BEFORE THE REVIEW COMMITTEE
OF THE AMERICAN MIDWIFERY CERTIFICATION BOARD

In the Disciplinary Matter of:

Jennifer Powell-Taschetti, CNM

Respondent

Decision

On March 18, 2023, the American Midwifery Certification Board (AMCB) received a written Discipline Complaint from a patient (Complainant) of Jennifer Powell-Taschetti, CNM (Respondent) containing allegations that Respondent was grossly negligent in the midwifery care she provided during the birth of Complainant's baby girl on May 27, 2022. The Complainant goes further to state that Respondent, among many other allegations of sub-standard midwifery care, failed to recognize that the infant was in respiratory distress upon birth and did not provide immediate resuscitation which caused the infant to suffer an HIE. The injury was so severe it ultimately led to the infant's death 11 days later when she was removed from life support.

The Discipline Complaint Form completed by the patient outlines the following allegations of Respondent's midwifery care that were inconsistent with professional standards:

1. Failing to handle or prepare for birth knowing the patient was 6cm, fully effaced with a bulging bag of waters on the day prior to the birth.
2. Attending a home birth without a birth assistant.
3. Coming to birth unprepared with appropriate birth equipment.
4. Coming to birth unprepared with appropriate resuscitation equipment (ie: ambu bag, intubation equipment and oxygen).
5. Did not access birthing mother's vitals on arrival or any time during the birth.
6. Did not properly monitor baby's heart tones during active labor and pushing.
7. Did not properly assess newborn after birth, including heart tones, or APGAR.
8. Did not react or recognize the emergency of a newborn needing immediate medical attention, including resuscitation with a reasonable amount of time.
9. NRP guidelines were not followed.
10. PPV not started until 5-6 minutes (at the earliest) after birth of the newborn who never took a breath on their own.
11. Abandoned patient after transfer of care.
12. Fraudulent and insufficient charting in medical record.
13. Editing medical records months after birth.
14. Reason to believe midwife was under the influence or possibly suffering from a mental health emergency due to her demeanor before, during and after the medical emergency. Her inability to recognize, act on, or take control of emergency medical situation.

Along with the complaint, the patient submitted sworn and notarized affidavits from herself and the following individuals who attended the birth:

1. Friend of patient (K.A.)
2. Doula and birth photographer (J.C.) (referred to further as Doula)
3. Mother of patient (D.B.)
4. Father of patient (K.B.)

Also in attendance was the husband of patient (father of the infant) who did not provide a written statement.

The patient also provided the following supplemental documents:

1. Infant hospital records (1,147 pages)
2. Infant EMS Report (12 pages)
3. Photos and videos
4. Patient hospital records (152 pages)
5. 911 calls and incident report
6. Text screenshots between patient and respondent
7. Text screenshots between doula (J.C.)
8. Respondent's Infant chart (6 pages)
9. Respondent's patient chart (96 pages)
10. Respondent's patient chart (96 pages)
11. Letter dated August 27, 2022, from the referring CNM (name redacted- referred to further as CNM2) who also provided postpartum and bereavement care to patient in early July 2022. The letter references records (documents 8-10 above) which she downloaded from directly from Client Care (web-based EMR system) using Respondent's credentials as directed by Respondent to access and download the patient's records.

Along with the above, this committee also reviewed the ACNM Standards for the Practice of Midwifery and the ACNM Clinical Bulletin Midwifery Provision of Home Birth Services. and the neonatal resuscitation guidelines in effect at the time this incident occurred.

The patient also filed a complaint with the South Carolina BON LLR in June of 2022. AMCB is unaware of the outcome of this investigation/case. No public document has been posted on their website or attached to the Respondent's license. Of note, Respondent's licenses, both the RN and APRN are listed as EXPIRED as of 4/30/2024.

AMCB Procedures. In accordance with AMCB procedures, Dr. Linda Hunter, President, reviewed the patient complainant and affidavits. In a certified letter dated April 11, 2024, the AMCB notified Respondent that a Discipline Review Committee had been appointed. The formation of this committee was in response to the patient complaint which suggested a possible violation of the AMCB's Discipline 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 AMCB notice sent via FED EX (Signature required) requested that the certificant submit a written answer to these charges within 30 days of receipt of the letter, in addition to providing a copy of her current CV.

On or about April 29, 2024, the AMCB notice was returned by FED EX marked “Incorrect Address-Recipient Moved”.

