

Circuit Court for Wicomico County  
Case No. C-22-JV-18-000134

UNREPORTED  
IN THE COURT OF SPECIAL APPEALS  
OF MARYLAND

No. 2219

September Term, 2018

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IN RE: D.S.

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Wright,  
Kehoe,  
Moylan, Charles E., Jr.  
(Senior Judge, Specially Assigned),

JJ.

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PER CURIAM

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Filed: October 1, 2019

\*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.

The Circuit Court for Wicomico County, sitting as a juvenile court, found D.S., appellant, involved in the delinquent acts of second-degree child abuse, second-degree assault, reckless endangerment, and neglect of a minor, following the death of D.S.’s infant daughter. D.S. noted an appeal, in which she challenges the sufficiency of the evidence on all charges. For the following reasons, we shall reverse the finding of involvement in the delinquent act of neglect of a minor and shall otherwise affirm the judgments of the circuit court.

### **FACTS**

On March 10, 2017, D.S., then 16-years-old, gave birth to a daughter, S.S. D.S. had been living with Hanan Parker, the mother of one of D.S.’s friends, for a period of time prior to the birth of S.S.<sup>1</sup>

After S.S. was born, Ms. Parker helped D.S. access various social services that provided necessary supplies and parental skills training. Ms. Parker was concerned about “different behaviors” that D.S. exhibited, such as yelling at S.S. to “shut up,” leaving S.S. unattended on a couch, and sleeping in the same bed with S.S. “with the baby tucked underneath of her.” Ms. Parker was aware that, prior to the birth of S.S., D.S. had a baby that had died of SIDS, and that D.S. had been counseled by the social worker against “co-sleeping” with S.S.<sup>2</sup>

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<sup>1</sup> According to Ms. Parker’s testimony, D.S. was in either her fifth or eighth month of her pregnancy when she came to live with her.

<sup>2</sup> SIDS is a common acronym for Sudden Infant Death Syndrome.

Because of the history of a sibling who had died of SIDS, S.S.’s doctors had arranged for a heart monitor for S.S. to wear at night. Ms. Parker asked D.S. not to reset the monitor when its alarm sounded until Ms. Parker had a chance to read the monitor’s display, “so that [she would] know for sure” why the heart monitor went off. Ms. Parker was apparently distrustful of D.S.’s explanations for why the monitor’s alarm sounded, citing D.S.’s “history of not being honest.” D.S. would, however, reset the monitor before Ms. Parker could see it. Ms. Parker described D.S. as “nonchalant about having the baby[,]” “not really connected to the baby,” and “very neglectful.”

Shortly after S.S. was born, D.S. moved out of Ms. Parker’s home and into the home of Amber Smith.<sup>3</sup> Amber cared for S.S. during the day while D.S. went to school. Amber described D.S. as “very neglectful,” and “careless.” She described an incident in which S.S. was left on a bed, unattended and in danger of falling, while D.S. was in another room. On another occasion, while D.S. was carrying S.S. through a doorway, S.S.’s head hit the wall. Amber was concerned about D.S.’s use of “the oxy” pain medication that was prescribed for D.S. after she had foot surgery. Amber felt that D.S. was “becoming dependent” on the medication, so she took the pills away from D.S. and “flushed them.”

Mariah Smith, Amber’s sister, lived with Amber in May 2017, while D.S. and S.S. were also living there. Mariah frequently observed D.S. interact with S.S. and felt that D.S. “needed to be more careful” with S.S. Mariah stated that D.S. “rough handle[d]” S.S. and did not support S.S.’s head and neck properly when holding her. On one occasion,

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<sup>3</sup> We shall generally refer to Amber Smith and another witness, Mariah Smith, by their first names, to avoid confusion between the two.

