Circuit Court for Montgomery County
Petition No. 06-I-19-170

UNREPORTED

IN THE COURT OF SPECIAL APPEALS

OF MARYLAND

No. 2093

September Term, 2019

IN RE: A.H.

Nazarian,
Arthur,
Sharer, J., Frederick
(Senior Judge, Specially Assigned),

JJ.

Opinion by Arthur, J.

Filed: June 19, 2020

*This is an unreported opinion, and it may not be cited in any paper, brief, motion, or other document filed in this Court or any other Maryland Court as either precedent within the rule of stare decisis or as persuasive authority. Md. Rule 1-104.

This appeal concerns an infant child who has required frequent hospitalizations because of life-threatening episodes of breathing cessation. The Montgomery County Department of Health and Human Services received a report of suspected child abuse or neglect regarding the mother's conduct while she was attending to the child in the hospital. Based on that report, the Department petitioned for court intervention.

After a contested adjudicatory hearing, the Circuit Court for Montgomery County, sitting as juvenile court, found that the child had been neglected and that her parents were unable to give proper care and attention to the child and her needs. The court committed the child to the custody of the Department for placement in foster care. In addition, the court required that the parents' visits with the child be supervised by the Department.

The mother has appealed, contending that the court should have excluded certain evidence at the adjudicatory hearing, that the court made erroneous findings, and that the court made improper rulings regarding the ultimate disposition. For the reasons discussed in this opinion, the judgment will be affirmed.

FACTUAL AND PROCEDURAL BACKGROUND

A.H. was born in December 2018. She spent the first 10 months of her life in the care of her mother ("Mother") before she was removed from the home. At that time, Mother was 19 years old and resided with her parents while she was completing high school. A.H.'s father ("Father"), who was 17 years old at that time, lived in a separate residence and was not involved in caring for A.H.

When A.H. was six months old, she started to experience frequent episodes of apnea (temporary cessation of breathing) and perioral cyanosis (blue coloring around the

mouth). Mother observed that these episodes occurred about once per day, both while A.H. was asleep and while she was awake. Normally, Mother could resolve the episodes by blowing air onto A.H.'s face.

As reported by Mother, A.H. has a family history of apnea. A.H.'s father has had apnea since his early childhood. Mother's cousin requires frequent treatment for sleep apnea. Other members of Mother's family also have breathing issues. A year before A.H. was born, another child of Mother's died suddenly in her sleep, at the age of three months, from causes that could not be determined.

Mother sought treatment when she first observed A.H. experience an apneic episode in June 2019. A.H. was admitted for one week at Children's National Medical Center. At that time, A.H. tested positive for a respiratory infection.

While at home on July 16, 2019, A.H. experienced an episode that lasted for seven minutes. Her breathing stopped, her lips and face turned blue, and she did not respond to attempts to restore her breathing. Mother called for emergency medical assistance. A.H. was taken to Suburban Hospital and transferred to MedStar Georgetown University Hospital, where she underwent extensive testing over the next 13 days. A sleep study showed that she had severe obstructive sleep apnea. Overall, however, her physicians concluded that the etiology of her apnea was "[u]nclear."

After A.H. was admitted to MedStar Georgetown University Hospital, Mother received a home apnea monitor and instructions on how to use it. A few days later, a nurse observed that the apnea monitor in A.H.'s room had been turned off. The nurse noted that Mother said that she had turned the monitor off because it was not staying

charged. Later that day, Mother received a replacement apnea monitor.

On one of the first days of A.H.'s stay, Mother made a police report claiming that an acquaintance had threatened to suffocate A.H. at the hospital. A few days later, the Montgomery County Department of Health and Human Services received a report alleging that Mother previously had subjected A.H. to unsafe treatment. While investigating that report, a case worker visited Mother and A.H. at the hospital. Mother told the case worker that she suspected that the allegations were retaliatory and malicious. After A.H. was discharged from the hospital, the case worker visited Mother's home and determined that Mother was providing appropriate care for A.H. The Department ultimately ruled out a finding of child neglect.

A.H. was discharged from MedStar Georgetown University Hospital on July 30, 2019. The doctors instructed Mother to continue using the home apnea monitor, to use a continuous positive airway pressure (CPAP) machine, to see A.H.'s primary care physician within two days, and to see a pulmonologist within one week.

While at home on August 17, 2019, A.H. experienced another episode in which she was unresponsive and had blue coloring around the mouth. The episode lasted for about five minutes, during which Mother attempted to revive her daughter. A.H. was transported to Shady Grove Hospital and then re-admitted to MedStar Georgetown University Hospital.

According to hospital records, Mother acknowledged that she had not taken A.H. to the follow-up appointment with a pulmonologist. Mother said that she missed the appointment because of her involvement in the child protective services investigation.

Upon A.H.'s re-admission, a pulmonologist reviewed the data from the home apnea monitor, which showed "inconsistent use" of the monitor at home. When A.H. was discharged on August 22, 2019, Mother received instructions to continue using the home apnea monitor and the CPAP machine.[1]

While at home on September 15, 2019, A.H. stopped breathing and became unresponsive for a prolonged period of time. The maternal grandfather attempted to resuscitate A.H. while Mother called for emergency medical assistance. A.H. was transported to Shady Grove Hospital for apparent respiratory failure and was briefly intubated. Once stabilized, A.H. was admitted to MedStar Georgetown University Hospital for the third time.

During the next few weeks, health care providers observed two significant episodes of apnea, one of which occurred while A.H. was awake. Despite the comprehensive testing, A.H.'s physicians lacked findings that would explain the cause of A.H.'s life-threatening episodes. A.H.'s physicians considered performing a tracheostomy, a procedure that involves cutting an opening in a patient's neck and inserting a tube into the opening to allow air to flow into the lungs. After the surgery, A.H. would be connected to a ventilator, which would control her breathing.

While considering the treatment options, A.H.'s physicians consulted with a medical ethicist, Daniel Sulmasy, M.D., Ph.D. Dr. Sulmasy documented his discussions with the hospital staff in an entry titled "Consultation Notes." Noting that "the child

[1] Sometime in early September 2019, A.H. was admitted at Johns Hopkins Hospital. No records from that hospitalization were introduced into evidence in this case.

nearly died at home while having been sent home with a monitor and failed to respond to [CPR],” Dr. Sulmasy recommended a tracheostomy instead of “continued monitoring.”

A.H.’s physicians explained to Mother and her parents that A.H. would require a ventilator after the surgery and that she might require a transitional facility as well as in-home nursing. Mother gave her consent, and A.H. underwent a tracheostomy on October 4, 2019. Afterwards, Mother began receiving instructions on how to perform suctioning and other special care that A.H. would require after the tracheostomy.

The central focus of this case is Mother’s conduct on the night of October 14, 2019, ten days after the tracheostomy. In a “Progress Note” regarding A.H.’s care during an overnight shift, Madeline Dwivedi, R.N., made a record of Mother’s actions and statements while she was staying in A.H.’s hospital room.

At 7:51 p.m., Nurse Dwivedi recorded that she saw Mother “shove [the] patient aggressively down onto the bed from a sitting position to flat on her back.” Nurse Dwivedi noted that A.H. was “crying and visibly upset,” and that the “[v]entilator was alarming” at the time. Nurse Dwivedi wrote that, when she explained to Mother that her handling of the child was not appropriate, Mother said that A.H. “was ‘tired’ and ‘needed to go to sleep.’”