On 5/7/2024, AMCB’s Discipline Director tried to reach Respondent via mobile number on file. After several rings, the call transferred to voicemail where the “mailbox is full and unable to accept messages” recording was received. Having no previous mail returned from the Respondent’s address on file, AMCB mailed our Disciplinary notice, patient complaint and supplemental documents to Respondent via USPS mail on 5/8/2024. On 5/8/2024, AMCB also emailed Respondent the Disciplinary notice, patient complaint and supplemental affidavits. Having no response from Respondent and with no USPS returned mail, AMCB again sent our Disciplinary notice, patient complaint and supplemental documents to Respondent via FED EX (No signature required) on 5/22/2024. On 5/29/2024, AMCB Discipline Director received a phone call from homeowner who received our FED EX package. The homeowner states bought the home and has lived there since February 2023. He continues to receive mail for Respondent, whom he never met, does not know where she is or why she has not updated her address with the USPS. AMCB Discipline Director advised the homeowner to destroy package. The AMCB Discipline Director was able to leave detailed voicemail messages on Respondent’s voicemail on 5/30 and 6/7/2024 and forwarded our April 29, 2024 notice, patient complaint and supplemental documents on 6/7/2024.

On June 7, 2024, AMCB received an email response from Respondent stating “Thank you for letting me know about this. I will submit my statement as soon as possible regarding this matter.” On June 25, 2024, AMCB’s Discipline Director emailed Respondent again asking for her response stating the Committee will be meeting to discuss this matter on July 18th.

On July 18, 2024, AMCB received a response from Respondent addressing the complaint and each individual affidavit. Respondent also provided her signed statement dated August 9, 2022, she provided to the South Carolina Board of Nursing’s investigator.

On July 24, 2024, AMCB sent Respondent via email a request for additional information, specifically the patient’s complete medical chart, Respondent’s collaborative agreement in effect at the time services were provided to the patient, any and all consent forms used at the time care was provided to the patient and signed by the patient and Respondent’s clinical practice guidelines in effect at the time services were provided to the patient.

On 8/7/2024, AMCB re-sent July 24th email and request to Respondent via email with a note to please send her updated address or login to her portal record and update it there.

On 8/27/2024, AMCB emailed Respondent requesting answer to our July 24th request with a deadline of September 4 to respond.

On 8/28/2024, AMCB received a response from Respondent with the patient’s chart, her 11/24/2021 collaborative agreement, JPT Midwifery Practice Guidelines, and a blank, unsigned contract under the referring CNM’s company letterhead. In her email response, she stated she was still trying to locate the consent forms.

Finally, on 9/9/2024 AMCB received a response from Respondent stating she was unable to locate any consent forms signed by the patient.

Findings

The Review Committee found the following facts:

1. AMCB (previously known as ACC) was formed in 1991 by the American College of Nurse-Midwives 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 revised and approved in April 2018.
3. Respondent Jennifer Powell-Taschetti was initially certified by AMCB on September 23, 2021 and is currently certified through 12/2026 (certification #CNM07383).
4. The respondent holds an inactive RN license from the State of South Carolina North Carolina Board of Nursing, (#25644A) (expiration: 4/30/2024) and an APRN license (#25644) (expiration date: 4/30/2024).
5. It is unclear if the South Carolina Board of Nursing has concluded their investigation and case opened from the complaint filed by the patient in June 2022. Verification of the RN and CNM license by the SCBON indicates that there are “no charges or discipline” related to the certificant.

The Discipline Committee met and reviewed all of the documents submitted by the patient as well as the Respondent. The committee also reviewed the ACNM Standards for Midwifery Practice, Clinical bulleting on Midwifery Provision of Home Birth Services, ACNM Code of Ethics, and the neonatal resuscitation guidelines current at the time of this incident as well as other resource documents which will be identified within the context of the discussion.

Discussion

In this matter, we were called upon to decide whether and what discipline is warranted against the CNM, Jennifer Powell-Taschetti, regarding the patient complaint.