Mariah discovered S.S. on the edge of the bed with a blanket over her face while D.S. sat on the couch in another room. On another occasion, D.S. told Mariah that the reason S.S.'s heart monitor was beeping was because the monitor was broken, but D.S. had not reported the broken monitor to S.S.'s doctor. Mariah felt that D.S. was “on her phone too much” instead of paying attention to S.S. Mariah shared Amber's concern about D.S.'s use of Oxycodone because she was “taking it a lot and she was sleeping.” Mariah told her to limit her use of the medication because she needed to be awake to care for the baby. Mariah discussed her “high level” concerns with D.S. but felt that “it was just going in one ear and out the other.”

On the morning of August 2, 2017, Amber left the house to go to a doctor's appointment, leaving D.S. at home alone with S.S. In the middle of her doctor's appointment, Amber received a call from the hospital and learned that something was wrong with S.S. When Amber arrived at the hospital, S.S. was deceased. D.S. told Amber that she “went to make [S.S.] a bottle and when she came back [S.S.] wasn't breathing.”

Officer Brian Weglarz of the Salisbury Police Department responded to the hospital after receiving a call for a “suspicious death of an infant.” He saw S.S., who had “several bruises on her face” and he noticed that the bruising became more apparent as time passed. Amber testified that she saw S.S. before she left that morning, and S.S. did not have any injuries. Similarly, Mariah stated that she saw S.S. the night before she died, at which time S.S. did not have any marks on her face or on her head.

Dr. Carol Allen supervised the autopsy of S.S. on August 3, 2017, and testified as an expert in the field of forensic pathology. She stated that S.S., who was four months and

23 days old at the time of her death, had a “patterned area of bruising” on her forehead, three bruises on her left forearm, and two bruises on the inside of her right ankle and right foot. There was “fairly extensive bleeding into the soft tissue of the scalp and over the surface of the skull,” and “areas of bleeding” underneath the bruising on the left arm, right ankle and right foot.

Dr. Allen opined, based on the “inflammatory response” that was observed, that S.S.’s injuries were several hours old. The injuries were consistent with blunt force trauma. Dr. Allen stated that, due to the patterning of the bruises, they would not have resulted from “a simple . . . falling against a flat surface” or from the administration of CPR.

Dr. Allen agreed that the bruises were not “significant enough to cause death.” She explained that there were “too many variables in the circumstances surrounding [S.S.’s] death” to conclude that the cause of death was SIDS. The autopsy report, which was admitted into evidence as State’s Exhibit 6, indicated that the cause and manner of death were undetermined:

The anatomic injuries identified at autopsy were not sufficient to cause [S.S.’s] death. However, due to the presence of an inflicted injury and the confounding circumstances of bed sharing, which can be associated with infant death due to overlay or re-breathing of exhaled carbon dioxide, the history of a sibling whose cause of death was “Sudden Unexplained Infant Death” with an undetermined manner of death, and the presence of a conduction system abnormality in the heart, the cause and manner of death are best certified as “Could Not Be Determined.”

Detective Daniel Schultz interviewed D.S. twice. The first interview took place at the hospital the day that S.S. died. D.S. told Detective Schultz that she was cleaning the house and stopped to give S.S. a bottle. After the feeding, she put S.S. on the bed and went

back to her chores, and then noticed that “the baby had foam coming from the nose and . . . seemed . . . lifeless.” She started CPR, then ran outside and flagged down a passing motorist, who drove her to the hospital. D.S. did not mention any injuries to S.S.’s head or limbs during the first interview.

Detective Schultz conducted a second interview of D.S. the following day and told D.S. that the autopsy had revealed blunt force trauma to S.S.’s head. D.S. offered a series of explanations for what happened that were “vastly different” from what she said in the first interview.

First, D.S. offered that S.S. had “a little red rash.” When Detective Schultz told D.S. that it was more than a rash, D.S. said that, two days before S.S. died, she was holding S.S. while she was walking into a room, and, by accident, S.S.’s head hit the doorframe.