At 8:25 p.m., Nurse Dwivedi wrote that she saw Mother “holding [the] patient down in the bed.” Nurse Dwivedi wrote that A.H.’s “face [was] red” and that she was “screaming,” but her “[c]ries were not audible because of [the] tracheostomy.” Nurse Dwivedi noted that the ventilator alarm had been “disconnected, when previously, [the] alarm was connected and alarming” earlier in the evening. Nurse Dwivedi wrote that,

when she “asked why [Mother] was holding [the] patient down in bed,” Mother “shrugged [her] shoulders and stated again that [the] patient ‘needed to go to bed and was tired.’” Nurse Dwivedi wrote that “Dr. Wright” then entered the room to ask why the child was crying, and Mother “stated, ‘I don’t know what she wants, she is crying there must be something wrong with her.’” [Sic.] Nurse Dwivedi wrote that Dr. Wright “explained to [the] patient’s mother that her crying could be attributed to age appropriate behavior” and “suggested holding the patient and comforting her in an appropriate manner.”

In the same entry, Nurse Dwivedi noted that she “found scissors in [the] patient[’]s bed two separate times after witnessing [Mother] playing with scissors[.]” Nurse Dwivedi wrote that, after the first occurrence, she had “educated [Mother] about keeping sharp[object]s out of the patient[’]s bed for safety reasons.” Nurse Dwivedi wrote that, after the second occurrence, “all sharp[object]s [were] removed from [the] room.”

Nurse Dwivedi also noted that Mother made “[o]ther statements” that were “concerning” during the same overnight shift. According to Nurse Dwivedi, Mother stated: “Would it be possible to sedate her when we go home so I can sleep at night[?]”; “If she can’t eat then can she get a GTube[?]”;[2] and “She has nothing to cry about she is just needy.” [Sic.]

The next day, October 15, 2019, a social worker employed by the hospital made a report of suspected child abuse or neglect to the Montgomery County Department of

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[2] A gastronomy tube, or G-tube, is a tube that is inserted into the abdomen to deliver nutrition directly to a person’s stomach.

Health and Human Services. The hospital began providing a "one-on-one sitter" to supervise Mother whenever she was present in A.H.'s room.

On October 17, 2019, the Department filed a child-in-need-of-assistance ("CINA") petition in the Circuit Court for Montgomery County, sitting as juvenile court. Citing reports from hospital staff of "risky" behavior by Mother, the Department alleged that A.H. had been neglected. The juvenile court authorized shelter care for A.H. in the hospital and permitted Mother and Father to have unlimited visitation, as long as those visits were supervised by the hospital staff.

Mother and Father both appeared with counsel at a shelter care hearing on October 24, 2019. Afterwards, the juvenile court issued an order authorizing the continuation of shelter care. The order provided that, if A.H. was transferred from the hospital to a facility that did not provide supervision, then the parents would have supervised visitation for a minimum of once per week, for two hours, under the direction of the Department. The order stated that "visitation between [A.H.] and Mother" at the rehabilitative care facility "may be supervised by [the] maternal grandparents[.]"

A.H. was discharged from MedStar Georgetown University Hospital on November 4, 2019. Thereafter, she was transferred to the Kennedy Krieger Institute. Mother accompanied A.H. during the transfer. For a brief time, Mother was alone with A.H., without supervision, when Mother failed to leave A.H.'s new room even though all health care providers had left the room.

On November 12, 2019, the juvenile court held an adjudicatory hearing in the CINA case. At the beginning of the hearing, the Department submitted an amended

CINA petition. The original petition had alleged that A.H. had been neglected, but the amended petition alleged that A.H. had been "abused and neglected." Mother, who was present and represented by counsel, contested the allegations. Father was not present, but he participated through counsel for the purpose of supporting Mother's defense of the allegations. Appointed counsel appeared on behalf of the child.

In its case-in-chief, the Department offered excerpts from hospital records made during A.H.'s three stays at MedStar Georgetown University Hospital. The Department argued that those hospital records were admissible as records of regularly conducted business activity. Through counsel, Father and Mother made objections concerning some statements in the records from the seven-week stay that began in September 2019.

First, counsel for Father argued that one paragraph from Dr. Sulmasy's "Consultation Notes" should be excluded as hearsay. The paragraph included Dr. Sulmasy's summary of his discussion with hospital staff, in which they expressed some concerns about Mother's ability to care for A.H. Father's counsel argued that those statements were not germane to A.H.'s treatment and therefore did not qualify under the business records exception to the hearsay rule. Mother's counsel also raised an objection concerning statements from Dr. Sulmasy's notes.

Next, Father's counsel argued that Nurse Dwivedi's notes, describing Mother's actions and comments in A.H.'s hospital room on the night October 14, 2019, were not germane to A.H.'s treatment and should be excluded as hearsay. Mother's counsel also objected, arguing that admitting the statements would be "unfair" because Mother "would not have the opportunity to cross-examine" Nurse Dwivedi.

The court initially expressed its intention to exclude parts of Dr. Sulmasy's consultation notes, but it ultimately admitted both documents in full. The court reasoned that both sets of statements were reasonably related to A.H.'s medical treatment because they addressed whether A.H. would receive "appropriate aftercare" upon discharge from the hospital. Later in the hearing, Mother introduced excerpts from the same hospital records, including some pages that had already been introduced by the Department.

The Department's only witness was Kayla Silva, the case worker assigned to assess the report of suspected abuse or neglect. The Department established that Ms. Silva was licensed in Maryland in the field of "masters level social work." The Department offered Ms. Silva "as an expert in the field of social work," including "the field of safety and risk." No party objected to that designation, and the court accepted Ms. Silva as an expert in those fields.

Ms. Silva testified that, in assessing A.H.'s safety and risk, she spoke with Mother, Father, and the maternal grandparents. In addition, Ms. Silva reviewed portions of A.H.'s hospital records and records of Mother's prior contact with the Department. To a reasonable degree of professional certainty, Ms. Silva opined: "At this time, it would be unsafe for [A.H.] to return to her mother's care."

In explaining her opinion, Ms. Silva said that A.H. has "special needs," in that she had been experiencing "respiratory failure" over a period of several months, without any "medical explanation" for her condition. Ms. Silva said that A.H., as an 11-month-old child, was "non-verbal, so she ha[d] no ability to self-protect." Ms. Silva said that "we don't know [Mother's] mental stability to appropriately care" for a child who would need

"extensive" medical care "once released from the hospital."

When asked to identify particular safety concerns, Ms. Silva recounted Nurse Dwivedi's report that Mother had "shove[d] [A.H.] aggressively down," had "h[eld] [A.H.] down" while she was lying down, and had "made various comments that are of concern," about A.H.'s crying and her care. Ms. Silva said that the "ventilator alarm system had been disconnected on two occasions," but later acknowledged that the hospital records documented only one such occasion. Ms. Silva also mentioned the report that "on two other occasions, a pair of scissors [was] found in [A.H.'s] hospital crib."