Timeline of Care

Patient Intake

The patient was a 31-year-old in her third pregnancy. Her first birth was by Cesarean with a subsequent in-hospital vaginal birth. The patient was attended by CNM2, in her last birth (VBAC) but CNM2 was on maternity leave at the time of this patient’s due date with her third baby, so CNM2 referred her to the Respondent. The patient planned a home birth. She initiated care with the Respondent at 9 weeks gestation and maintained a regular schedule of visits throughout her pregnancy. The patient states she was never given or signed a consent form or treatment of care contract—it was all verbal. The medical record at the 9 week visit states “all questions answered, and client oriented to practice. Low risk and appropriate for CNM care and planned home birth..” The content of the conversation during the first visit is not recorded in the record. There are no consent forms or treatment plans in the client chart and upon AMCB’s request, the Respondent could not produce said signed documents.

Deviation from standards: The ACNM Clinical Bulletin “Midwifery Provision of Home Birth Services” dated November 2015 (Replaces ACNM Clinical Bulletin March 2003) identifies previous Cesarean birth as “high risk and indication for planned hospital birth”. Table 1 page 2. A full disclosure, risk discussion and consent are standards or care for all clients and especially those with risk factors such as previous Cesarean birth planning an out of hospital birth. The ACNM Position Statement “Care of the Pregnant Person with a History of Cesarean Birth” states “ACNM encourages an integrated maternity care system with options for pregnant people who have experiences prior cesarean birth and alignment with ACOG recommendations for hospital-based care for those seeking VBAC with access to emergency services.”

Management at Term Gestation

At the May 26, 2022, 40-week prenatal visit, the patient was seen in the office and given an “induction cocktail” according to the patient’s statement. The patient reports she was given instructions on a sticky note and some herbs that were dispensed to use in the cocktail. The chart has a note at this visit that states “Plans to take CO cocktail in the morning”. There is no note of the name or contents of the medication in the chart and no note about herbs that the patient says she received. The Respondent in her statement to the SC BON, states “We discussed in prenatal care the use of the cocktail for self-induction and the risks that come with it.” Noted in the Respondent’s SC BON statement and evidenced by text message screen shot submitted by the patient on 5/27/2022 at 9:42am the patient states “I’m going to do the cocktail today if that’s good with you?” Respondent’s response “Go for it”. The next message sent by the patient at 1:36pm states “Cocktail down”. There is nothing outlined in Respondent’s Practice Guidelines regarding induction of labor.

Deviation from Standards: The ACNM Bulletin “Midwifery Provision of Home Birth Services” published March 2003 states that pharmacologic induction or augmentation of labor is not appropriate for home birth *Tables 1 and 2. It is not clear what substances were used by the Respondent for induction. The exact components are not documented in the chart. If the ingredients were pharmacologic agents, they were contrary to standard. However, in any case, the failure to document the exact components of the “cocktail” is a breach of standards of practice.

Failure to document medication in the medical record is outside the standard of care. It is of concern that the medications/herbs are not documented in any medical record.

Management of Labor

The patient began her labor around 2000 (8pm) on May 27 per patient, family and birth attendees. The patient was in the bathtub and felt her membranes rupture at 8:25pm per text message screenshot between patient the Respondent which states “Water broke in a bath. Intense back labor right now.” Next message from Respondent at 8:31pm “On the road”. The fluid seemed clear. Contractions and pressure became more intense, and she contacted her doula, a friend who would serve as a birth photographer until doula arrived (photos of birth and baby were reviewed for this case), and the Respondent. All arrived shortly after 2100 (9 pm). By the Respondent’s response, she was delayed due to traffic and arrived around 9:45pm. By the patient and birth attendees account, Respondent was found to be at the wrong house when she arrived

approximately at 9:25pm. The Respondent arrived and went to the client who was now in the birthing pool in the bathroom. The Respondent took gloves to the client's side. She did not have any other equipment—it was left in her bag in the bedroom down a short hall. The Respondent did not assess the patient or the baby according to statements by the patient, doula and friend. The medical record does not show any vital signs on the patient or any evaluation except a vaginal exam.

Respondent left her birth equipment bag in another room outside the bathroom where the birth was taking place. She did not bring oxygen to birth. Both facts the Respondent has admitted to in her response to AMCB and her statement to the SCBON. The Respondent stated she had forgotten it at home in her rush to travel to the birth. In the statement submitted from doula, it states "After my client (Patient) was transferred, I told the midwife (Respondent) I had tried to get the oxygen, and she told me then that she did not have oxygen in her car and that her oxygen tank was empty."