Detective Schultz informed D.S. that S.S.’s injuries were incurred more recently than two days prior. D.S. stated that, the day before S.S. died, D.S. had fallen asleep on the couch, with S.S. on top of her, and that S.S. slipped out of her hands and hit her head on a car seat that was on the floor next to the couch before D.S. caught her. Detective Schultz told D.S. that S.S.’s injuries were caused by “something more violent” or “more tragic” than a fall from a couch and said that D.S. was “still lying about what happened.”

D.S. then said that on the day of her death, S.S. fell off the bed “really hard” and “crashed down” on the edge of the metal bed frame. D.S. had “a feeling” that “it was a bad injury” but did not mention it during the first interview because she “didn’t . . . want to look like a murderer.” Detective Schultz continued to insist that the injuries could not have been caused by a “fall from that distance,” at which point D.S. explained that, in

addition to hitting her head on the bedframe, S.S.’s head accidentally came into contact with a part of the metal scooter that D.S. was using during her recovery from foot surgery.

When Detective Schultz said that the injuries could not have been caused by the scooter, D.S. said that S.S. woke up very early the morning of her death and was crying. D.S. was “really, really tired.” D.S. stated, “I didn’t really mean to, but I just - - my hand, like, it just hit her against the wall. . . . I took her head and just tried to, like, push it down, but I pushed it against the wall.”

At that point, D.S. was placed under arrest. She was charged with manslaughter, two counts of first-degree child abuse, second-degree child abuse, first-degree assault, second-degree assault, reckless endangerment, and neglect of a minor.

When the State rested its case, defense counsel moved for judgment of acquittal on all charges. The court denied the motion.

After closing arguments, the court found D.S. not involved in the delinquent acts of manslaughter, first-degree child abuse, and first-degree assault, finding that there was no evidence establishing that D.S.’s conduct caused S.S.’s death, or that the conduct created a substantial risk of death or caused “serious” or “severe” physical injury, as defined in the applicable statutes.<sup>4</sup> The court found beyond a reasonable doubt that the S.S.’s bruises were caused by D.S., and, based on that finding, found D.S. involved in second-degree child abuse, second-degree assault, and reckless endangerment. The court found D.S.

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<sup>4</sup> See Maryland Code (2002, 2012 Repl. Vol.), Criminal Law Article §§ 3-201(d) and 3-601(a)(5).

involved in neglect of a minor, based on its finding that D.S. either ignored S.S.’s heart monitor or “failed to take it seriously.”

Additional facts will be included in the discussion as they become relevant.

## DISCUSSION

The standard of review of evidentiary sufficiency that applies when reviewing a case from the juvenile court is the same standard that applies to other criminal cases. *In re: James R.*, 220 Md. App. 132, 137 (2014). Specifically, “[w]e must determine whether, after viewing the evidence in the light most favorable to the prosecution, *any* rational trier of fact could have found the essential elements of the crime beyond a reasonable doubt.” *Id.* (citation and internal quotation marks omitted). We do not consider evidence tending to support the defense theory of the case, as exculpatory inferences are not part of the version of the evidence most favorable to the State. *Cerrato-Molina v. State*, 223 Md. App. 329, 351 (2015).

In reviewing a challenge to the sufficiency of the evidence, “we defer to the fact finder’s opportunity to assess the credibility of witnesses, weigh the evidence, and resolve conflicts in the evidence.” *Sewell v. State*, 239 Md. App. 571, 607 (2018) (citation and internal quotation marks omitted). We will not set aside the judgment of the trial court absent clear error. *James R.*, 220 Md. App. at 138.