Ms. Silva said that, when she spoke with Mother about those reports, Mother said that the nurses were "making false allegations." In her testimony, Ms. Silva remarked that Mother "appear[ed]" to have "no insight . . . as to . . . how these behaviors or comments would alarm anyone." Ms. Silva recommended a "psychiatric evaluation" of Mother, to "rule out . . . anything . . . that would prevent [Mother] from being able to keep [A.H.] safe."

Ms. Silva testified that, when she spoke with the maternal grandparents, they stated that they did not believe the allegations about Mother's conduct in the hospital. Ms. Silva expressed "concerns" that the maternal grandparents were "continu[ing] to back-up their daughter without getting further information" from other sources. Ms. Silva acknowledged that the Department had previously agreed that the maternal grandparents could supervise Mother's visits with A.H., but she suggested that the arrangement might not be appropriate. Ms. Silva opined, to a reasonable degree of

professional certainty, that A.H. could not be safely placed with her maternal grandparents as of the hearing date.

The maternal grandfather testified on Mother's behalf. Based on his observations, he characterized Mother as "protective of [A.H.]," "very gentle," and "just an overall loving mom." Among other things, he discussed an event that had occurred about one week before the hearing, while A.H. was still staying at MedStar Georgetown University Hospital. Mother had called him in a panic, telling him that A.H. needed to be re-connected to a ventilator but that the nurses were not listening to her. In response, the maternal grandfather spoke with the head nurse and the hospital's patient advocate, asking that A.H. be placed back on the ventilator.

In her testimony, Mother admitted that she made one of the comments reported by Nurse Dwivedi. Specifically, Mother recalled asking Nurse Dwivedi "about feeding tubes[.]" Mother said that she had "noticed that [A.H.] had a feeding tube in her nose," and wondered whether the feeding tube was "going to be permanent." Mother's testimony indicated that she thought that the feeding tube was called a "G tube."

Aside from that admission, Mother denied making any of the other comments reported by Nurse Dwivedi. Mother further denied that she had ever shoved or held A.H. down while she was crying, that she knew how to turn off an alarm for a ventilator, and that she ever possessed scissors while in the hospital. Mother believed that one or more nurses fabricated allegations against her because she had "told a few staff members, in the past," that she "d[id] not want them working with [her] kid."

After deliberating on the evidence, the juvenile court announced that it would

sustain the factual allegations from the amended petition as to both Mother and Father. The court said that, overall, it "f[ound] the hospital records compelling."

The court credited the report that, on October 14, 2019, Mother "shove[d] [A.H.] down" onto her back and then did "the same thing" about 30 minutes later. The court stated that "the ventilator was alarming" during the first instance and "in a short period of time was found disconnected." The court stated that Mother's "response to the child crying" did not change after the hospital staff "tried to educate her" about how to respond. The court also stated that, "on two occasions, hospital staff found scissors" in the child's bed, and the second occasion occurred after Mother "was educated about the danger of leaving sharp objects within the reach" of the child. In addition, the court expressed concern about Mother's inconsistent use of the home apnea monitor and the missed follow-up appointment with a pulmonologist after an earlier hospital stay.

The court recognized that some of the reported behavior might be attributed to confusion or to the stress of being in a hospital for months. The court observed, however, that Mother had testified simply that "none of this ever happened." The court found it to be implausible that one or more nurses would make "false allegations," for which they would be "subject to discipline" and "loss of job," merely because of some conflicts with Mother.

The court ultimately found, by a preponderance of the evidence, that A.H. had been neglected. The court said that the issue of whether the Department had proven the allegation of abuse was a "close call," but the court concluded that Mother's conduct amounted to neglect. The court reasoned that, because sufficient "safety concerns" had

already been "demonstrated and documented," the court did not need to "wait until something bad happens."

After the court announced its findings, Mother's counsel asked the court to postpone the disposition hearing until after the completion of a psychological evaluation of Mother. The court denied the motion, finding that Mother had not shown good cause for delaying the disposition hearing.

The Department requested that Mother's visits with A.H. be supervised by someone other than the maternal grandparents. The court agreed, remarking that a "skeptical" party would be more likely to "closely monitor[]" Mother's interactions with A.H. Because the Kennedy Krieger Institute would not provide supervision and no other resource had been identified, the court decided that the Department would need to supervise the visits. The Department represented that it could provide supervision of each parent for one hour per week. The court directed the Department to combine those visits, so that Mother and Father could visit A.H. for two hours per week.

On November 13, 2019, the juvenile court entered an Adjudication and Disposition Order. By a preponderance of the evidence, the court "adopt[ed] and sustain[ed]" the allegations set forth in the amended petition. The court found that A.H. "has been neglected," that Mother "is unable to give proper care and attention to [A.H.'s] needs at this time," and that Father "is unable and unwilling to give proper care and attention to [A.H.'s] needs at this time." The court committed A.H. to the custody of the Department for placement in foster care.

The court ordered Mother and Father to participate in visitation once weekly, for a

minimum of two hours, under the supervision of the Department. The court also ordered the Department to "explore kinship resources who may be able to supervise visits between [A.H.] and her parents, so those visits can increase in frequency[.]" In addition, the court ordered Mother and Father to engage in parenting education or counseling and "[e]ducation services through Kennedy Krieger to gain knowledge of [A.H.'s] medical needs," and it ordered Mother to "[f]ollow all treatment recommendations made by Kennedy Krieger in regard to [A.H.]" Finally, the court ordered Mother to "[c]omplete a psychological evaluation and follow all treatment recommendations."

After the entry of the court's order, Mother filed a timely notice of appeal. Father did not appeal from the order.

DISCUSSION

In this appeal, Mother seeks reversal of the order adjudicating A.H. as a child in need of assistance and restricting Mother's access to A.H. The Department asks this Court to affirm the order. The child, through appointed counsel, also seeks to uphold the order. Father has not participated in this appeal.

In her appellate brief, Mother presents the following five questions:

> 1. Did the Court err by admitting into evidence highly prejudicial hearsay statements, contained in Department's Exhibit 3 . . .?
>
> 2. Should the majority of the testimony of the Department Social Worker be stricken?
>
> 3. Did the Court commit legal error in finding that the Department established neglect of A.H. by Mother?

4. Did the Department fail to make reasonable efforts to prevent or eliminate the need for removal?

5. Was the Court's denial of Mother's request to delay disposition an abuse of discretion? And was the Court's dispositional ruling an abuse of discretion?

For the reasons discussed below, we conclude that the juvenile court did not commit reversible error or otherwise abuse its discretion in its adjudication and disposition of the CINA petition. The judgment will be affirmed.

I. Admission of Hospital Records

First and foremost in this appeal, Mother challenges the admissibility of certain statements made in records from A.H.'s hospitalizations at MedStar Georgetown University Hospital. Mother contends that two entries, Dr. Sulmasy's "Consultation Notes" and Nurse Dwivedi's "Progress Note," include inadmissible hearsay.