At the time the Respondent arrived, friend and family were already there, the client was pushing spontaneously in the birth pool in the bathroom. The Respondent states she set up gloves, an instrument pack and fetal doppler at the birthing tub. By the affidavits provided by the patient, mother of patient and friend of patient, the Respondent only reported to the birthing tub with gloves and asked the mother of the patient to go and retrieve her doppler in her bag in the other room.

The doula said the first attempt to hear fetal heart tones with the doppler was 9:32pm but they were not found until 9:45pm after a position change of the patient. The midwife listened for "a few seconds—no more than 15" per the Affidavits submitted by the doula, friend, and family. The doula reported that heart tones were not heard clearly until 10:08pm. The affidavit of JC states, "The last time she listened, the midwife verbalized that the heart tones were in the 120s range." The Respondent's labor record states "FHTs assessed before, during, and after contraction and found to range 120-145". This is contrary to reports by the doula friend and patient. No maternal vital signs were taken until postpartum. It is not clear whether the heart tones heard briefly were maternal or fetal.

There is no note in the medical record or in any statements regarding plans/arrangements for a birth assistant for the Respondent. Newborn care standards require two people trained/certified in neonatal resuscitation for every birth—regardless of site of birth. A brief screenshot of texts between doula and the Respondent suggest that no birth assistant was planned. In this case, the doula seemed to be trained but it was not her identified role in the situation and the Respondent and doula were not organized as a team for emergencies. In the record, the Respondent states her assistant arrived right after EMS. This is consistent with the Affidavit submitted by the father of the patient. According to the EMS report, they were on the scene at 10:34pm. We will note here that the Respondent was notified of possible imminent birth by the patient at 8:25pm, the birth assistant arrived over 2 hours after the Respondent was first contacted by the patient.

Deviation from Standards:

Failure to assess the vital signs of the mother on arrival
Failure to assess and confirm the status of the baby
Failure to monitor fetal well-being in labor/birth

Failure to have appropriate equipment at bedside to assess mother and baby: Doppler, sphygmomanometers, stethoscope
Failure to plan or have adequately trained staff for emergencies or a birth assistant at the birth site

Management at Birth (See Attached Summary of Resuscitation)

Birth time 2216 or 2218

It is difficult to be certain of the timeline. The Respondent did not have an assistant or anyone recording time and actions. It seems the record may have been re-constructed by the Respondent after the birth. (See comments further in this document about record discrepancies.) The doula and friend taking pictures seem to have the most reliable times because they had time stamps on their photos. The committee had reports from the time stamps but were unable to actually see the time stamps. However, when possible, the times given by the doula and friend were compared to other records, such as the EMS records, and found to be consistent.
The baby was born spontaneously in the birth pool at 2218 (10:18 pm) according to the doula and at 2216 according to the Respondent's medical record. The newborn was pale, limp with no heart rate or respiratory effort. The Respondent was "smiling" according to statements by patient and family. Statements of those in attendance: patient, doula, friend and patient's mother—report the newborn as pale, limp, not moving and not breathing. The photos confirm the color and lack of tone. Breathing and heart rate cannot be assessed by the still photos, of course. The Respondent began stimulation and rubbing with a washcloth although the medical record states "dry and stimulation". The newborn was still in the pool on the maternal abdomen so could not be dry. No efforts to warm the newborn were underway at this time.

It is unclear if the Respondent had a stethoscope—two different statements report that she was given a stethoscope. The patient's mother's affidavit states she brought a stethoscope with the doppler when requested in labor. The doula's affidavit says she ran to the Respondent's bag a few seconds after the baby was born to retrieve a stethoscope and hung it around the Respondent's neck. Review of the photos submitted by the patient (photo marked - 805A5968.CR3) does show a stethoscope around Respondent's neck. In any case, the Respondent did not use a stethoscope or any other tool to assess the newborn according to the affidavits submitted by the attendees. The medical record does not record any full newborn assessment or Apgar score. The Apgar section of the record shows all zeros at 1/5/10 minutes. This is correct as evidenced by the photos, witnesses and EMS evaluation on arrival. There is no evidence that the Respondent performed any assessment of the newborn as required by the Neonatal Resuscitation Guidelines. Respondent's own admission in her statement to the SCBON it states "When the baby was born, I placed her on (Patient's) chest. The baby wasn't crying, and I began tactile stimulation by drying her back and rubbing the soles of her feet and her back, which is standard of care when a baby is first born and not responsive." (Per aafp.org). The Respondent further states, "At this point, which was approximately 30 to 45 seconds after birth, I observed the baby was limp, pale and not making any respiratory efforts I immediately suctioned the baby's mouth with a suction bulb."

