	*	IN THE
	*	SUPREME COURT OF
IN RE: B.CD. & B.CB.	*	MARYLAND
	*	September Term, 2025
	*	No. SCM-REG-0047-2025

* * * * * * * * * * * * *

CONSENT MOTION TO FILE *AMICUS* BRIEF IN SUPPORT OF APPELLANT

NOW COMES proposed *amici curiae* Physicians for Reproductive Health ("PRH"), Doing Right By Birth ("DRBB"), and three medical providers who join the legal position in support of Appellant, by and through their undersigned counsel, and in accordance with Maryland Rule 8-511, hereby move for leave to file the *amicus* brief appended to this motion as Exhibit A. Each party has consented to the filing of amicus brief in this appeal.

Respectfully submitted,

/s/ Melinda Johnson

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CERTIFICATE OF SERVICE

I hereby certify that, pursuant to Rule 20-201(g), on January 12, 2026, the foregoing document was electronically filed via MDEC File and Serve and that two copies will be served by first-class mail on the next business day, on:

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IN RE: B.CD. & B.CB.	*	MARYLAND
	*	September Term, 2025
	*	No. SCM-REG-0047-2025

* * * * * * * * * * * * *

[PROPOSED] ORDER

Upon consideration of the "Consent Motion to File *Amicus* Brief in Support of Appellant" filed by Physicians for Reproductive Health, Doing Right by Birth, and three medical providers (the "*Amici*") in the above-captioned case on January 12, 2026, in which amicus curiae advises that each party has consented to the filing of amicus briefs in the case, and having noted that no opposition has been filed, it is this ___ day of _____ 2026,

ORDERED, by the Supreme Court of Maryland, that the *Amici*'s Consent Motion to File Amicus Brief in Support of Appellant is GRANTED, and the *Amici*'s proposed amicus curiae brief, filed with their motion, is accepted; and it is further

ORDERED, that upon receipt of this Order, *Amici* shall file 8 paper copies of their brief as required by Maryland Rule 8-502(c).

/s/_____
Justice

EXHIBIT A

In The

Supreme Court of Maryland

No. 47

September Term, 2025

SCM-REG-047-2025

IN RE: B.CD & B.CB.

On Writ of Certiorari to the Appellate Court of Maryland

BRIEF OF AMICI CURIAE PHYSICIANS FOR REPRODUCTIVE HEALTH, DOING RIGHT BY BIRTH, AND THREE MEDICAL PROVIDERS

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STATEMENT OF INTEREST[1]

Physicians for Reproductive Health ("PRH") is a physician-led nonprofit seeking to ensure meaningful access to comprehensive reproductive care. PRH's network includes over 550 physicians from all fifty states, the District of Columbia, and Puerto Rico. PRH has unique insight into the challenges that patients and providers, especially those in communities disproportionately impacted by health disparities, face when patients are prevented from accessing necessary care or utilizing health resources, such as safe haven laws.

Doing Right By Birth ("DRBB") is a physician-led nonprofit seeking to re-center the care of pregnant people, their children, families, and communities on science, compassion, and human rights. DRBB seeks to shift focus to parent, infant, and dyadic well-being and away from substance exposure, as well as support for early childhood development.

Dr. Carolyn Sufrin, MD, PhD, is a physician and researcher at Johns Hopkins School of Medicine, where she is an associate professor. Dr. Sufrin has conducted research on and has clinical experience in management of pregnant and parenting individuals with opioid use disorder, especially those who are incarcerated.

Dr. Jessica Ratner is a board-certified internist, pediatrician, and addiction medicine specialist and an Assistant Professor at Johns Hopkins School of Medicine. She provides

[1] No counsel for a party authored this brief in whole or in part, and no entity or person, other than amicus curiae, or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

primary and addiction specialty care for and works on public health efforts to improve systems of care that serve pregnant and parenting people with substance use disorders and their children.

Dr. Katrina Mark, is a physician and clinical researcher at the University of Maryland School of Medicine. Dr. Mark holds dual Board Certifications in Obstetrics and Gynecology and Addiction Medicine and is the Director of the Substance Use in Pregnancy practice at the University of Maryland, where she cares for pregnant and parenting people with opioid use disorder.

SUMMARY OF THE ARGUMENT

In the midst of an ongoing maternal health crisis in the United States, in the early 2000s Maryland adopted a safe haven law with the goal of providing a safe resource for postpartum persons to surrender their unharmed newborn(s) without fear of penalty (the "Safe Haven Law" or the "Law"). In fact, lawmakers expressly stated that the Law was designed to shield persons "who are in such desperate situations" from penalty, reasoning that punishing postpartum persons in crisis could cause "a grave injustice."[2] Despite the clear intent of the Law, the interpretation urged by Respondent would penalize postpartum persons for availing themselves of the Law, thereby frustrating its purpose and further exacerbating the maternal health crisis.

[2] Sarah Koenig, *Infant Havens Statute is Eyed; Bills Would Shield People Who Abandon Babies at 'Safe' Spots; 'To Prevent Tragedies,'* The Baltimore Sun, Feb. 16, 2001 (quoting Montgomery County delegate Sharon M. Grosfeld, a Safe Haven bill sponsor).

On August 8, 2025, the Appellate Court of Maryland affirmed the Circuit Court of Anne Arundel County's decision that postpartum persons who safely surrender a newborn under the Law can be punished by a neglect finding under Maryland's Children in Need of Assistance ("CINA") framework. The decision is contrary to the spirit of the Law and ignores severe collateral legal and health consequences that stem from a CINA neglect finding. When considered in the context of an ongoing maternal health crisis (particularly with respect to Black, Hispanic, and Indigenous parents), this interpretation of the Law would punish Maryland's most at-risk patients, including those suffering from postpartum stressors such as postpartum depression ("PPD"), other anxiety disorders, and systemic barriers to accessing care and postpartum resources. The lower courts' decisions (the "Lower Courts' Decisions")[3] threaten to discourage postpartum persons from availing themselves of the Law—potentially leading to tragic outcomes for parents and their newborns—and should be reversed.