"'Hearsay' is a statement, other than one made by the declarant while testifying at the trial or hearing, offered in evidence to prove the truth of the matter asserted." Md. Rule 5-801(c). Under Maryland Rule 5-802, "hearsay must be excluded as evidence at trial unless it falls within an exception to the hearsay rule." *Hall v. University of Maryland Med. Sys. Corp.*, 398 Md. 67, 83 (2007). A trial court's decision to admit hearsay under an exception is ordinarily a legal determination that is subject to de novo review. *See id.*

At the adjudicatory hearing, the court admitted hospital records under the hearsay exception for records of regularly conducted business activity, Md. Rule 5-803(b)(6). That rule provides that "[a] memorandum, report, record, or data compilation of acts,

events, conditions, opinions, or diagnoses" is not excluded by the hearsay rule "if (A) it was made at or near the time of the act, event, or condition, or the rendition of the diagnosis, (B) it was made by a person with knowledge or from information transmitted by a person with knowledge, (C) it was made and kept in the course of a regularly conducted business activity, and (D) the regular practice of that business was to make and keep the memorandum, report, record, or data compilation."[3]

The rationale for this exception is that, if "the records are reliable enough for the running of a business, in part because of the business duty imposed on the reporter and the recorder," then "they are reliable enough to be admissible at trial." *Hall v. University of Maryland Med. Sys. Corp.*, 398 Md. at 89. "The trustworthiness and reliability of any business record arises from the fact that entries recording an act or event are made in the 'regular course of business' and it is the 'regular course of business' to record those entries at the time of that act or event or soon thereafter." *State v. Garlick*, 313 Md. 209, 222 (1988). "In a hospital the 'regular course of business' is to treat people, that is, to care for patients." *Id.* at 221. The "proper care of patients would be impossible" without systematic record keeping. *Id.* at 222. Thus, "hospital records, made in the hospital's regular course of business," ordinarily fall within this exception. *Department of Pub. Safety & Corr. Servs. v. Cole*, 342 Md. 12, 28 n.4 (1996) (citing *State v. Garlick*, 313 Md.

[3] *See also* Md. Code (1974, 2013 Repl. Vol., 2019 Supp.), § 10-101(b)-(c) of the Courts and Judicial Proceedings Article (stating that a "writing or record made in the regular course of business as a memorandum or record of an act, transaction, occurrence, or event is admissible to prove the act, transaction, occurrence, or event" if it is "the practice of the business . . . to make such written records of its acts at the time they are done or within a reasonable time afterwards").

at 216).

Despite the "general tendency to permit the admission of hospital records," not all entries are necessarily admissible. *Hall v. University of Maryland Med. Sys. Corp.*, 398 Md. at 92. A particular statement made within a hospital record will qualify under this exception if it is "pathologically germane," meaning that the statement "fall[s] within the broad range of facts which under hospital practice are considered relevant to the diagnosis or treatment of the patient's condition." *Id.* (citations and quotation marks omitted). "'[F]acts helpful to an understanding of the medical or surgical aspects of the case, within the scope of medical inquiry[,]' are pathologically germane." *Id.* at 92-93 (alterations in original) (quoting *State v. Garlick*, 313 Md. at 222). The "recordations" of "events that are 'pathologically germane'" to the treatment of hospital patients may be admitted under this exception. *State v. Garlick*, 313 Md. at 222.

On appeal, Mother contends that certain statements from Dr. Sulmasy's "Consultation Notes" do not qualify under this hearsay exception. The entry contains three sections: a background section describing A.H.'s condition, a section listing options for A.H.'s treatment, and a section summarizing a discussion with hospital staff and Dr. Sulmasy's ultimate recommendation. Dr. Sulmasy concluded that, because A.H. "nearly died at home while having been sent home with a monitor and failed to respond to [CPR], the maxi-min principle," which he defined as "protecting the child against the worst case scenario," would "seem[] to favor the trach[eostomy] over continued monitoring."

Mother argues that two sentences from the "Patient/Background" section are inadmissible because they describe "the thoughts and collective beliefs and opinions of

unidentified hospital personnel who apparently met with Dr. Sulmasy."[4] The two sentences read:

> Mother (and to some extent the patient's grandparents) have been thought to have an inappropriately passive reaction to the idea of trach, have shown evidence of not being able to center attention on the needs of the child, have often neglected to feed the child. Some stories, such as that of the death of the older sister, are not reported harmoniously by the mother and by the grandparents, and some of the patient's events have been witnessed only by the mother before reporting to the staff.

When the Department first offered the hospital records into evidence, Father's counsel sought to exclude the paragraph containing those sentences. Father's counsel argued that the statements were not germane to A.H.'s treatment, and thus that the statements did not qualify under the business records exception. Counsel for the Department and counsel for the child each argued that all statements were relevant to A.H.'s treatment, and thus that the entry should be admitted in its entirety.

In her appellate brief, Mother tells us that her counsel "joined" the objection made by Father's counsel at the hearing. As the appellees point out, however, Mother's counsel was, at best, equivocal as to whether she objected to the admission of these statements. In fact, Mother's counsel appeared to acquiesce in the argument that the statements were germane to A.H.'s treatment. Mother's counsel stated that, the "specific comments" in the paragraph were "hearsay," but said that, "[i]n any event," the

[4] Dr. Sulmasy wrote: "We met for over an hour and had an extensive and honest discussion." Dr. Sulmasy did not identify the participants in the discussion, but he did mention remarks from the hospital's social workers and Pediatric Critical Care Staff.

statements "m[ight], as the child's attorney sa[id], be relevant to the care" of the patient.[5]

Mother's counsel then stated that she did "object to the Department's arguments [in] regards to the thoughts of the expert." The Department's counsel, in discussing the relevance of the statements, had said that Dr. Sulmasy was "trying to . . . resolve everything in the light most favorable" to Mother. Mother's counsel concluded: "We just object to the section where they read in the thoughts, and that the expert reached his conclusions looking at this in the light most favorable" to Mother.

It is difficult to imagine how the objection by Mother's counsel could be construed as an objection on the ground that Dr. Sulmasy's statements were not admissible under any hearsay exception. To preserve an appellate challenge to the admission of evidence, "[i]t is not enough that another party has objected to the same evidence." *Fireman's Fund Ins. Co. v. Bragg*, 76 Md. App. 709, 719 (1988). "Each party must make it clear that he or she has an objection to the particular evidence." *Id.* If a party "provides the trial judge with specific grounds for an objection, the [party] may raise on appeal only those grounds actually presented to the trial judge." *Anderson v. Litzenberg*, 115 Md. App. 549, 569 (1997). "All other grounds for the objection, including those appearing for the first time in a party's appellate brief, are deemed waived." *Id.*[6]

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[5] The transcript states that Mother's counsel said that the statements might be "relevant to the care of the mother." In context, it is clear that all attorneys were discussing whether the statements were relevant to the care of the child.

[6] After the court admitted Dr. Sulmasy's consultation notes, Mother's counsel asked for "a continual objection to anything here that may not be relevant[.]" The court properly declined to grant a continuing objection, concluding that the objection was "too vague" for the court to grant a continuing objection. *See* Md. Rule 2-517(b).

In any event, even if Mother's counsel had joined the objection made by Father's counsel, the issue is still not properly preserved. Later in the hearing, Mother's counsel introduced a copy of Dr. Sulmasy's consultation notes into evidence, without redaction or limitation. The apparent purpose of offering the document was to dispel suspicions that Mother had somehow caused A.H.'s apneic episodes.[7] But by affirmatively offering the statements into evidence, Mother effectively waived any prior objection to the admissibility of those statements. *See Halloran v. Montgomery Cty. Dep't of Pub. Works*, 185 Md. App. 171, 199-200 (2009). Moreover, any error in the initial admission of the statements was rendered harmless by its subsequent admission at the request of Mother's counsel. *See In re Beverly B.*, 72 Md. App. 433, 442-43 (1987).

