

**BEFORE THE REVIEW COMMITTEE
OF THE AMERICAN MIDWIFERY CERTIFICATION BOARD**

In the Disciplinary Matter of

Brenda Keep, CNM
Respondent

DECISION

On October 6, 2024, the American Midwifery Certification Board (AMCB) received written Complaint from a patient of Brenda Keep, CNM (Respondent), containing allegations that Respondent in charge of her birth was not available on site when there was evidence of fetal distress, and further, that she instructed the students present to wait for her arrival to call the ambulance. The patient further alleged that Respondent arrived at the same time as the ambulance and encouraged them to “hurry and not wait like they did last time” after which the patient asserts the ambulance crew made comments about the midwife having delayed calling previously and “[gave] them a hard time.”

In accordance with AMCB procedures, the complaint was reviewed by the President of AMCB Board of Directors, who determined that the matters alleged in the notice of possible violation, if true, could constitute grounds for disciplinary action.

Accordingly, by letter dated August 13, 2025, AMCB notified Respondent that it had initiated a disciplinary proceeding to determine whether good grounds existed for discipline under the provisions of Section A.9 of the Disciplinary Policy:

A.9. Engaging in conduct which is inconsistent with professional standards, including but not limited to (i) any practice that creates unnecessary danger to a patient’s life, health or safety; and (ii) any practice that is contrary to the ethical conduct appropriate to the profession that results in termination or suspension from practice. Actual injury to a patient or the public need not be shown under this provision.

The notice requested that Respondent submit a written answer to these charges within 30 days of receipt of notice. On 9/10/2025, AMCB received a brief response from Respondent which included her CV. On 9/30/2025, AMCB requested additional information from Respondent. On 10/16/2025, Respondent submitted her response which included the patient’s medical records, Waco Birth Center & Clinic Policies and Procedures, Waco BC data collection – Births and transfers for (2 years), student midwife Webb CV, BLS certificate, NARM application containing supervised births, prenatal exams, newborn exams under supervision, postpartum exams under supervision, etc. By 10/27/2025, the Respondent submitted the patient’s postpartum notes and the Baylor Scott & White Maternal Transport Follow Up Feedback report.

A Review Committee comprised of the Chair of the Discipline Committee, and two additional members was duly convened.

The Review Committee has now considered the charges against Respondent and the above-described matters of record. On the basis of the factual findings and reasons set forth below, the Committee unanimously concludes that reprimand is an appropriate response.

FINDINGS

The Review Committee finds the following facts:

1. AMCB (formerly known as ACC) was formed in 1991 by the American College of Nurse Midwives (ACNM) as an independent entity to carry on the existing program of ACNM for certifying the competency of individuals as entry-level nurse-midwives.
2. AMCB has assumed responsibility for discipline of ACNM/ACC/AMCB certificants through the Disciplinary Policy, the most recent version of which AMCB adopted in November 2012 REV 2018.
3. Respondent was certified by AMCB on 1/14/2014.
4. AMCB received a patient complaint stating:
 - a. She was 42 weeks pregnant and went into active labor around 3:00am and arrived at the birth center at 4:05am.
 - b. Upon arrival, student Rhonda and midwife student AW (midwife student) were on location, Respondent was not.
 - c. At around 7:00am midwife student was unable to locate her baby's heartbeat.
 - d. The midwife student called Respondent and was instructed not to call the ambulance until Respondent arrived; however, the student midwife called for the ambulance.
 - e. Respondent and EMS arrived around the same time.
 - f. Respondent argued with the ambulance driver about delays in leaving for the hospital.
5. AMCB received a response from the Respondent indicating that:
 - a. When the Patient arrived, she was found not to be in active labor based on an examination by the midwife student, also identified as the birth assistant;
 - b. that as soon as she was notified that the Patient now met the criteria for admission, Respondent left for the birth center.
 - c. while she was en route, the midwife student called to alert her to lost fetal heart tones;
 - d. EMS was called immediately by the student;
 - e. at no time did she tell the student to delay, as this would have been against birth center policy.