ARGUMENT

Birthing persons in Maryland and across the United States are in crisis. Despite continuing medical advancements and increased attention to perinatal care, persons giving birth continue to face serious health complications, or even death, throughout all stages of pregnancy, including during the postpartum period. The frequency of grave outcomes associated with pregnancy-related health complications is collectively known as the

[3] *See In re B.CD.*, 267 Md. App. 61 (2025), *cert. granted*, No. 309, 2025 Sept. Term, 2025 WL 3522895 (Md. Nov. 24, 2025); *In the Matter of [Party Name Redacted]*; Case No.: C-02-JV-24-000463 (Md. Cir. Ct. Jan. 14, 2025); *In the Matter of [Party Name Redacted]*; Case No.: C-02-JV-24-000464 (Md. Cir. Ct. Jan. 14, 2025).

maternal health crisis, and the United States is considered to have the most serious maternal health crisis of developed countries.[4] Barriers to care contributing to the maternal health crisis include maternity care deserts, inadequate insurance coverage, systemic racism, and a lack of non-punitive perinatal resources.

In this context—and in a post-*Dobbs*[5] world where reproductive freedom is under attack—safe haven laws provide a critical resource for postpartum persons who may be unable to parent due to severe peripartum or postpartum health conditions. Simply put, in an environment with very little support and resources protecting postpartum health, a postpartum person can turn to safe haven laws at a time of crisis. Penalizing postpartum persons for doing so poses grave risks to postpartum persons and their newborns.

I. THE MARYLAND SAFE HAVEN LAW

The Maryland Safe Haven Law expressly protects those utilizing its protections from penalty by "***[p]roviding immunity from civil liability and criminal prosecution*** for a [postpartum parent] who leaves an unharmed newborn with a responsible adult person…."[6] Specifically, the Law allows a postpartum person to safely surrender their newborn to

[4] Munira Z. Gunja, et al., *The U.S. Maternal Mortality Crisis Continues to Worsen: An International Comparison*, Commonwealth Fund Blog (Dec. 1, 2022), https://www.commonwealthfund.org/blog/2022/us-maternal-mortality-crisis-continues-worsen-international-comparison.

[5] Since the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*, 597 U.S. 215 (2022) eliminated the constitutional right to an abortion, many states have restricted or eliminated access to abortion care. In some of those states, politicians and courts have pointed to safe haven statutes as a substitute for abortion rights. *See* Alana Semuels, *Why Baby Boxes Are Suddenly Everywhere*, TIME (Oct. 8, 2025), https://time.com/7299476/baby-box-infant-abandonment/.

[6] Md. Code Regs. 07.02.27.01(A)(1) (2018) (emphasis added).

designated facilities, such as hospitals, licensed medical providers, police departments, state police barracks, and insured fire companies, without threat of legal ramifications.[7] Once the newborn is safely surrendered, the Law directs the facility to notify the local social services department so that a government agency can assume custody of the newborn.[8] However, according to the Lower Courts' Decisions, the Law requires the local social services department to first file a CINA petition, which requires one of four findings: abuse by the parent/guardian, neglect by the parent/guardian, developmental disability of the newborn, or mental disorder of the newborn.[9] Where, as here, there is no evidence of abuse, developmental disability, or mental disorder, the local department, by default, requests a CINA finding based on neglect, even where there are also no allegations of neglect (other than that the postpartum person availed themselves of the Law).[10] Thus, the mere fact that a postpartum person safely surrendered their newborn, in a manner consistent with the Safe Haven Law, can lead to a CINA neglect finding.[11]

A CINA neglect finding poses numerous problems. ***First***, it is directly contrary to the immunity promised by the Law. A CINA neglect finding by definition is punitive: it is a formal determination by the court that a legal caretaker has neglected a child in their care and is therefore unable to provide proper care to their child's needs, carrying the risk of attendant penalties.[12] ***Second***, and particularly relevant given the ongoing maternal

[7] Md. Code Regs. 07.02.27.01(A)(4) (2018).
[8] Md. Code Ann., Cts. & Jud. Proc. § 5-64(c)(2) (2024).
[9] *In re B.CD.*, 267 Md. App. at 76.
[10] *Id.* at 88-91.
[11] *Id.*
[12] Md. Code Ann., Cts. & Jud. Proc. § 3-801 (2024).

health crisis, a CINA neglect finding exacerbates existing inequities and negative health consequences for both the birthing person and their newborn.

II. IMPOSING CIVIL PENALTIES ON PARENTS WHO ACCESS SAFE HAVEN LAWS WILL EXACERBATE THE MATERNAL HEALTH CRISIS

The United States is in the midst of a maternal health crisis illustrated by its high rates of maternal mortality and morbidity.[13] There are an estimated 19 deaths per 100,000 live births in the United States,[14] though research shows that up to 80% of pregnancy-related deaths are preventable.[15] This is in stark contrast to other developed countries such as France, Japan, and Sweden that only have 7.6, 3.4, and 2.6 deaths per 100,000 live births

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[13] Marge Koblinsky et al., *Maternal Morbidity and Disability and Their Consequences: Neglected Agenda in Maternal Health*, 30(2) J. Health Popular Nutrition 124, 124-30 (Jun. 2012), https://pmc.ncbi.nlm.nih.gov/articles/PMC3397324/pdf/jhpn0030-0124.pdf. Maternal mortality, which measures pregnancy-related deaths, is "a sentinel event used globally to monitor maternal health, the general quality of reproductive health care, and the progress countries have made toward international development goals." Stacie E. Geller, et al., *A Global View of Severe Maternal Morbidity: Moving Beyond Maternal Mortality*, 15 Reproductive Health 98, PDF p. 32 (June 22, 2018) https://pmc.ncbi.nlm.nih.gov/articles/PMC6019990/pdf/12978_2018_Article_527.pdf. Maternal morbidity is the onset unexpected health conditions attributed to or complicating pregnancy and childbirth that have a negative impact on one's well-being. *Maternal Morbidity and Mortality*, Nat'l Inst. of Child Health & Human Dev, https://www.nichd.nih.gov/health/topics/maternal-morbidity-mortality (last visited December 16, 2025).