Despite Mother's insistence that the statements in Dr. Sulmasy's consultation notes were "highly prejudicial," the record does not show that the court actually relied on those statements. The court adopted a paragraph from the amended petition that quoted those statements, but the court did not mention the consultation notes or make any finding based on those notes in its oral ruling. The court's findings about Mother's conduct were derived mainly from the entries made by Nurse Dwivedi. The only other entries mentioned by the court were related to the inconsistent use of the home apnea monitor and the missed appointment with a pulmonologist. As stated in Mother's reply

[7] Dr. Sulmasy wrote that some hospital staff members voiced suspicion that Mother "could be the cause of these events[.]" Dr. Sulmasy opined that, "it was not thought that the case reaches the level of child abuse or Munchausen's by proxy." He explained: "The witnessed case cannot be explained by the mother attempting, for instance, to suffocate the baby." He added: "Being immature is not the same thing as being abusive."

brief, "the evidence provided by Nurse Dwivedi . . . is the primary, if not sole, basis for the Juvenile Court's finding that A.H. is a child in need of assistance." Because the admission of Dr. Sulmasy's notes did not create any substantial likelihood of prejudice, any error in its admission was harmless. *See In re H.R.*, 238 Md. App. 374, 408 (2018); *see also In re Adoption/Guardianship of T.A., Jr.*, 234 Md. App. 1, 29-30 (2017) (holding that the erroneous admission of a document was harmless, in a termination-of-parental-rights proceeding, where the court's ruling made only one reference "in passing" to the document).

Separately, Mother contends that Nurse Dwivedi's entry in the hospital records was not admissible under the business records exception. In that entry, Nurse Dwivedi recorded that a series of events occurred in A.H.'s hospital room on the night of October 14, 2019. At 7:51 p.m., Mother "shove[d] [the] patient aggressively down onto the bed from a sitting position to flat on her back[,]" while A.H. was "crying and visibly upset," and the "[v]entilator was alarming." At 8:25 p.m., the "[v]entilator alarm [was] disconnected," and Mother was "holding [the] patient down in the bed[,]" while she was "screaming" and her "face [was] red," but her "[c]ries were not audible because of [the] tracheostomy." In both instances, Mother said that A.H. was tired and needed to sleep. Nurse Dwivedi also "found scissors in [the] patient[']s bed two separate times after witnessing [Mother] playing with scissors[.]" During the same shift, Mother stated: "Would it be possible to sedate her when we go home so I can sleep at night[?]"; "If she can't eat then can she get a GTube[?]"; and "She has nothing to cry about she is just

needy."[8] [Sic.]

The juvenile court admitted the entire entry, concluding that all statements were reasonably relevant to A.H.'s treatment after her tracheostomy. The court stated that, in deciding the appropriate time to discharge a patient, doctors need to consider whether the patient will receive "appropriate aftercare." The court noted that the care of a child who has undergone a tracheostomy involves "many issues with regards to . . . keeping it clean, keeping it unclogged, feeding, all those things." The court concluded that Nurse Dwivedi's statements were pathologically germane and thus admissible because they addressed "whether or not" Mother would be able to "take care of the child upon discharge."

On appeal, Mother acknowledges the court's explanation of the relevance of the statements, but she makes no direct challenge to the court's rationale. Mother nevertheless argues that Nurse Dwivedi's statements "are not objective, scientific findings and not the result of routine tests or procedures that are done in the usual course and upon which other medical personnel routinely rely." Mother contends that, in order for hearsay statements made in a hospital record to be admissible, "the statements must be as to facts, not opinions, that are pathologically germane."

As the appellees point out, no such doctrinal restriction exists. By its terms, the

[8] Mother argues that Nurse Dwivedi's written account of what Mother said is hearsay within hearsay. *See* Md. Rule 5-805. Even if the Department had offered Nurse Dwivedi's statements to prove the truth of assertions by Mother, Mother's own statements would not be excluded when the Department offered those statements against her. *See* Md. Rule 5-803(a)(1).

exception for records of regularly conducted business activities may apply to "[a] memorandum, report, record, or data compilation of acts, events, conditions, *opinions*, or diagnoses" made in the regular course of business. Md. Rule 5-803(b)(6) (emphasis added). Statements of opinion in hospital records may be admitted as long as "the portion of the record is pathologically germane to the patient's treatment at the hospital, and it contains opinions of a person shown by the hospital record to be qualified to express them[.]" *In re Colin R.*, 63 Md. App. 684, 692-93 (1985) (citations omitted).

Mother also asserts that "expert opinions do not fall within the business records exception to the hearsay rule," under the holding of *In re Adoption No. 95195062/CAD in Circuit Court for Baltimore City*, 116 Md. App. 443 (1997). The actual holding of that case, however, is that a report prepared by a psychiatrist who had been directed to evaluate a mother's mental health in anticipation of a CINA hearing was not admissible as a business record. *Id.* at 464. This result merely illustrates that this exception "does not 'embrace self-serving records, made in anticipation of litigation.'" *In re Adoption/Guardianship of T.A., Jr.*, 234 Md. App. at 10 (quoting *Sail Zambezi, Ltd. v. Maryland State Highway Admin.*, 217 Md. App. 138, 156 (2014)).

In her reply brief, Mother appears to acknowledge that opinions may be admitted under this exception. Mother nonetheless argues that the record fails to show that Nurse Dwivedi possessed any "special qualification" to offer her "subjective characterizations and opinions" of Mother. To the contrary, the notes consist of the nurse's first-hand observations of Mother's conduct and statements. A person needs no special qualifications to observe that an adult was shoving or holding down a screaming infant,

that an alarm was disconnected shortly after it had been sounding, that scissors were found in a child's crib shortly after they were in someone's possession, or that a person made a particular comment. Any registered nurse present in the room would be "entirely competent to make the observation[s] and notation[s] entered in th[ese] hospital records." *Sarrio v. Reliable Contracting Co.*, 14 Md. App. 99, 105 (1972) (upholding admission of hospital records that included an intern's notations that a patient in the emergency room was intoxicated, even though the intern's qualifications were unknown).

Mother emphasizes that Nurse Dwivedi's written account of the events of the night of October 14, 2019, is "in direct contradiction" to Mother's testimony denying the allegations. Yet even a "direct conflict" between a witness's testimony and entries made in a hospital record does "not preclude . . . their admissibility" under the business records exception. *Hall v. University of Maryland Med. Sys. Corp.*, 398 Md. at 91. Aside from Mother's denials, we see nothing about "the source of information or the method or circumstances of the preparation of the record" that would "indicate that the information in the record lacks trustworthiness." Md. Rule 5-803(b)(6).