### I. Second-degree child abuse

To prove second-degree child abuse, the State was required to prove that D.S. “cause[d] abuse” to S.S. Md. Code (2002, 2012 Repl. Vol.), Criminal Law Article (“Crim. Law”), § 3-601(d)(1)(i). “Abuse” is defined as “physical injury sustained by a minor as a



result of cruel or inhumane treatment or as a result of a malicious act under circumstances that indicate that the minor’s health or welfare is harmed or threatened by the treatment or act.” Crim. Law § 3-601(a)(2). D.S first contends that the court stated that it was “not sure” whether D.S. “banged” S.S.’s head, and therefore, the court’s factual findings “cannot sustain a finding of involvement in second-degree child abuse because they are based on speculation and mere conjecture.” Although we disagree with D.S.’s characterization of the court’s findings,<sup>5</sup> we note that, in evaluating the legal sufficiency of the evidence, we are “not concerned with the findings of fact based on the evidence or the adequacy of the factfindings to support a verdict.” *Chisum v. State*, 227 Md. App. 118, 129 (2016). The issue of legal sufficiency “is concerned only, at an earlier pre-deliberative stage, with the objective sufficiency of the evidence itself to permit the factfinding even to take place.” *Id.* at 129-30. In other words, we are “not concerned with what a factfinder,

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<sup>5</sup> Read in context, the court appeared to be unsure only about what, if any, weight should be given to D.S.’s explanation that the injuries were the result of her unintentionally pushing S.S.’s head into the wall with her hand. It is clear, however, that the court found that D.S. hit S.S.’s head, with either her hand or some other object, with enough force to cause the bruising:

... while I found [D.S.’s] statement to be voluntary ... I’m not sure whether she banged [S.S.’s] head or didn’t bang [S.S.’s] head is, it’s obviously relevant, I’m just not sure it’s truthful. ... I think something occurred there. I think she hit [S.S.’s] head. Whether that was with something else or her hand, but I think she did. And I don’t think she was truthful. ... I just don’t think she was truthful about what occurred. I think with the testimony of Dr. Allan, with the testimony of the Smiths that there was no bruising before, I think the Court finds beyond a reasonable doubt that [D.S.] caused that physical injury to [S.S.’s] head.

judge or jury, does with the evidence[,]” but only “with what any judge, or any jury, anywhere, could have done with the evidence.” *Id.* at 130.

The evidence showed that S.S. did not have any visible injuries when Amber left for her doctor’s appointment the morning of S.S.’s death. When D.S. brought S.S. to the hospital, S.S. had bruises on her face that became more apparent as time passed. The “patterned” bruises and “extensive bleeding” into the soft tissue of S.S.’s scalp were “several hours old,” which would put the time of injury within the window of time that D.S. was alone in the house with S.S. The injuries were the result of blunt force trauma, but the patterning suggested that the trauma was not simply a fall onto a flat surface. D.S., who witnesses described as “not really connected” to S.S., “very neglectful,” and dishonest, gave a voluntary statement in which she initially did not mention that S.S. had sustained an injury. Then, when confronted with autopsy findings, D.S. attempted to explain the injuries with a sequence of arguably innocent explanations, none of which the juvenile court found credible. *See Whittlesey v. State*, 340 Md. 30, 61-62 (1995) (evidence offered to show that the defendant “felt the need to tell a false story, indicating consciousness of guilt[,]” is “relevant to the issue of criminal agency.”) *See also Grimm v. State*, 447 Md. 482, 511 (2016) (“[t]he finding that a party has deliberately furnished false information permits the inference that the party did so because he knew that his cause should not prevail.” (quoting Joseph J. Murphy, Jr., MARYLAND EVIDENCE HANDBOOK § 409 at 167 (4<sup>th</sup> ed. 2010))). Based on our review of the record, we conclude that the evidence, viewed in the light most

favorable to the State, was sufficient for the juvenile court to conclude beyond a reasonable doubt that S.S.’s injuries were the result of D.S.’s cruel, inhumane or malicious actions.<sup>6</sup>

## **II. Second-degree Assault**

To prove that D.S. was involved in the delinquent act of second-degree assault, the State was required to prove beyond a reasonable doubt that D.S. intentionally caused offensive physical contact to S.S. without consent or legal justification. *Nicolas v. State*, 426 Md. 385, 403-04 (2012). D.S. argues, as she does with respect to second-degree child abuse, that the evidence was insufficient for the juvenile court to have found, without engaging in “unsound speculation,” that she caused S.S.’s injuries and that she did so intentionally. For the same reasons we stated above, in our discussion of second-degree child abuse, we conclude that the evidence was sufficient to find D.S. involved in second-degree assault.