[14] Mike Stobbe, *US maternal death rate rose slightly last year, health officials say*, Associated Press, (Apr. 30, 2025), https://apnews.com/article/us-maternal-deaths-2024-statistics-12091a25830162cfa005cb5c801a1c1b.

[15] Anna Gibbs, *U.S. pregnancy-related deaths continuing to rise*, The Harv. Gazette, (Apr. 23, 2025), https://news.harvard.edu/gazette/story/2025/04/u-s-pregnancy-related-deaths-continuing-to-rise/

respectively.[16] Moreover, the risk of maternal mortality among Black birthing persons (including those in Maryland) is three to four times higher than that of White birthing persons, reflecting one of the largest racial disparities in maternal health.[17] As with maternal mortalities, there is a racial disparity in maternal morbidity: Black birthing persons are more than twice as likely as White birthing persons to endure severe maternal morbidity.[18]

Extensive research has shown that the maternal health crisis in the United States is a direct result of inadequate investment in maternal and postpartum health and systemic racism and inequity in maternal and postpartum healthcare.[19] And while maternal mortality and morbidities encompass all facets of the reproductive experience, the postpartum period

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[16] Gunja et al., *supra* note 4.

[17] Kristi Mitchell et al., *Reducing Maternal Mortality Among Women of Color*, Avalere Health (Jan. 5, 2021), https://avalere.com/insights/reducing-maternal-mortality-among-women-of-color; Shalina Chatlani, *Focusing on maternity and postpartum care for Black mothers leads to better outcomes*, Am. Psych. Assoc. (May 6, 2024), https://www.apa.org/monitor/2022/10/better-care-black-mothers; *Black Maternal Health in Maryland* 2, Network for Pub. Health L., (March 2023), https://www.networkforphl.org/wp-content/uploads/2023/05/Black-Maternal-Health-in-Maryland.pdf ("In 2018, Black mothers in Maryland passed away due to childbirth related complications at a rate of 44.6 deaths per 100,000—3.7 times higher than White mothers.").

[18] Eugene Declercq & Laurie C. Zephyrin, *Severe Maternal Morbidity in the United States: A Primer*, Commonwealth Fund (Oct. 28, 2021), https://www.commonwealthfund.org/publications/issue-briefs/2021/oct/severe-maternal-morbidity-united-states-primer#:~:text=A%20study%20of%20Massachusetts%20women,and%20one%20year%20after%20birth.

[19] Gray Babbs, et al., *Expanding Postpartum Medicaid Benefits To Combat Maternal Mortality And Morbidity*, Health Affs. (Jan. 14, 2021), https://www.healthaffairs.org/content/forefront/expanding-postpartum-medicaid-benefits-combat-maternal-mortality-and-morbidity.

often receives less attention from healthcare professionals. Indeed, many postpartum morbidities, such as PPD and other mood and anxiety disorders, may not even be included in the severe maternal morbidity statistics.[20] Barriers to accessing healthcare in the postpartum period—including maternity care deserts, lack of adequate insurance coverage, systemic racism, and lack of non-punitive resources—further contribute to the maternal health crisis by leaving serious health conditions untreated.

Medical professionals, including *amici*, agree that a nationwide failure to invest in the health of people who are pregnant and parenting contributes to the high rates of maternal morbidity and mortality in the United States. Moreover, structural racism in maternal health further exacerbates these morbidities and mortalities by fostering distrust in the current medical infrastructure. By penalizing postpartum persons for availing themselves of one of the few available lifelines, medical distrust will continue to grow and postpartum persons will be discouraged from availing themselves of safe haven laws.[21]

A. The Postpartum Period and the Maternal Health Crisis

The postpartum period, which is often described as the "fourth trimester," refers to the period of time "when infants are adjusting to life outside the womb and [parents] are adjusting to new parenthood."[22] While it is joyous time for many, it is "also a very

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[20] Declercq & Zephyrin, *supra* note 18.
[21] Babbs et al., *supra* note 19.
[22] Sarah B. Verbiest et al., *Promoting Maternal and Infant Health in the 4th Trimester* at 34, Zero to Three (Mar. 2017), https://www.mombaby.org/wp-content/uploads/2017/10/ZERO-TO-THREE-Journal.pdf; Pamela Berens, *Overview of the Postpartum Period: Normal Physiology and Routine Maternal Care*, Wolter Kluwer (2023), https://www.uptodate.com/contents/overview-of-the-postpartum-period-normal-physiology-and-routine-maternal-care.

vulnerable time [as postpartum persons] experience substantial physiological, social, and emotional changes."[23] In fact, "[m]ultiple issues intersect during this critical time: maternal mood and emotional well-being; infant care and feeding; sexuality, contraception, and birth spacing; sleep and fatigue; physical recovery from childbirth; and medications, substances, and exposures."[24]

Additionally, the postpartum period is linked to an increased onset of mood and anxiety disorders, like PPD, which are a significant cause of maternal morbidity.[25] PPD is a serious and widespread mental health condition affecting about 1 in 8 postpartum parents.[26] Common symptoms of PPD include "classical depression, including mood fluctuations, bouts of crying, lack of interest in the child, and even thoughts of suicide."[27] While PPD manifests differently for each person, PPD can be harmful to the

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[23] Ilona T. Goldfarb, *The fourth trimester: What you should know*, Harv. Med. Sch. (Apr. 6, 2021), https://www.health.harvard.edu/blog/the-fourth-trimester-what-you-should-know-2019071617314.