In addition to her challenge based on the Rules of Evidence, Mother argues that the juvenile court denied her due process of law by admitting the evidence even though Mother had no opportunity to cross-examine Nurse Dwivedi. Mother argues that "the principles and reasons for the accused's right of confrontation" in criminal prosecutions "apply equally" in a CINA proceeding. The appellees point out that "the right of confrontation applicable in [a criminal prosecution] is not available to the parents of an alleged [CINA]." *In re Colin R.*, 63 Md. App. at 693-94 (citing *Woods v. Department of*

Soc. Servs., 11 Md. App. 10, 18 (1971)); *see also In re J.J.*, 456 Md. 428, 455 (2017) (noting that "Maryland courts have found that the right to confrontation does not apply in civil, let alone CINA, proceedings").

A parent is entitled to due process in a CINA proceeding, because the parent faces at least the temporary loss of care and custody of a child. *In re Maria P.*, 393 Md. 661, 675-76 (2006). "[B]ut the process due is less than that owed a parent at a [termination-of-parental-rights] hearing[,]" in which the State seeks to permanently sever the parent-child relationship, "and still less than that owed an individual who faces the loss of personal liberty[,]" such as a criminal defendant, probationer, or an alleged juvenile delinquent. *In re Blessen H.*, 163 Md. App. 1, 18 (2005), *aff'd*, 392 Md. 684 (2006); *accord In re Karl H.*, 394 Md. 402, 423 n.17 (2006). Accordingly, we conclude that Mother was not denied due process through the admission of evidence under a long-recognized hearsay exception that is justified, in part, by the "inherent trustworthiness of entries in a hospital record relevant to the life and death decisions being made by the treating physicians of a hospital patient[.]" *In re Colin R.*, 63 Md. App. at 693.

In sum, we see no reversible error in the court's admission of hospital records.

II. <u>Expert Opinion Testimony from Social Worker</u>

As her next argument for reversal, Mother contends that the juvenile court improperly permitted the Department's caseworker, Ms. Silva, to offer expert opinion testimony. Mother argues that Ms. Silva was not qualified to offer her opinion that it would be unsafe to return A.H. to Mother's care.

On direct examination, Ms. Silva stated that she had earned an undergraduate

degree from the University of Maryland, Baltimore County, and a master's degree in social work from the University of Baltimore. Her education included "course work specifically for child welfare" and two internships at "child welfare agencies in the state." As an intern, Ms. Silva was "personally responsible" for approximately 50 cases and had been "mandated" to "assess safety and risk" in all of those cases. Ms. Silva was currently licensed by the State of Maryland in "masters level social work," and to maintain her license, she must complete "at least 40 hours of continuing education credits" every two years. Ms. Silva had worked for the Department for more than three years, during which she had handled approximately 500 cases. She had assessed safety in all of those cases because those assessments are "mandated." Her "overall role" as a social worker is to make those types of assessments.

After establishing those qualifications, the Department offered Ms. Silva "as an expert in the field of social work," including "the field of safety and risk." No party objected or took the opportunity to ask additional questions about Ms. Silva's qualifications. The court accepted Ms. Silva as an expert in the designated field. Later, no party objected when the Department asked Ms. Silva "to a reasonable degree of social work certainty" whether A.H. could be safely returned to the care of Mother.

As Mother concedes, her counsel did not object to Ms. Silva's expert opinion testimony at the hearing. Consequently, her contention that Ms. Silva was not qualified to offer her opinion is not properly preserved for appellate review. *See Gallagher v. Gallagher*, 118 Md. App. 567, 578 (1997) (citing Md. Rule 8-131(a)). The admission of the expert opinion testimony "is no longer subject to challenge." *Terumo Med. Corp. v.*

Greenway, 171 Md. App. 617, 622 (2006) (applying Md. Rule 5-103(a)).

Mother asks this Court to address the admissibility of Ms. Silva's testimony under its discretionary authority to decide issues that are neither raised in nor decided by the trial court. Mother contends that, in *In re Adoption of Tatianna B.*, 417 Md. 259 (2010), the Court of Appeals held that only licensed clinical social workers may testify as experts in safety and risk assessment. Her argument mischaracterizes the holding of that case.

The issue in *Tatianna B.* was "solely, whether a licensed clinical social worker can qualify as an expert witness in social work and opine . . . regarding the safety and risk of a child were she to be returned to her mother's care." *In re Adoption of Tatianna B.*, 417 Md. at 264. The witness possessed a master's degree in social work, six years of work experience with the Montgomery County Department of Health and Human Services, and a Maryland license in clinical social work. *Id.* at 262. The Court held that the juvenile court "did not abuse [its] discretion in qualifying [the witness] as an expert in social work, because of [her] education, training[,] and expertise as a licensed clinical social worker." *Id.* at 265. The Court concluded that, "[o]nce qualified as an expert in social work," the witness who handled the child's case "could opine regarding the risk of future harm to [the child] were she to be returned to [the mother's] care." *Id.* at 267. The Court noted that, when investigating suspected child abuse and neglect, social workers must "'[a]ssess immediate safety and risk of maltreatment of children who are household or family members or in the care or custody of the alleged maltreator[.]'" *Id.* at 265-66 (quoting COMAR 07.02.07.07).

Although the witness in *Tatianna B.* was licensed in clinical social work, the Court

neither stated nor suggested that *only* licensed clinical social workers may qualify as experts in social work. To become a licensed clinical social worker, a person must complete "clinical course work" and attain experience "in the assessment, formulation of a diagnostic impression, and treatment of mental disorders and other conditions[.]" Md. Code (1981, 2014 Repl. Vol., 2019 Supp.), § 19-302(e)(2)-(3) of the Health Occupations Article. Certain aspects of social work, such as the "[e]valuation, diagnosis, and treatment of biopsychosocial conditions, mental and emotional conditions and impairments, and behavioral health disorders," may be performed only by a licensed clinical social worker. *Id.* § 19-101(p)(4)(ii). Because Ms. Silva was not a licensed clinical social worker, she would not be qualified to render the diagnosis of a mental disorder. *See In re Adoption/Guardianship No. CCJ14746*, 360 Md. 634, 642-44 (2000).

Ms. Silva did not, however, render any such diagnosis when she assessed A.H.'s safety and risk. Ms. Silva focused on A.H.'s special needs and on Mother's conduct, as reported in the hospital records. Ms. Silva acknowledged that any evaluation of Mother's mental health would need to be performed by a psychiatrist. The scope of Ms. Silva's opinion did not exceed her area of expertise.

Mother also contends that Ms. Silva's opinion was inadmissible because it was primarily based on "inadmissible hospital records." Mother points out that, in making her safety and risk assessment, Ms. Silva relied "almost exclusively" on Nurse Dwivedi's written reports of Mother's conduct. There are at least two critical defects in that argument.

First, as explained previously, the statements were, in fact, admissible under the

business-records exception to the hearsay rule. Second, expert witnesses may, in some circumstances, base their opinions on inadmissible evidence, including hearsay. *See, e.g.*, *Gillespie v. Gillespie*, 206 Md. App. 146, 166 (2012). Mother has failed to show that hospital records are not the type of record that experts in the field of safety and risk "would reasonably rely on . . . in forming an opinion on the subject[.]" Md. Rule 5-703(a).

