

## WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES



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STATE OF WISCONSIN  
BEFORE THE DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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IN THE MATTER OF DISCIPLINARY  
PROCEEDINGS AGAINST

SANDRA C. PERA,  
RESPONDENT.

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FINAL DECISION AND ORDER

**ORDER 0008875**

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Division of Legal Services and Compliance Case Nos. 21 RMA 002 and 23 RMA 002

The parties to this action for the purpose of Wis. Stat. § 227.53 are:

Sandra C. Pera  
Wakefield, MI 49968

Wisconsin Department of Safety and Professional Services  
P.O. Box 8366  
Madison, WI 53708-8366

Division of Legal Services and Compliance  
Department of Safety and Professional Services  
P.O. Box 7190  
Madison, WI 53707-7190

The parties agree to the terms and conditions of the attached Stipulation as the final disposition of these matters, subject to the approval of the Wisconsin Department of Safety and Professional Services (Department). The Department has reviewed this Stipulation and considers it acceptable.

Accordingly, the Department adopts the attached Stipulation and makes the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Respondent Sandra C. Pera (Year of Birth 1961) is licensed by the state of Wisconsin as a midwife, having license number 38-49, first issued on March 7, 2008, and current through June 30, 2024. Respondent's most recent address on file with the Department is in Wakefield, Michigan 49968.

Case No. 21 RMA 002

2. On November 30, 2020, Patient A presented to Respondent for prenatal care during her first pregnancy.

3. On June 7, 2021, Patient A tested for Group B Streptococcus (GBBS), the results of which were positive. On June 24, 2021, Respondent discussed the GBBS results with Patient A. Other than Patient A's initial Informed Disclosure and Consent form, which identifies the medications Respondent carries for potential use, Respondent did not chart an informed consent discussion with Patient A about the risks and benefits of GBBS treatment, or a written refusal from Patient A to be treated.

4. At 6:00 p.m. on July 4, 2021, Patient A informed Respondent that she was "leaking fluid" but was not having contractions. Respondent did not go to Patient A's home to evaluate Patient A or confirm/initiate labor until 11:25 p.m. on July 5, 2021, more than 18 hours after rupture of membranes (ROM). When Respondent arrived, Patient A was 1.5 cm dilated.

5. Although Respondent documented when Patient A urinated during labor, she did not document the amount of urine output or fluid intake in the birthing record. Respondent also did not chart that she was monitoring or palpating the bladder to determine risk of distension, or any discussion about catheterizing Patient A. Respondent maintains that monitoring or palpating the bladder is something she does within her custom and practice.

6. Respondent did not chart in the birthing record a discussion with Patient A on the risks of ROM with a positive GBBS status or a running clock as to how long ago ROM had occurred.

7. At 8:10 a.m. on July 7, 2021, Respondent charted Patient A had a distended belly, and they were "going in for ultrasound." Patient A was transported to the hospital more than 60 hours after ROM.

8. Patient A arrived at the hospital at 9:04 a.m. Respondent accompanied Patient A to the hospital. When Respondent was asked about Patient A's GBBS status, Respondent reported Patient A was positive but since she had not had a fever, "she was not treating it," which is against American College of Obstetricians and Gynecologists (ACOG) guidelines. Hospital staff told Respondent treatment was not for the mother's care, but to prevent GBBS pneumonia in the baby.

9. Respondent reported to hospital staff that Patient A's membranes ruptured at 7:00 a.m. on July 5, 2021, only 48 hours prior.

10. Patient A was catheterized in the hospital, which yielded over 1200 cc of urine.

11. At 12:28 p.m. on July 7, 2021, Patient A underwent a C-Section and gave birth to a 9-pound, 6-ounce baby girl who was transferred to the NICU with an Apgar score of 1 at one minute, 4 at five minutes. The placenta and membranes were stained with meconium, and copious amounts of meconium had to be suctioned out before baby's breathing could be initiated. Baby was diagnosed with mild to moderate neonatal encephalopathy.

#### Case No. 23 RMA 002

12. On July 25, 2022, Patient B presented to Respondent for prenatal care. This was not Patient B's first pregnancy.

13. At 7:48 p.m. on February 27, 2023, Respondent was informed that Patient B was in labor and that contractions were five minutes apart. Respondent arrived at Patient B's home at 9:28 p.m. At 10:46 p.m., Patient B was 10 cm dilated and began pushing.