DISCUSSION

In this matter we are called upon to decide whether and what discipline is warranted against a CNM who has had a patient complaint submitted to AMCB regarding failure to meet professional standards, specifically by not appropriately caring for a pregnant patient nor providing professional supervision for student midwives.

We reviewed all documents provided from the birth center, hospital and EMS. Significant aspects of the patient's pregnancy history include regular prenatal care from the first trimester, BMI 39.5 at intake, gestational hypertension with mild features for which she was taking oral magnesium 1000 mg daily. During this review we found that the patient was G1P0 at 41 6/7 weeks, had been taking a birth tincture containing blue cohosh

since 35 weeks, and was given both castor oil and black cohosh to stimulate contractions the previous day (6/18/2024). The birth center policy makes no specific mention of use of herbal supplements for induction. The drop of cohosh was administered by a midwife student with no evidence of consultation with Respondent.

She was initially seen at the birth center 6/18/2024 at 1130, again at 1400 and at 1540. She left to go home at 1753 at 3 cm dilated. All notes are signed only by a person identified as a student nurse midwife (RM). She went home and returned about 0430. She was not admitted at that time because she was not in active labor. It is not clear from the medical records if any communications between Respondent and patient and or Respondent and the two midwife students on site at the birth center occurred.

On 6/19/2024, the patient texted Respondent around 0311 stating her contractions were about 4.5 minutes apart, lasting for 1 minute for the last hour. The notes between this time and her admission, she was permitted to stay at the center due to travel distance. Although labor support was documented, neither maternal nor fetal wellbeing data is recorded. At 0658, the patient was examined and found to be 6 cm dilated. At this time Respondent was notified to come to the birth center.

At 0730, the fetal heart tones were present and there was fetal movement. At 0745, no heart tones were audible; the students called Respondent, who stated that she was almost to the birth center and advised the students to check with the ultrasound. Again, no heart rate or visible heart motion was identified. This was verified by Respondent when she arrived at the same time as the EMS crew. The call was placed to the ambulance service at 0757; that ambulance arrived at the birth center at 0805 and left for the hospital at 814.

On arrival at the hospital at 0830 fetal heart tones again could not be located. After multiple attempts with bedside ultrasound, cord pulsation was identified. The heart rate was identified with minimal variability and decelerations. Cervical exam indicated full dilation at -2 station, without a regular contraction pattern. The female infant was delivered by emergent cesarean section. She was taken to the NICU with Apgar 5/8 and increased work of breathing requiring CPAP. Newborn weight was 5533 grams (11 lb 12 oz).

Specific concerns include the presence of gestational hypertension with no preeclampsia labs recorded until 38weeks 6 days gestation, a person laboring without regular blood pressure monitoring in the setting of gestational hypertension, and the absence of direct supervision of student midwives managing induction and labor in a community setting. We do note that the hospital did not fault the transfer. We are glad that the outcome of the birth was positive for both infant and mother.

The Committee is persuaded that Respondent did not provide care within the expected standard of care and we conclude that there is a basis for formal sanction under section A.9 (Engaging in conduct which is inconsistent with professional standards, including but not limited to (i) any practice that creates unnecessary danger to a patient's life, health or safety; and (ii) any practice that is contrary to the ethical conduct appropriate to the profession that results in termination or suspension from practice. Actual injury to a patient or the public need not be shown under this provision) of the AMCB Discipline Policy.

SANCTIONS FOR VIOLATIONS

The Discipline Review Committee determines that the following sanctions shall be imposed for the violations found:

1. Reprimand
2. Continuing Education: <https://www.midwifece.com/courses/hypertensive-disorder> Respondent must

submit a certificate of completion of this course to AMCB no later than April 30, 2026, or additional sanctions may be applied to Respondent's certificate.

3. We encourage Respondent to consider the risks associated with inadequate supervision of individual team members, specifically of student midwives, and that language clarifying what level of student supervision clients can expect be added to the Waco Birth Center & Clinic Policies.

Effective: 3/23/2026

REVIEW COMMITTEE

Jan M. Kriebs, CNM, MSN, FACNM Chair
Jeanne Murphy, CNM, PhD, FACNM
Carla Morrow, DNP, CNM