## **III. Reckless Endangerment**

To prove reckless endangerment, the State was required to prove that D.S: 1) engaged in conduct “that created a substantial risk of death or serious physical injury to [S.S.]; 2) that a reasonable person would not have engaged in that conduct; and 3) that

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<sup>6</sup> D.S. also contends that the evidence was insufficient to find that S.S.’s injuries were the result of D.S.’s “cruel,” “inhumane,” or “malicious” conduct because Ms. Parker, Amber Smith, and Mariah Smith described D.S. as “a loving mother” who “would never do anything to intentionally hurt S.S.” Even if the juvenile court believed that these witnesses held that general opinion, it would not preclude the court from finding that, on the date in question, D.S. intentionally caused injury to S.S. *See also Roes v. State*, 236 Md. App. 569, 590 (2018) (the factfinder “can accept all, some, or none of the testimony of a particular witness.” (citation omitted)).

[D.S.] acted recklessly.” *Hall v. State*, 448 Md. 318, 329 (2016) (quoting *Jones v. State*, 357 Md. 408, 427 (2000)). D.S. asserts that the evidence was insufficient to sustain a finding of involvement in reckless endangerment, asserting the same argument that she did with respect to second-degree child abuse and second-degree assault; that is, that the judge’s factual findings were based on speculation and conjecture. We reject that argument for the same reasons stated above.

D.S. further contends that the evidence was insufficient to find that her conduct created a substantial risk of death or serious physical injury to S.S. because the court made a finding that there was insufficient evidence that D.S.’s conduct caused death or serious physical injury to S.S., and therefore found her not involved in the more serious charges of manslaughter and first-degree child abuse. We disagree. We concur with the State’s assertion that a rational trier of fact “could reasonably determine that hitting a four-month-old infant in the head[,] with sufficient force” to cause bruising and extensive bleeding into the soft tissue of the infant’s head, created a substantial risk of serious physical injury, regardless of whether serious physical injury resulted. *See Jones*, 357 Md. at 426 (“It is the reckless conduct and not the harm caused by the conduct, if any, which the [reckless endangerment] statute was intended to criminalize.”) (quoting *Minor v. State*, 326 Md. 436, 441 (1992)).

#### **IV. Neglect of a Minor**

To prove neglect of a minor, the State was required to prove that D.S. intentionally failed to provide necessary assistance and resources for the physical needs or mental health of S.S., and that such failure created a substantial risk of harm to S.S.’s health. Crim. Law

§ 3-602.1(a)(5)(i). “It is not conjecture about potential harm [ ] that governs, but rather whether the conduct at issue, evaluated objectively, created a substantial risk of harm.” *Hall*, 448 Md. at 328. “The standard to be utilized [ ] is whether the parent intentionally failed to provide necessary assistance and resources for the physical needs of the child by acting in a manner that created a substantial risk of harm to the child, measured by that which a reasonable person would have done in the circumstances.” *Id.* at 331. “[T]his standard means that we consider what [the defendant] could be reasonably expected to foresee as possible outcomes” of the defendant’s conduct. *Id.* at 338 (McDonald, J., concurring).

S.S. was born at Peninsula Regional Medical Center on March 10, 2017. Two days later, D.S. and S.S. were discharged from the hospital with the following notation in the discharge summary: “[h]ome monitor arranged given [history] of SIDS death, adolescent mother, and concerns of possible maternal [history] of abnormal heart rhythm.” The medical records do not include any other information on why the monitor was necessary or how it was to be used, other than to use the monitor “as directed by company.”

According to Ms. Parker, S.S. was supposed to be on the heart monitor when she was sleeping. Ms. Parker explained that S.S. was “sometimes” hooked up to the monitor, but her “bigger concern” was that, when the alarm on the monitor went off, D.S. would reset it without first letting Ms. Parker read the display.