[24] Verbiest et al., *supra* note 22 at 34.

[25] Catherine Atuhaire et al., *Prevalence of Postpartum Depression and Associated Factors Among Women in Mbarara and Rwampara Districts of South-Western Uganda*, 21 BMC Pregnancy and Childbirth 503 (Jul. 12, 2021), https://link.springer.com/article/10.1186/s12884-021-03967-3.

[26] *See* PostpartumDepression.org, *What Is Postpartum Depression?*, https://www.postpartumdepression.org/postpartum-depression/ (last visited August 20, 2025); PostpartumDepression.org, *Statistics on Postpartum Depression*, https://www.postpartumdepression.org/resources/statistics/ (last visited August 26, 2025) ("PPD Statistics"); Usha Ranji et al., *Expanding Postpartum Medicaid Coverage*, Kaiser Fam. Found. ("KFF") (Mar. 9, 2021), https://www.kff.org/womens-health-policy/expanding-postpartum-medicaid-coverage/#1fa4d315-f21b-4acd-b512-96cd15e0e0c8.

[27] Iris Agrawal et al., *Risk Factors of Postpartum Depression*, 14(10) Cureus e30898 (Oct. 2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC9711915/pdf/cureus-0014-00000030898.pdf ("Cureus").

maternal/infant dyad if a postpartum person does not receive any support. Indeed, extreme symptoms of PPD can include isolation, insomnia, self-harm/suicide, thoughts of harming or killing the baby, and infanticide.[28]

Historically, postpartum care, which ranges from "recovery from childbirth, follow-up on pregnancy complications, management of chronic health conditions, access to family planning, and addressing mental health conditions," has been "centered around one clinical visit six to eight weeks after delivery."[29] However, based on the high rates of maternal mortalities and morbidities in the United States post-birth, medical professionals, like *amici*, agree that existing postpartum care is inadequate. Postpartum care should be a comprehensive, ongoing process to address both the postpartum persons' and the infants' interconnecting needs.[30] Consistent with this view, the American College of Obstetricians and Gynecologists ("ACOG") recommends that birthing persons interact with the obstetrician/gynecologist or other obstetric care provider within the first three weeks postpartum, followed up with ongoing care as needed, and concluding with a

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[28] *See* Cleveland Clinic, Postpartum Depression, https://my.clevelandclinic.org/health/diseases/9312-postpartum-depression (last visited August 20, 2025); Cureus, *supra* note at 27.

[29] Ranji et al., *supra* note 26; "[P]ostpartum care is often fragmented among maternal and pediatric healthcare providers… This lack of attention to maternal health needs is of particular concern given that [as much as one third to over one half] of pregnancy-related deaths occur after the birth of the infant." Am. Coll. of Obstetricians and Gynecologists, *ACOG Committee Opinion: Optimizing postpartum care*, 131 J. OBSTETRICS & GYNECOLOGY 853, e141, e141 (2018), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum ("*ACOG Committee Opinion*"); Dana Smith, *Postpartum Health is in Crisis*, Harv. Sch. of Pub. Health (Jun. 22, 2022), https://hsph.harvard.edu/news/postpartum-health-is-in-crisis/.

[30] Ranji et al., *supra* note 26; Smith, *supra* note 29.

comprehensive postpartum visit no later than 12 weeks after birth.[31] Furthermore, ACOG recommends that women with chronic medical conditions (e.g., hypertensive disorders, obesity, diabetes, thyroid disorders, renal disease, and mood disorders) be counseled regarding the importance of timely follow-up with their obstetrician/gynecologists or primary care providers for ongoing coordination of care.[32] In addition, community centered approaches to postpartum care are needed to ensure that postpartum persons who are at the greatest risk (often due to factors beyond their control, such as access to affordable care), receive high quality culturally and linguistically effective care.[33]

Such comprehensive care "is essential for the prevention and detection of potentially fatal pregnancy-related complications," which is particularly high for birthing persons from historically underserved populations.[34] But comprehensive postnatal care is not the reality for many.[35] And without access to resources treating postpartum health conditions, or at the very least access to resources providing support to the postpartum

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[31] *ACOG Committee Opinion*, *supra* note 29 at e141.
[32] *Id.*
[33] Laura M. Segovia et al., *Prenatal and Postpartum Care Experiences Among Black Birthing People in the United States: An Integrative Review*, 70 J. Midwifery Women's Health 235 (2024), https://onlinelibrary.wiley.com/doi/10.1111/jmwh.13705.
[34] Arianna M. Rappy, *The Maternal Healthcare Crisis: Expanding The Scope Of Postpartum Care And Minimizing The Racial And Ethnic Gap*, 43 Women's Rights L. Rep. 243, 244 (2022).
[35] Patient Centered Outcomes Res. Inst., *Postpartum Care for Women up to One Year After Birth (A Systematic Review)* (June 2023), https://www.pcori.org/research-results/2021/postpartum-care-women-one-year-after-birth-systematic-review#Review-Report ("Despite the increased risk of postpartum mortality and morbidity, a surprisingly large number of women (40 percent to 50 percent) . . . do not receive routine care after birth from a medical provider.").

persons suffering from any health condition (both preexisting and postpartum), both parents and their newborns are at risk of worse health outcomes.

