entry Midwifery  
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## **Midwifery Supervision Guidelines**

The supervisee must meet with the Board approved supervisor to develop a plan of supervision. The supervisee will notify the supervising midwife upon discovery of any confirmed or suspected Absolute or Non-Absolute Risks listed in OAR 332-025-0021.

The supervisor will meet with the supervisee at the following points throughout the course of care to review and discuss the client's charts for a total of no less than four meetings for each supervised birth. The supervisor will at minimum address the areas listed below with specific attention to areas where violations have occurred as listed in the final order and standards of care pursuant with midwifery laws and rules. The supervisor will address any areas of concern with the supervisee.

### **I. Intake and initial risk assessment (meeting to take place shortly after initial visits or initial assessments)**

- 1) Medical History
  - a) OB/GYN History
  - b) Surgical History
  - c) Family History
- 2) Dating parameters identified & discrepancies resolved per accepted standards
- 3) Absolute or Non-Absolute Risks identified-did the supervisee appropriately assess and recognize risk factors.
  - a) Was there an appropriate consultation and with who
  - b) Consult to confirm risk factor
  - c) What was the result of that consultation
  - d) Was there a documented discussion with the client
  - e) What was the result
- 4) Other potential risks identified or preexisting conditions
  - a) Therapeutic actions/interventions instituted in alignment with identified problems
  - b) Consult to rule out a risk factor
- 5) Informed choice discussions documented
  - a) Supervisees recommendations
- 6) Records of Care properly documents

### **II. Care During Pregnancy (Antepartum) (meeting to take place around 36 weeks)**

- 1) Assess, identify, evaluate and support maternal and fetal well-being throughout the process of pregnancy
- 2) Lab work and testing
- 3) Absolute or Non-Absolute Risks identified- did the supervisee appropriately assess and recognize risk factors.
  - a) Was there an appropriate consultation and with who
  - b) Consult to confirm risk factor
  - c) What was the result of that consultation
  - d) Was there a documented discussion with the client
  - e) What was the result
- 4) Other potential risks identified or preexisting conditions
  - a) Therapeutic actions/interventions instituted in alignment & identified problems
  - b) Consult to rule out a risk factor

#### ***Antepartum continued***

- 5) Informed choice discussions documented
  - a) Risks/benefits
  - b) Pros/cons
  - c) Midwife's recommendations
- 6) Informed consent documentation
- 7) Records of Care properly documents

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**III. Later Pregnancy and Post Dates** (meetings to take place as necessary)

- 1) Absolute or Non-Absolute Risks identified- did the supervisee appropriately assess and recognize risk factors.
  - a) Was there an appropriate consultation and with who
  - b) Consult to confirm risk factor
  - c) What was the result of that consultation
  - d) Was there a documented discussion with the client
  - e) What was the result
- 2) Postdates testing
- 3) Informed consent documentation
- 4) Records of Care properly documents

**IV. Labor, Birth and Immediately Thereafter (Intrapartum)** (meetings to take place as necessary)

- 1) Vital signs at appropriate intervals temperature, blood pressure, pulse, fetal heart tones
- 2) Urine dip done
- 3) If abnormal vital signs – what action taken & is it consistent?
- 4) Labor progress assessed. How?
- 5) Interventions
- 6) Documentation of interventions & effect
- 7) Absolute or Non-Absolute Risks identified- did the supervisee appropriately assess and recognize risk factors.
  - a) Was there an appropriate consultation and with who
  - b) Consult to confirm risk factor
  - c) What was the result of that consultation
  - d) Was there a documented discussion with the client
  - e) What was the result
- 8) Informed consent documentation
- 9) Records of Care properly documents

**V. Postpartum** (meetings to take at the end of Midwifery care or as necessary)

- 1) Postpartum
  - a) Assessment at appropriate intervals
  - b) ID deviations
  - c) Action taken documented