D.S. took S.S. to the emergency room on March 23, 2017, when S.S. was thirteen days old, because the monitor had been “steadily alerting for 20 minutes.” The records indicate that S.S. was hooked up to the hospital’s cardiac monitor, and “maintained pulse

>150 on assessment, while home monitor continued to alarm.” The diagnosis was “[m]alfunction of device.” S.S. was discharged from the emergency room approximately two hours after she arrived, with instructions to “follow up with the home monitor company in the morning.”

Amber Smith described the monitor as a “precautionary measure.” She responded affirmatively when she was asked, “was [S.S.] hooked up to the heart monitor?” and she stated that she sometimes heard the monitor go off. She explained that when the monitor went off, D.S. was supposed to “check the baby [and] check the leads” to make sure that everything was hooked up correctly. Amber did not state that D.S. failed to respond appropriately when the heart monitor alarm sounded or that she had any other concerns about D.S.’s use of the monitor.

Mariah Smith testified that on one occasion, D.S. told her that the heart monitor was beeping because it was broken, but that she had not mentioned the broken monitor to the doctor. Mariah did not mention any other concerns about D.S.’s use of the monitor.

The court found D.S. involved in neglect of a minor, stating as follows:

[T]here was testimony both from Amber Smith, Mariah Smith and Ms. Parker as to [D.S.’s] attentiveness as it relates to the heart monitor. She had a child obviously prior that passed away. She had another child now who had a heart condition. The testimony . . . was that [S.S.] was supposed to be on the heart monitor when she was sleeping. The testimony was that that was neglected to be done. Further, that there were times that it was going off and that [D.S.] ignored it or failed to take it seriously, and the Court finds that as it relates to count eight I find her involved as it relates to her intentional failure to monitor that and provide the necessary assistance in making sure that that was taken care of as it relates to her daughter’s needs.

D.S. contends that the juvenile court’s finding that S.S. neglected to use the heart monitor is clearly erroneous and was unsupported by the evidence. D.S. further contends that “the State provided no evidence regarding what D.S. was supposed to do with [information from the monitor] other than to make sure S.S. was breathing” and that “there was no evidence of a duty of care that D.S. neglected or failed to meet.” The State asserts that the evidence was sufficient to support the finding that D.S. “intentionally failed to properly attend to the heart monitor.” We agree with D.S.

The State presented no evidence of how the monitor was to be used, other than the general understanding that it was to be used when S.S. was sleeping. At most, the evidence suggested that S.S. was “sometimes” not hooked up to the monitor, and that, on one occasion, the monitor was apparently broken and needed to be checked.<sup>7</sup>

Even if there had been sufficient evidence of how the monitor was supposed to be used, there was insufficient evidence of why it was necessary or what risk(s) reasonably could be foreseen without proper use. Although the discharge summary mentions a concern about the history of a sibling who died of SIDS, D.S.’s age, and D.S.’s “possible” history of abnormal heart rhythm, there was no evidence of the nature or degree of risk that these factors presented to S.S. Nor was there evidence of how the monitor would minimize or eliminate such risk.

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<sup>7</sup> We disagree with the State’s unsupported assertion that the fact that D.S. reset the monitor before Ms. Parker had a chance to see it “support[s] an inference that D.S. was resetting the device without addressing the issues indicated by the device.”

In our view, to find D.S. involved in child neglect on the record before us would require improper “conjecture about potential harm.” We conclude that the evidence was insufficient to establish, beyond a reasonable doubt, that D.S.’s use of the monitor, evaluated objectively, amounted to an intentional failure to provide necessary assistance or resources to S.S., and that such failure created a substantial risk of harm.

**FINDING OF INVOLVEMENT IN  
NEGLECT OF A MINOR (COUNT 8)  
REVERSED, JUDGMENTS OTHERWISE  
AFFIRMED. COSTS TO BE PAID 3/4 BY  
APPELLANT AND 1/4 BY WICOMICO  
COUNTY.**