B. Postpartum Persons Face Many Barriers to Care that Further Exacerbate the Maternal Health Crisis

Birthing persons face myriad restrictions to accessing postpartum care. Maternity care deserts, lack of adequate insurance coverage, structural and systemic racism, and, in light of the Lower Courts' Decisions, a dearth of non-punitive resources individually and jointly delay, restrict, and worsen available health care. Without adequate postpartum support, postpartum persons will continue to experience worse overall health outcomes, such as severe medical and mental disorders, or even death.[36]

Maternity Care Deserts and Medically Underserved Areas. There are more than 2.3 million birthing persons of childbearing age living in areas known as maternity care deserts,[37] which are typically defined as counties with no maternity care—no hospital(s) offering obstetric care, no birth center, and no obstetric provider.[38] Startlingly, 35% of all counties in the United States are maternity care deserts and "[t]wo in three maternity care

[36] Babbs et al., *supra* note 19; Danielle J. Brown, *Maryland's Gains in Maternal Mental Health Stall As Other States, Nation Advance, Report Finds*, Maryland Matters (May 19, 2025), https://marylandmatters.org/2025/05/19/marylands-gains-in-maternal-mental-health-stall-as-other-states-nation-advance-report-finds/.

[37] March of Dimes, *Nowhere To Go: Maternity Care Deserts Across The U.S.* 3 (2024), https://www.marchofdimes.org/peristats/assets/s3/reports/2024-Maternity-Care-Report.pdf ("March of Dimes").

[38] *Id.*

deserts are rural counties," which disproportionately impacts historically underserved populations.[39] Indeed, one in six Black newborns are born in rural maternity care deserts.[40]

An additional 4.8 million birthing persons of childbearing age live in "low access" counties, which have fewer than two hospitals and/or birthing centers offering obstetric care, and fewer than 60 obstetric providers. [41] Birthing persons living in maternity care deserts and counties travel 2.6 times longer to receive obstetric care, receive less perinatal care, have worse health prior to pregnancy, and experience higher rates of preterm birth.[42] For example, people living in maternity care deserts and in counties with low access to prenatal care respectively face a 14% and 12% risk of receiving inadequate or no prenatal care.[43] More and more Americans face this situation as the number of maternity care deserts has grown. This growth is partially due to the closure of more than 400 maternity healthcare centers between 2006 and 2020, which left nearly six million birthing persons with limited to no access to maternal care.[44]

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[39] Eli Y. Adashi et al., *Maternity Care Deserts: Key Drivers of the National Maternal Health Crisis*, J. Am. Bd. Fam. Med. (Jan. 2025), https://www.jabfm.org/content/38/1/165; March of Dimes, *supra* note 37.

[40] Johns Hopkins Univ. Nursing, *Confronting the Issue of Maternity Care Deserts* (Aug. 28, 2023), http://nursing.jhu.edu/magazine/articles/2023/08/confronting-the-issue-of-maternity-care-deserts/; Eli Y. Adashi et al., *supra* note 37.

[41] March of Dimes, *supra* note 37.

[42] *Id.* at 29.

[43] *Id*. at 11.

[44] Innovation Dist. Childs. Int'l, *Evidence Review: Maternal Mental Conditions Drive Climbing Death Rate in U.S.* (Feb. 21, 2024), https://innovationdistrict.childrensnational.org/maternal-mental-conditions-drive-climbing-death-rate-in-u-s/; Rolonda Donelson et al., *Republican's New Health Care Law Will Impact Over 130 Rural Labor and Delivery Units*, Nat'l P'ship for Women & Fams. (June 2025), https://nationalpartnership.org/report/republican-budget-bill-could-close-over-140-rural-labor-and-delivery-units/.

While the state of Maryland has less counties defined as maternity care deserts compared to the United States overall,[45] a Maryland funded Primary Care Needs Assessment found that the state had 42 medically underserved areas, encompassing around 17% of the entire state population.[46] And despite being the second most populous county in the state, Prince George's County has three medically underserved areas.[47] In addition, Prince George's County faces a shortage of licensed obstetric beds, lack of financial resources, and low obstetrician-to-patient ratios.[48] Consequently, an estimated eight out of ten expecting persons leave Prince George's for delivery.[49] Unsurprisingly, given the number of medically underserved areas, the county's infant mortality rate is 7.5 per 1,000 live births, which is higher than the national average.[50]

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[45] March of Dimes, *Where You Live Matters: Maternity Care in Maryland*, https://www.marchofdimes.org/peristats/assets/s3/reports/mcd/Maternity-Care-Report-Maryland.pdf (last visited Jan. 6, 2026) (only "4.2 percent of [Maryland] counties are defined as maternity care deserts").

[46] Adam T. Eskinder et al., *Examining Contributors To Black Maternal Health Experiences In Prince George's County, Maryland* 25 (2025) (M.P.H. thesis, University of Maryland), https://drum.lib.umd.edu/items/77328309-0607-4e0c-8ea3-8377f9478237. A medically underserved area ("MUA") and medically underserved populations ("MUP") are "federally designated locations or population groups that have a shortage of primary care resources. MUAs/MUPs are designated based on four criteria: infant mortality rate, percent of the population living in poverty, percent of the population over the age of 65, and the population to primary care provider ratios." The MUA designation applies to a distinct geographic area, while the MUP designation applies to specific population groups. Maryland Dep't of Health, *2021 Primary Care Needs Assessment* 12 (Sept. 2, 2021), https://health.maryland.gov/pophealth/Documents/Primary%20care/Final%20Needs%20Assessment%20090221.pdf.

[47] Eskinder et al., *supra* note 46.

[48] *Id*.

[49] *Id.*

[50] PGC Health Zone, *Infant Mortality Rate*, https://www.pgchealthzone.org/indicators/index/view?indicatorId=289&localeId=1260 (last visited Jan. 11, 2026).

The consequences of maternity care deserts (or limited access to maternity care) are chilling, especially for postpartum persons suffering from severe mental health conditions without proper access to treatment and support.