Deviation from Standards of Care:

Failure to have equipment for birth at birth side
Failure to recognize severely compromised newborn
Failure to have assistant prepared to assist in emergencies
Failure to have emergency resuscitation equipment, including oxygen at the birth site
Failure to assess newborn immediately and ongoing per Neonatal Resuscitation: Current evidence and guidelines published in 2021 (guidelines in effect at the time of this birth)
Failure to initiate neonatal resuscitation as indicated: within 60 seconds with newborn not breathing, pale without heartbeat. PPV must be started within the first 60 seconds per NRP Guidelines in effect at the time of this birth.

1 minute of age 2217 (Patient's medical record) or 2219 (Doula)

The newborn was clearly not breathing, limp, pale and no one checked for heart rate. According to the Respondent's statement to the SCBON, "I listened for a heartbeat with my fetal stethoscope but found that there was no heartbeat." According to the affidavits submitted by the patient, friend of patient, and doula, no one witnessed Respondent using the stethoscope. The Respondent's medical record states the following:

5/27/2022 22:16
Baby Born

5/27/2022 22:16
Dry and Stimulate

5/27/2022 22:17
Inflation breaths

5/27/2022 22:17
Chest Compressions Coordinate with PPV

5/27/2022 22:18
EMS Activated

5/27/2022 22:18
PPV Room Air

Guidelines at this time for a severely compromised newborn include warming, PPV with oxygen and chest compression. None of this was done.

Deviation from Standards of Care:

Failure to have equipment for birth at birth side
Failure to have assistant prepared to assist in emergencies
Failure to have emergency resuscitation equipment, including oxygen at the birth site
Failure to assess newborn immediately and ongoing per Neonatal Resuscitation: Current evidence and guidelines published in 2021

Failure to initiate neonatal resuscitation as indicated: within 60 seconds of newborn not breathing, pale and without heartbeat.

2 minutes of age 2218 (Patient's medical record) or 2220 (Doula)

The medical record states that chest compressions and PPV were started at 2218. This is not possible. The Respondent asked the doula to "call" meaning EMS at 2218 per the medical record and 2220 doula records. The doula reports she made the call within a minute 2221 her time and at the same time ran to her car to get an ambu bag. It is not possible for the PPV to be started before this time. The doula was not asked to provide an ambu bag---she did this on her own initiative.

Mobile phone screenshot (provided by patient) shows the 911 call initiated at 10:21pm. EMS records and 911 recording confirm the call was received at 2221—consistent with the doula time. The baby was not warmed at this time.

Deviation from Standards of Care

Failure to have equipment for birth at birth side
Failure to have assistant prepared to assist in emergencies
Failure to have emergency resuscitation equipment, including oxygen at the birth site
Failure to assess newborn immediately and ongoing per Neonatal Resuscitation: Current evidence and guidelines published in 2021
Failure to initiate neonatal resuscitation as indicated: within 60 seconds with newborn not breathing, pale without heartbeat per guideline.

3 minutes of age 2219 (Patient's medical record) or 2221 (Doula)

Per the 911 recording – at 22:21:32 the doula is outside and at the 1:00 minute mark (approximately), the doula is back inside the house. The earliest the PPV could be started was approximately after 2222 or 4 minutes after birth. This is consistent with the timeline given in the affidavit provided by doula. When the doula returned with the ambu bag, she took over chest compression and the Respondent did the PPV.

6 minutes of age 2222 (Patient's medical record) or 2223-2224 (Doula)

The infant was moved to the side of the birthing pool. The Respondent did not have a cord clamp or sterile scissors for the cord. A cord clamp was retrieved from Respondent's bag still in another room by K.A. per her affidavit. The patient's husband cut the cord and held the baby's cut cord until the clamp was retrieved. The placental end of the cord was never clamped. The doula called for towels to wrap the baby at this time—the first action to maintain the newborn temperature.

7 minutes of age 2223 (Patient medical records)

Medical record by the Respondent states EMS on site at 2223. However, EMS records state that EMS was on site as 2234. EMS times on their record are consistent with 911 records. EMS records show the newborn was apneic, no heartbeat, pale and no tone. Newborn was placed in EMS vehicle. EMS proceeded through PALS protocol including intubation and administration of epinephrine. EMS left the scene for the hospital at 2253. Baby was handed to EMS and transferred to hospital at approximately 16 minutes of age.