Mother criticizes Ms. Silva for reviewing only a small fraction of A.H.'s medical records and for not speaking directly with Nurse Dwivedi and other health care providers. Mother argues that these failures "speak[] volumes as to [Ms. Silva's] credibility and the weight that her testimony should be accorded." But issues regarding the depth of Ms. Silva's knowledge of A.H.'s circumstances "go to the weight of her testimony, not the admissibility of her testimony." *In re Adoption of Tatianna B.*, 417 Md. at 268 (citing *Terumo Med. Corp. v. Greenway*, 171 Md. App. at 623-24). As an appellate court, "we may not reassess the credibility of this expert witness, or the weight of [her] testimony." *Leavy v. American Fed. Sav. Bank*, 136 Md. App. 181, 199-200 (2000) (applying Md. Rule 8-131(c)).

Thus, Mother has failed to show that, if she had objected at the hearing, the court would have been required to exclude Ms. Silva's testimony.

III. <u>Finding of Neglect</u>

Although the Department alleged both abuse and neglect, the juvenile court ultimately concluded that A.H. was a child in need of assistance based on a finding of neglect. Mother contends that the court erred in finding, by a preponderance of the

evidence, that A.H. had been neglected.

The CINA statute includes the following definition:

> "Neglect" means the leaving of a child unattended or other failure to give proper care and attention to a child by any parent or individual who has permanent or temporary care or custody or responsibility for supervision of the child under circumstances that indicate:
>
> > (1) That the child's health or welfare is harmed or placed at substantial risk of harm; or
> >
> > (2) That the child has suffered mental injury or been placed at substantial risk of mental injury.

Md. Code (1974, 2013 Repl. Vol., 2019 Supp.), § 3-801(s) of the Courts and Judicial Proceedings Article.

Under this definition, "there may be neglect of a child without actual harm to the child." *In re Andrew A.*, 149 Md. App. 412, 418 (2003). A child has been neglected when a parent's act or omission creates "a substantial risk of harm" to the child. *Id.* A child "may be considered 'neglected' before actual harm occurs, as long as there is 'fear of harm' in the future based on 'hard evidence' and not merely a 'gut reaction.'" *In re Nathaniel A.*, 160 Md. App 581, 601 (2005) (quoting *In re William B.*, 73 Md. App. 68, 78 (1987)). To determine whether a child has been neglected, the court "must look at the totality of the circumstances[.]" *In re Priscilla B.*, 214 Md. App. 600, 621 (2013). The court "may examine the parents' 'track record' to determine if a child is 'merely *placed at risk* of significant harm.'" *In re J.R.*, 244 Md. App. 644, 687 (2020) (emphasis in original) (quoting *In re Dustin T.*, 93 Md. App. 726, 735 (1992)).

Without any supporting authority, Mother tells us that a finding of neglect is a

legal determination subject to de novo review. To the contrary, this Court grants substantial deference to a juvenile court's determination that a parent's conduct placed a child at substantial risk of harm. *See, e.g.*, *In re J.R.*, 244 Md. App. at 686-97; *In re Priscilla B.*, 214 Md. App. at 633. The juvenile court's findings will not be set aside unless clearly erroneous. *In re Nathaniel A.*, 160 Md. App. at 595. The pertinent question here is whether the court's findings were supported by sufficient evidence. *See id.* at 595-96, 601.

In light of the hospital records, the finding of neglect was by no means clearly erroneous. The court credited the evidence that Mother shoved the 10-month-old child down onto her back while she was crying and her ventilator alarm was sounding. The court credited the evidence that, a short while later, Mother held the child down while she was crying and the ventilator alarm was disconnected. The court also credited the evidence that, on two occasions, hospital staff found scissors in the child's bed after Mother was seen with scissors. The court noted concerns about comments Mother made in response to the child's crying. Finally, the court cited the evidence of Mother's inconsistent use of a home apnea monitor and the missed follow-up appointment with a pulmonologist after an earlier hospitalization.

Mother focuses not on the evidence on which the court relied, but on the other evidence showing that she had consistently sought medical care and remained at her child's bedside while she was hospitalized for months. Mother quotes the observation that "'[i]t makes sense to think of 'neglect' as part of an overarching pattern of conduct." *In re Priscilla B.*, 214 Md. App. at 625. Mother asserts that the evidence

"overwhelming[ly]" showed her "vigilance, concern for, and involvement in, her daughter's care."

The finding of neglect here was not based on inattention, but on a failure to give proper care and attention to A.H. and to her needs, in a manner that posed a substantial risk to A.H.'s health and welfare. Collectively, the evidence supported the conclusion that Mother had engaged in conduct that created a substantial risk of harm to A.H., an 11-month-old child who had undergone a tracheostomy because of a life-threatening medical condition. Accordingly, there is no basis to set aside the finding of neglect.

IV. <u>Finding of Reasonable Efforts by the Department</u>

Mother contends that the juvenile court erred in finding that the Department made reasonable efforts to prevent A.H.'s placement in the custody of the Department.

A local department of social services has a statutory obligation to make "reasonable efforts . . . to preserve and reunify families: (i) prior to the placement of a child in an out-of-home placement, to prevent or eliminate the need for removing the child from the child's home; and (ii) to make it possible for a child to safely return to the child's home." Md. Code (1984, 2019 Repl. Vol.), § 5-525(e)(1) of the Family Law Article. "In determining the reasonable efforts to be made and in making" those efforts, "the child's safety and health" is "the primary concern." *Id.* § 5-525(e)(2).

At an adjudicatory hearing, the court must "make a finding whether the local department made reasonable efforts to prevent placement of the child into the local department's custody." Md. Code (1974, 2013 Repl. Vol., 2019 Supp.), § 3-816.1(b)(1) of the Courts and Judicial Proceedings Article. In this context, the term "'[r]easonable

efforts' means efforts that are reasonably likely to achieve the objective[]" of preventing the child's placement in the local department's custody. *Id.* § 3-801(w). This statutory definition is "amorphous." *In re Shirley B.*, 191 Md. App. 678, 710 (2010), *aff'd*, 419 Md. 1 (2011). "[T]here is no bright line rule to apply to the 'reasonable efforts' determination; each case must be decided based on its unique circumstances." *Id.* at 710-11; *accord In re Shirley B.*, 419 Md. 1, 25 (2011). We apply the clearly erroneous standard in reviewing a court's factual finding that a local department of social services made the requisite reasonable efforts. *See In re Shirley B.*, 419 Md. at 18.

In its written order, the juvenile court adopted language from the amended petition, stating that "the Department ha[d] made reasonable efforts to prevent or eliminate the need for removal, including but not limited to: interfacing with the child and placement; arranging for services; and interfacing with the mother." This language, although vague, accurately describes actions recounted in the testimony of the social worker, Ms. Silva.

Mother contends that the Department failed to make reasonable efforts to prevent A.H.'s placement in the custody of the Department. Mother argues that the Department did not "ask her to do anything other than take the [tracheostomy] classes, which [she] did." Mother asserts that "there is nothing she is not willing to do with regard to the care of A.H. or with regard to concerns the Department has."

At the time of the adjudicatory hearing here, the Department was still assessing the family's needs, a necessary step before the provision of services. "Quite frequently," child welfare agencies encounter "circumstances in which it is unclear how much effort is

reasonable." *In re James G.*, 178 Md. App. 543, 579 (2008) (citation and quotation marks omitted). "'At the initial stage of . . . its involvement with a family, the child welfare agency assesses the family's needs and circumstances[,]'" and the agency "'should make reasonable efforts to prevent the child's removal from home . . . commensurate with the assessment." *Id.* (citations and quotation marks omitted).