Lack of Insurance. Healthcare coverage is critical for all persons, but especially for birthing persons "well before they become pregnant and well after childbirth."[51] ACOG recommends birthing persons have consistent healthcare in order to "increase preventive care, reduce avoidable adverse obstetric and gynecologic health outcomes, increase early diagnosis of disease and reduce maternal mortality rates."[52] However, a large percentage of the population cannot afford consistent healthcare,[53] and thus, rely on government programs, such as Medicaid, to provide healthcare expenses to low-income persons.[54] Today, Medicaid covers more than 40% of all births nationally and 64% of deliveries by Black birthing persons.[55]

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[51] Adam Searing & Donna Cohen Ross, *Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Mothers and Babies* 1, Geo. Univ. Health Pol'y Inst. (May 2019), https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf.

[52] *Id.*

[53] Many individuals do not qualify for Medicaid, but still cannot afford private insurance, creating a coverage gap. *See* Rappy, *supra* note 34 at 250. While the middle class often has better rates of good health insurance, they are also less likely to qualify for financial assistance and debt relief. *See* Tami Luhby, Medical Debt Hits the Middle Class Hardest, CNN (Aug. 21, 2023), https://www.cnn.com/2023/08/21/politics/medical-debt-middle-class/index.html.

[54] KFF, *Medicaid State Fact Sheets*, https://www.kff.org/interactive/medicaid-state-fact-sheets/ (last visited December 17, 2025).

[55] Annaliese Johnson et al., *Medicaid Cuts Threaten Pregnancy And Postpartum Coverage, Access to Care, and Health*, Health Affs. (Oct. 20, 2025), https://www.healthaffairs.org/content/forefront/medicaid-cuts-threaten-pregnancy-and-postpartum-coverage-access-care-and-health.

Despite heavy reliance on Medicaid by persons giving birth, Medicaid coverage is limited in scope, and historically, it has not provided sufficient resources or options to effectively combat the maternal health crisis.[56] Indeed, research shows that Medicaid expansion is particularly critical to provide comprehensive care and decrease the number of preventable fatal health outcomes during the postpartum period, ultimately shrinking the racial disparities in maternal and infant health.[57]

In states like Maryland, which have expanded Medicaid coverage for birthing persons,[58] there is still a care deficit because Medicaid does not cover all necessary services for parents and their children. For example, in a recent "report card" on Maryland's maternal mental health, Maryland received a "C" in part because Maryland's Medicaid health plan does not require screenings and data collection for mental health concerns, such as prenatal depression and postpartum depression.[59] Such screening can "really improve[] the likelihood for recovery of the mother . . . [and] supports healthy childhood development."[60] But even if Maryland's Medicaid health plan did require these screenings,

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[56] Ranji et al., *supra* note 26.
[57] Searing & Ross, *supra* note 51; Maria W. Steenland & Laura R. Wherry, *Medicaid Expansion Led* to *Reductions in Postpartum Hospitalizations*, 42 Health Affs. 18, 24 (Jan. 2023), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2022.00819 ("This study provides the first evidence of a decrease in postpartum hospitalizations associated with expanded Medicaid.").
[58] Maryland Dep't of Health, *Maryland Department of Health Announces Expanded Medicaid Coverage for New Mothers* (Mar. 30. 2022), https://health.maryland.gov/newsroom/Pages/Maryland-Department-of-Health-announces-expanded-Medicaid-coverage-for-new-mothers.aspx (The Maryland Department of Health allows Medicaid-eligible pregnant birthing persons full Medicaid benefits for the duration of their pregnancy and the 12-month postpartum period.).
[59] Brown, *supra* note 36.
[60] *Id*.

the screening are only "effective at *detecting* postpartum depression," which is "not the same as *treating* maternal depression."[61] Moreover, even with expanded Medicaid coverage for postpartum care, postpartum persons still may not be able to access appropriate postpartum care because of other barriers to healthcare access not addressed by Medicaid, such as lack of transportation, childcare availability, or language proficiency.[62]

Structural Healthcare Inequities. While maternity care deserts and lack of access to adequate health insurance play a role in the high rates of maternal mortality and morbidity in historically underserved groups in the United States, they do not paint the full picture. "Racial disparities in maternal health and medical care are deeply entrenched in our nation's history, dating back centuries to the legalized sexual exploitation [experimentation, and sterilization] of enslaved Black women."[63]

Indeed, it is structural racism, rather than poverty and access to care, that is the strongest predictor of maternal mortality and morbidity.[64] For example, high income Black birthing persons have the same maternal mortality rates as the poorest White birthing persons in the United States.[65] And in Maryland, according to a 2019 Prince George's

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[61] Babbs et al., *supra* note 19 (emphasis added).
[62] Sarah C. Haight et al., *Racial and Ethnic Inequities In Postpartum Depressive Symptoms, Diagnosis, and Care In 7 US Jurisdictions*, 43(4) Health Affs. 486, 492 (Apr. 2024).
[63] Rappy, *supra* note 34 at 248; Jamila K. Taylor, *Structural Racism and Maternal Health Among Black Women,* 48 J. L. Med. & Ethics 506, 507-10 (Fall 2020), https://www.urban.org/sites/default/files/2025-02/TaylorRacismMHJLME.pdf.
[64] Rappy, *supra* note 34 at 248.
[65] *See* Ctr. for Reproductive Rts., *What Is the U.S. Maternal Health Crisis?* (Oct. 9, 2025), https://reproductiverights.org/resources/what-is-the-u-s-maternal-health-crisis/.