Placenta management

The patient was transferred to be with the baby about 30 minutes later. The placenta was not sent to the hospital with the mother. The pathological examination of the placenta is critical in the search for a cause for the newborn's compromise. The placenta should have been bagged, labelled and sent to the hospital with the baby, if possible, but if not possible, with the mother later. Instead, this placenta was wrapped in a towel and thrown in the kitchen trash can. The family was unaware until they came across it more than 24 hours later. If the placenta was not sent to the hospital as it should have been, then it should have been placed in a medical waste container and taken by the Respondent for proper disposal. Management of the placenta was unprofessional and contributed to the ongoing question of why this newborn was severely compromised.

Medical Records

Documentation in the medical records is inadequate. Additional concern in this case is the discrepancy in medical records. The Respondent submitted the patient's records. As noted, many inadequacies in the documentation exist—failure to document medication such as the "induction cocktail" and failure to document actual fetal heart tones.

Of greater concern is that a second copy of the patient's record was obtained by CNM2, who took over care postpartum.

There is a letter from CNM2 dated August 27, 2022, which was in contribution to the Nursing Board case (2022-273) submitted by the patient. The letter documents that she resumed postpartum and bereavement care of the patient in early June after the Respondent lost her physician collaborative agreement and found herself no longer able to practice. CNM2 was given Respondent's credentials to log-in to Client Care and downloaded the patient's medical records on 6/18/2022. The letter goes further to state "In late July I spoke with Jennifer Powell-Taschetti by phone regarding records on another unrelated patient and she told me then that she had "just finished" charting the (name redacted) birth, as it had been "the bare minimum that night to get to the hospital." CNM2 again downloaded the patient's medical records, knowing it had been altered. This second set of medical records along with the infant records were downloaded on 7/26/2022.
CNM2 2 postulated the intent was to shift responsibility for the baby's damage to EMS. However, we can find no evidence of problems with EMS—the failures during the birth are evident. Alteration of medical records is a major breach of standards of care and ethical conduct.

The allegation outlined in the complaint regarding the patient's belief that Respondent was under the influence or possibly suffering from a mental health emergency due to her demeanor before, during and after the medical emergency, could not be evaluated by AMCB.

Review Committee Analysis

The Respondent failed on multiple levels. First, the appropriateness of this client for out of hospital birth is an issue. Second, the Respondent failed to make the basic and most essential preparations for a safe birth: appropriate birth equipment at the birth side, complete resuscitation equipment including oxygen at the site and a planned birth assistant in the event of emergency. Third, the Respondent failed to make assessments of maternal and fetal status in labor. Fourth, it is not clear that fetal well-being was established prior to birth and preparation for possible compromised newborn was not made. Fifth, maternal assessment was not done. Sixth, when the compromised newborn was born, the equipment was not available, and the Respondent did not recognize and immediately implement neonatal resuscitation guidelines. Seventh, failure to send the placenta to the hospital for analysis and in addition failure to dispose of the placenta properly are below the standard of care.

Summary of Committee Findings

The committee had two primary areas of concern. First the care provided was below the most basic standard of midwifery care. It is uncertain if this was a lack of knowledge in basic midwifery care and standards, a lack of planning and organization, or a lack of knowledge of emergency care/protocols. The committee concludes it was a combination of all three factors. Failure to have basic equipment and failure to initiate appropriate and timely resuscitation for a severely compromised newborn is also indicative of poor judgement. Second, the committee had an ethical concern regarding completion of medical records without an individual documenting all relevant events an circumstances in real time—such as a birth assistant. The Respondent completing the records after birth calls into question the veracity of the records. In addition, the records were altered which constitutes a serious breach of ethics and professional honesty.

It was the Discipline Committee's unanimous decision that certificant Jennifer Powell-Taschetti violated A9 of AMCB's Discipline Policy in multiple, manifest and material ways. Therefore, we recommend revocation of her AMCB Certificate.

REVIEW COMMITTEE
Nancy Jo Reedy, CNM, Chair
Lucinda G. Manges, CNM
Elizabeth Robson, MSN, CNM, RNC-NIC & EFM

Effective date: 7-18-2025