14. After one hour of second stage labor, and at regular intervals thereafter, Respondent did not chart a discussion with Patient B about transport to the hospital, including the risks of not transporting.

15. After two hours of active second stage labor, Respondent did not consult a physician or certified nurse-midwife when Patient B did not progress.

16. At 3:08 a.m. on February 28, 2023, the fetal heart tones (FHT) suddenly dropped to the 90s and Respondent suggested someone call 911. Instead of waiting for emergency services, Patient B's husband transported Patient B and Respondent to the hospital. Baby was born in the backseat of the truck at 3:37 a.m. in front of the emergency room (ER) of the hospital with no pulse and no muscle tone. Resuscitative efforts were attempted in the ER but were not successful and baby expired.

17. Patient B was catheterized in the hospital 1.5 hours after arrival, which yielded 1600 cc of urine.

18. The Fond du Lac County Medical Examiner, who conducted the autopsy, determined baby died from complications of protracted labor. Respondent maintains she was not informed by Patient B that she was in labor for three days prior to calling Respondent, and had she been informed when labor first began, she could have evaluated Patient B earlier.

19. Respondent did not recognize baby's failure to progress during second stage labor and allowed Patient B, a woman who had a baby before, to push for four hours and 51 minutes before suggesting transport to the hospital. ACOG defines a prolonged second stage as one hour without epidural in multiparous women.

20. During labor, Respondent only documented Patient B's blood pressure and pulse once at 9:40 p.m. and did not document her temperature at all in the birthing record. Monitoring Patient B's pulse would have confirmed if Respondent was hearing the FHT accurately and not hearing Patient B's heartbeat instead. Respondent maintains she was regularly monitoring Patient B's vitals.

21. Although Respondent documented FHT regularly, she did not document how long she auscultated the FHT, which would have aided in identifying any prior decelerations. Respondent maintains she listened to the FHT for regular intervals before, during, and after contractions to determine decelerations.

22. Respondent did not document any vaginal exams or the state of baby's head, such as any appearance of caput succedaneum or the head's descent in the birth canal. Respondent did document the station of baby's head in the birthing record. She maintains she frequently assessed baby's descent in the birth canal by the station.

23. Respondent did not document Patient B's fluid intake, the amount of urine output, palpation of the bladder to determine risk of distension, or any discussion about catheterizing Patient B during labor. Respondent maintains that, upon arrival to Patient B's home, Patient B reported that she had just recently emptied her bladder, and reported emptying her bladder multiple times while Respondent was there.

24. Respondent denies falling below the standard of midwifery care or otherwise engaging in unprofessional conduct. However, in order to avoid contested disciplinary proceedings and in resolution of these matters, Respondent consents to the entry of the following Conclusions of Law and Order.

### CONCLUSIONS OF LAW

1. The Department has jurisdiction to act in these matters pursuant to Wis. Stat. § 440.986 and is authorized to enter into the attached Stipulation pursuant to Wis. Stat. § 227.44(5).

### ORDER

1. The attached Stipulation is accepted.

2. The VOLUNTARY SURRENDER by Respondent of her license to practice as a midwife in the state of Wisconsin (license number 38-49), as well as her right to renew such license, is accepted.

3. Respondent shall not petition the Department for reinstatement of her license to practice as a midwife in the state of Wisconsin for at least two (2) years from the date of this Order. If the Respondent petitions for reinstatement after two (2) years, whether to grant a license and whether to impose any limitations or restrictions on any license granted shall be in the sole discretion of the Department and such decision is not reviewable.

4. In the event Respondent petitions the Department for reinstatement of her license to practice as a midwife in the state of Wisconsin or applies for another credential in the state of Wisconsin under Wis. Stat. chs. 440 through 480, Respondent shall pay the costs of these matters in the amount of \$7,527.00, before any petition or application for a credential will be considered by the applicable board or Department.

5. Any requests, petitions, payments of costs (made payable to Department of Safety and Professional Services), and other information required by this Order shall be submitted to:

Department Monitor  
Division of Legal Services and Compliance  
Department of Safety and Professional Services  
P.O. Box 7190, Madison, WI 53707-7190  
Telephone (608) 266-2112; Fax (608) 266-2264  
DSPSMonitoring@wisconsin.gov

Respondent may also submit this information online at: <https://dpsmonitoring.wi.gov>.