Fewer than 30 days passed between the date when the Department received the report of suspected child abuse or neglect and the date of the adjudicatory hearing. During that time, the Department had determined that A.H. could not be safely returned to the home until Mother better demonstrated her caretaking ability. The Department had also assessed whether A.H. could be placed with Father or with the maternal grandparents, but it did not consider those options to be suitable. At the hearing, the Department asked the court to order Mother to undergo a psychological evaluation, so that the Department might gain a better understanding of what counseling or other services might address the issues that to led to neglect.[9]

Under these circumstances, the juvenile court was not clearly erroneous in finding that the Department's initial efforts were reasonable.

V. <u>Disposition Hearing</u>

Generally, the filing of a CINA petition triggers a two-stage hearing process: an adjudicatory hearing to determine whether the facts alleged in the petition are true; and a

[9] In her testimony, Ms. Silva suggested that the Department "should have" asked Mother to consent to a service plan at a mediation session that occurred before the adjudicatory hearing. Without elaboration, Ms. Silva said that those services were "never discussed" because "mediation didn't go as it usually goes."

disposition hearing to determine whether the child is in need of assistance and, if so, the nature of the court's intervention. Mother argues that, even if this Court upholds the juvenile court's finding of neglect, we should reverse the court's ultimate "dispositional rulings."

First, Mother contends that, at the conclusion of the adjudicatory hearing, the juvenile court was required to grant her request to postpone the disposition hearing. Generally, the decision to grant or deny a request for a postponement "lies within the sound discretion of the trial judge." *Touzeau v. Deffinbaugh*, 394 Md. 654, 669 (2006).

At the end of the adjudicatory hearing, Mother's counsel asked the court to postpone the disposition hearing until the completion of a psychological evaluation of Mother. The court asked the parties "how long" it would take for the report to be completed. Counsel for the Department answered that it would take "a couple months at least." Mother's counsel responded, "we can try to make that." The court declined Mother's request for a postponement, finding no good cause to delay the disposition hearing.

The juvenile court was correct in concluding that it could not grant Mother's request absent a showing of good cause. The court must hold the disposition hearing "on the same day as the adjudicatory hearing unless on its own motion or motion of a party, the court finds that there is *good caus*e to delay the disposition hearing to a later day." *See* Md. Code (1974, 2013 Repl. Vol., 2019 Supp.), § 3-819(a)(2) of the Courts and Judicial Proceedings Article (emphasis added). "If the court delays a disposition hearing, it shall be held no later than 30 days after the conclusion of the adjudicatory hearing

unless *good cause* is shown." *Id.* § 3-819(a)(3) (emphasis added).

In statutes such as this one, where the legislature does not define what constitutes good cause, the determination is committed to the discretion of the court. *See Madore v. Baltimore County*, 34 Md. App. 340, 344 (1976). "The discretion with which all courts determine whether good cause has or has not been shown is broad." *Id.* at 346. "A ruling made in the exercise of that discretion is entitled to the utmost respect" and "should not be overturned by an appellate court unless there is a clear showing . . . that the result falls outside its broad limits." *Id.*

Mother argues that the court abused its discretion in denying her request for a postponement. Mother faults the Department for failing to initiate the psychological evaluation process before the adjudicatory hearing. Even accepting the validity of her complaint, we fail to see how these facts might amount to good cause to delay the disposition hearing until some unknown date. These proceedings were not simply an adversarial contest between Mother and the Department. The court could reasonably conclude that the child A.H. would be better served by a prompt dispositional order establishing the terms of visitation with both parents at the Kennedy Krieger Institute. We see no abuse of discretion.

Finally, Mother contends that the court abused its discretion by refusing to permit Mother's visits with A.H. to be supervised by the maternal grandparents and, as a result, limiting her visitation to one, two-hour visit per week of supervised visitation.

At the previous shelter care hearing, the Department had agreed to allow the maternal grandparents to supervise Mother's visits with A.H. at her rehabilitative care

facility. At the disposition hearing, the Department argued the maternal grandparents should not supervise those visits, because the testimony did not show "that the grandparents would be able to create boundaries between their daughter and their grandchild." The court agreed with that recommendation, remarking that Mother might not be "sufficiently monitor[ed]" unless the supervisor was "skeptical" of Mother. The court ordered the Department to provide supervised visitation once per week, for a minimum of two hours, as the Department represented that it lacked resources to provide additional supervised visitation.

Decisions concerning the amount and conditions of visitation "generally are within the sound discretion of the trial court, and are not to be disturbed unless there has been a clear abuse of discretion." *In re Billy W.*, 387 Md. 405, 447 (2005). "Because the trial court is required to make such determinations in the best interests of the child, visitation may be restricted or even denied when the child's health or welfare is threatened." *Id.* Ordinarily, this Court will uphold a visitation decision unless "no reasonable person would adopt" the trial court's ruling or it is or "beyond the fringe of what [this] court deems minimally acceptable." *Michael Gerald D. v. Roseann B.*, 220 Md. App. 669, 686 (2014) (quotation marks omitted). Additionally, "in reviewing a visitation order, we must give 'due regard . . . to the opportunity of the [trial] court to judge the credibility of the witnesses[.]'" *Id*. at 687 (quoting *In re Yve S.*, 373 Md. 551, 584, 586 (2003)).

The court acted well within its discretion in requiring that Mother's visits be supervised by an independent third party. We need not recount the litany of evidence showing that A.H. was in an acutely vulnerable condition. The court credited hospital

records showing, among other things, that the ventilator alarm was unplugged when Mother was alone in A.H.'s hospital room. Ms. Silva had testified (without objection) that, when she spoke with the maternal grandparents, they stated that they both believed Mother when she denied the reports about her conduct. The maternal grandfather's testimony confirmed that he believed his daughter's denials. During the final week of A.H.'s hospital stay, the maternal grandfather had made a complaint to a head nurse and a patient advocate, based solely on what his daughter told him. Finally, during A.H.'s transfer to the Kennedy Krieger Institute, Mother was briefly present with A.H., unsupervised, when she failed to leave the room even though all health care providers left the room.

We see nothing unreasonable in the decision to ensure that A.H.'s visits would be supervised by someone other than Mother's parents. During the disposition hearing, the court said that it would direct the Department to try to "find somebody to supervise those visits, other than the grandparents," because the court recognized that it was "important that [the visits] happen more than once a week[.]" The order required the Department to "explore kinship resources who may be able to supervise visits between the Child and her parents, so those visits can increase in frequency[.]" It is understandable that Mother believes that one two-hour visit once per week is too little, but the court reasonably concluded that this arrangement was, at the time, the only available arrangement that would ensure A.H.'s safety.

CONCLUSION

The Adjudication and Disposition Order entered on November 12, 2019, is hereby affirmed.

JUDGMENT OF THE CIRCUIT COURT FOR MONTGOMERY COUNTY, SITTING AS JUVENILE COURT, AFFIRMED. COSTS TO BE PAID BY APPELLANT.