County Maternal Infant and Health Report, only 28.6% of Black birthing persons experienced adequate care in comparison to the 36.8% of White birthing persons.[66] Conversely, 22.2% of Black birthing persons in Prince George's County reported that they experienced inadequate care, while only 12.6% of White birthing persons reported the same.[67]

Moreover, in the United States one in six women report one or more types of mistreatment: loss of autonomy, being shouted at, scolded, or threatened, being ignored, refused or received no response to requests for help, while receiving maternity care, but for women of color, it is almost one in four.[68] This disparity is further illustrated by the fact that 22.5% of Black women were likely to report mistreatment by healthcare providers while only 14.1% of White women reported mistreatment.[69] The same study found that Black women are twice as likely as White women to be ignored, refused help, or not assisted timely.[70]

Of particular relevance here, rates of postpartum care for parents of color are notably low. This disproportionate impact is "a direct result of . . . reduced access to quality healthcare, experiences of racism and implicit bias from providers, higher rates of

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[66] Prince George's County Health Dep't, Office of Assessment & Planning, *Maternal and Infant Health Report* 17, 19 (2019), https://www.princegeorgescountymd.gov/sites/default/files/archive-center/2019_maternal_and_infant_health_report.pdf.

[67] *Id.*

[68] Saraswathi Vedam et al., *The Giving Voice to Mothers study: inequity and mistreatment during pregnancy and childbirth in the United States*, 16 Reproductive Health 77 (2019).

[69] *Id*.

[70] *Id*.

traumatic birth experiences, and the chronic stress associated with social and economic inequality."[71] Entrenched racial stress and trauma have lasting effects on medical and mental health, which leads to worse pregnancy results and a perpetual cycle of health inequity.[72] For example, Black, Indigenous, and Hispanic patients are less likely to receive treatment for postpartum mood disorders, ***even after*** diagnosis.[73] This underscores that structural racism resulting from historic inequities is yet another barrier to healthcare access for historically-excluded parents.

Lack of Non-Punitive Resources Regarding Reproductive Health. Finally, the maternal health crisis is further exacerbated by the lack of non-punitive resources available for birthing persons to manage their personal autonomy in reproductive health. Medical professionals like *amici* view the imposition of a CINA finding as an additional barrier to the health of postpartum persons because it decreases the likelihood of a birthing person seeking help—including by availing themselves of the Safe Haven Law—even when suffering from health conditions during the postpartum period. In fact, physicians consistently recommend that new parents experiencing postpartum distress be met with

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[71] *PPD Statistics*, *supra* note 26.

[72] Julie Kashen et al., *It's Time to Prioritize Maternal and Infant Mental Health*, Century Foundation (Dec. 20, 2023), https://tcf.org/content/report/its-time-to-prioritize-maternal-and-infant-mental-health/; Jamila Taylor & Christy M. Gamble, *Suffering in Silence*, Ctr. for Am. Progress (November 17, 2017), https://www.americanprogress.org/article/suffering-in-silence/; *see also* Haight et al., supra note 62 at 493.

[73] *See* Haight, *supra* note 62 at 489-90 (White respondents suffering from PPD received mental health care 67.4% of the time, while Hispanic and Black respondents received care 37.2% and 37.1% of the time, respectively).

compassion and support, and safe haven laws exist, in part, to provide a safe and compassionate resource for parents to surrender their children without judgment. However, the lower courts' interpretation of Maryland's Safe Haven Law as allowing a CINA neglect finding renders it a less effective resource.

III. THE GRAVE CONSEQUENCES THAT FLOW FROM A CINA NEGLECT FINDING

By coupling the Law with a civil penalty (i.e., CINA neglect finding), Maryland disincentivizes parents from using the Law, and therefore exacerbates the maternal health crisis by removing yet another resource from the already-lacking postpartum support infrastructure. The threat of a CINA neglect finding leaves a suffering parent with three (undesirable) choices, all of which have negative health outcomes: (1) surrender their newborn under the Safe Haven Law and face the negative legal and health consequences of a CINA neglect finding; (2) avoid a CINA neglect finding by continuing to care for their newborn, despite feeling unable or unwilling to do so; or (3) avoid a CINA neglect finding by relinquishing the newborn in a manner inconsistent with the Safe Haven Law.

A CINA neglect finding (both in and outside of the Safe Haven Law context) carries long-term legal and public health consequences, which fly in the face of the Law's clear intent to provide immunity.[74] For example, a neglect finding carries the risk of triggering a child protective services ("CPS") investigation. After making a neglect finding, the local department may subsequently extend their investigation to the parent's treatment of any

[74] Md. Code Regs. 07.02.27.01 (2018).

other children in their care.[75] The investigation may also lead to the parent being placed on Maryland's centralized child abuse registry.[76] The heightened surveillance that can stem from availing oneself of the Law may further result in declined physical and mental health, diminished sleep quality and quantity, and higher rates of maternal mortality.[77] Additionally, families who experience family policing investigations suffer from feelings of fear, stress, and powerlessness[78] which can lead to "trauma, anxiety,…depression, and isolation."[79]

Such investigations also leave enduring negative impacts on the family unit. Research shows that "after an investigation, parents limit social networks" and avoid "discussing family needs with educators, doctors and other helping professionals" to

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[75] Md. Code Ann., Family Law ("F.L.") §§ 5-706, 5-714.

[76] F.L. §§ 5-714, 5-706; *Prince George's Cnty. Dep't of Soc. Servs. v. Knight*, 158 Md. App. 130, 142 (2004) (Sonner, J. concurring) (placement on the child abuse registry has "substantial injurious collateral consequence").

[77] Elizabeth Wall-Wieler et al., *Mortality Among Mothers Whose Children Were Taken Into Care by Child Protection Services: A Discordant Sibling Analysis*, 187(6) Am. J. of Epidemiology 1182, 1186 (2018), https://pubmed.ncbi.nlm.nih.gov/29617918/; Elizabeth Wall-Wieler et al., *Maternal Mental Health after Custody Loss and Death of a Child: A Retrospective Cohort Study Using Linkable Administrative Data*, 63(5) The Can. J. of Psychiatry 322, 326 (2018), https://pmc.ncbi.nlm.nih.gov/articles/PMC5912297/pdf/10.1177_0706743717738494.pdf .