6. This Order is effective on the date of its signing.

WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

By: Aloysius Rohmeyer  
Aloysius Rohmeyer, Chief Counsel  
On Behalf of the Department

11/27/2023  
Date

STATE OF WISCONSIN  
BEFORE THE DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

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IN THE MATTER OF DISCIPLINARY  
PROCEEDINGS AGAINST

SANDRA C. PERA,  
RESPONDENT.

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STIPULATION

**ORDER 0008875**

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Division of Legal Services and Compliance Case Nos. 21 RMA 002 and 23 RMA 002

Respondent Sandra C. Pera and the Division of Legal Services and Compliance, Department of Safety and Professional Services, stipulate as follows:

1. This Stipulation is entered into as a result of two pending investigations by the Division of Legal Services and Compliance. Respondent consents to the resolution of these investigations by Stipulation.

2. Respondent understands that by signing this Stipulation, Respondent voluntarily and knowingly waives the following rights:

- the right to a hearing on the allegations against Respondent, at which time the State has the burden of proving those allegations by a preponderance of the evidence;
- the right to confront and cross-examine the witnesses against Respondent;
- the right to call witnesses on Respondent's behalf and to compel their attendance by subpoena;
- the right to testify on Respondent's own behalf;
- the right to file objections to any proposed decision and to present briefs or oral arguments to the officials who are to render the final decision;
- the right to petition for rehearing; and
- all other applicable rights afforded to Respondent under the United States Constitution, the Wisconsin Constitution, the Wisconsin Statutes, the Wisconsin Administrative Code, and other provisions of state or federal law.

3. Respondent is aware of Respondent's right to seek legal representation and has been provided an opportunity to obtain legal counsel before signing this Stipulation. Respondent is represented by Attorney Sean Gaynor.

4. Respondent agrees to the adoption of the attached Final Decision and Order by the Wisconsin Department of Safety and Professional Services (Department). The parties to the Stipulation consent to the entry of the attached Final Decision and Order without further notice, pleading, appearance or consent of the parties. Respondent waives all rights to any appeal of the Department's Order, if adopted in the form as attached.


5. If the terms of this Stipulation are not acceptable to the Department, the parties shall not be bound by the contents of this Stipulation, and the matter shall then be returned to the ~~Division of Legal Services and Compliance for further proceedings. In the event that the~~ Stipulation is not accepted by the Department, the parties agree not to contend that the Department has been prejudiced or biased in any manner by the consideration of this attempted resolution.

6. The parties to this Stipulation agree that the attorney or other agent for the Division of Legal Services and Compliance may appear before the Department, without the presence of Respondent or Respondent's attorney, for purposes of speaking in support of this agreement and answering questions that the Department may have in connection with deliberations on the Stipulation.

7. Respondent is informed that should the Department adopt this Stipulation, the Department's Final Decision and Order is a public record and will be published in accordance with standard Department procedure.

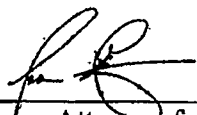
8. Respondent is further informed that should the Department adopt this Stipulation, the Department's Final Decision and Order will be reported as required by the National Practitioner Databank (NPDB) Guidebook and as otherwise required by any licensure compact or any other state or federal law.

9. The Division of Legal Services and Compliance joins Respondent in recommending that the Department adopt this Stipulation and issue the attached Final Decision and Order.

  
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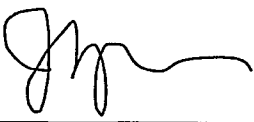
Sandra C. Pera, Respondent  
Wakefield, MI 49968  
License No. 38-49

11/22/23  
Date

  
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Sean Gaynor, Attorney for Respondent  
Leib Knott Gaynor, LLC  
219 N. Milwaukee St., Suite 710  
Milwaukee, WI 53202

11/22/23  
Date

  
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Julie Zimmer, Prosecuting Attorney  
Department of Safety and Professional Services  
Division of Legal Services and Compliance  
P.O. Box 7190  
Madison, WI 53707-7190

11/27/2023  
Date