[78] Maya Pendleton & Alan J. Dettlaf, *Policing Is Reproductive Oppression: How Policing and Carceral Systems Criminalize Parenting and Maintain Reproductive Oppression*, 13 Soc. Sci. 515 at 10 (2024) https://www.mdpi.com/2076-0760/13/10/515?mc_cid=6bfa2d70d8&mc_eid=bd3a491e04.

[79] Heritage Defense, *How CPS Investigations Harm Children* (Apr. 10, 2025), https://heritagedefense.org/How-CPS-Investigations-Harm-Children.

reduce the risk of future investigations.[80] This type of voluntary social isolation is detrimental to all parties involved.[81] Black families in particular bear the brunt of these investigations. More than half of all Black children will experience an investigation by a child protection agency by age eighteen.[82]

While investigations themselves are traumatic, they also often result in Black children being forcibly separated from their families at nearly double the rate of White children.[83] Children experience long-lasting physical and emotional harm when the state separates them from a parent.[84] Unanticipated location changes negatively affect a child's psychological well-being and can cause complex trauma.[85] Children who experience such complex trauma may suffer from body dysregulation, difficulty managing emotions, dissociation, poor self-regulation and self-concept, cognitive impairment, and other long-term health consequences.[86] The American Association of Pediatrics similarly found in

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[80] Nora McCarthy & Jeremy Kohomban, *Child Welfare Reckons With the Harm of Investigations*, The Imprint (Feb. 3, 2025), https://imprintnews.org/opinion/child-welfare-reckons-with-the-harm-of-investigations/258536.
[81] *Id.*
[82] *Id.*
[83] Pendleton & Dettlaf, *supra* note 78 at 10 (Nearly 70% of children who are separated from their parents and placed into the foster system are taken on grounds of "neglect." "This broad and ambiguous category [neglect] is defined by most states as a failure to provide for basic needs such as food, clothing, and shelter—conditions frequently rooted in poverty, which disproportionately affects Black and Indigenous families.").
[84] *See, e.g.*, Vivek Sankaran et al., *A Cure Worse Than the Disease? The Impact of Removal on Children and Their Families*, Univ. of Mich. L. Sch. Scholarship Repository (July 2019), https://repository.law.umich.edu/articles/2055/.
[85] Vivek Sankaran, Christopher Church, and Monique Mitchell, *A Cure Worse than the Disease? The Impact of Removal on Children and their Families*, 102 Marquette L. Rev. 1161, 1163-1194 (2019).
[86] *Id.*

2018 that a separation from a parent, even for a short period of time, can lead to "irreparable harm, disrupting a child's brain architecture and affecting [their] short- and long-term health. This type of prolonged exposure to serious stress—known as toxic stress—can carry lifelong consequences for children."[87]

Additionally, a CINA neglect finding may result in loss of custody, visitation, or other parental rights as to the postpartum person's *other* children. Courts making custody or visitation determinations consider evidence of *neglect*, including a CINA neglect finding, against "any child residing within the party's household, including a child other than the child who is the subject of the custody or visitation[.]"[88]

In sum, the legal and health consequences of utilizing the Safe Haven Law and subsequently receiving a CINA neglect finding are severe. Postpartum parents may therefore be deterred from utilizing the Safe Haven Law as one potential (albeit imperfect) postpartum resource (at least until the current postpartum care medical infrastructure can be expanded), which may lead to the unsafe relinquishment of the newborn and tragic outcomes.[89] The Safe Haven Law was intended to provide for the safe and anonymous

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[87] Peter Kamakawiwoole, *Why We Stand Firm: The Harmful Effects of CPS Investigations*, Home Sch. Legal Def. Assoc. (Sept. 1, 2024), https://hslda.org/post/why-we-stand-firm-the-harmful-effects-of-cps-investigations#_edn22 (*quoting* Colleen A. Kraft, *AAP Statement Opposing Separation of Children and Parents at the Border*, American Academy of Pediatrics (May 5, 2018) https://docs.house.gov/meetings/IF/IF14/20180719/108572/HHRG-115-IF14-20180719-SD004.pdf).

[88] F.L. § 9-101.1(b)(3) (2025); *In re Nathanial A.*, 160 Md. App. 581, 593 (2005); *In re Adoption No. 12612*, 353 Md. 209, 234 (1999); *In re William B.*, 73 Md. App. 68, 77 (1987).

[89] Maryland's Safe Haven law was created to "save the lives of the infants. The theory is that if distraught mother knows she can hand over her baby to a firefighter or nurse without

surrender of a newborn without fear of penalties. But the Lower Courts' Decisions, which allow the state to penalize postpartum persons who use the Law, will result in a chilling effect on its use and endanger maternal and pediatric health—particularly in historically underserved communities already experiencing health inequities.

CONCLUSION

This Court has the responsibility to uphold the explicit intent and language of the Law in supporting the wellbeing of newborns and parents by ensuring that postpartum persons are not deterred from availing themselves of the Safe Haven Law—legislation intended to improve maternal and infant health outcomes. Accordingly, the Court should reverse the judgment of the Appellate court.

Respectfully submitted,

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fear of punishment, she might not leave the baby under a park bench or on a supermarket shelf." Koenig, *supra* note 2 (discussing the tragic case of Tanisha Montague and her baby); *See also* Karma Allen, *Police Track Down Mother Whose Newborn Was Left Naked, Alone in Woods*; ABC News, Aug. 18, 2019, https://abcnews.go.com/US/police-track-mother-newborn-left-naked-woods/story?id=65049820.

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/s/ *Melinda Johnson*

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