IN THE COURT OF APPEALS OF NORTH CAROLINA

2021-NCCOA-569

No. COA21-174

Filed 19 October 2021

Mecklenburg County, No. 19 JA 287

IN THE MATTER OF: V.W.

Appeal by Respondent-Mother from orders entered on 13 November 2020 and 16 December 2020 by Judge Faith Fickling-Alvarez in Mecklenburg County District Court. Heard in the Court of Appeals 25 August 2021.

Gretchen L. Caldwell for Petitioner-Appellee Mecklenburg County Department of Social Services.

David A. Perez for Respondent-Appellant Mother.

Administrative Office of the Courts, by Michelle FormyDuval Lynch, for the Appellee-Guardian ad Litem.

JACKSON, Judge.

¶ 1 Respondent, the mother of Victoria,[1] appeals from the trial court's adjudicatory and dispositional orders. Respondent contends that the trial court erred in adjudicating Victoria neglected.[2] We affirm.

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[1] The parties have stipulated to the use of pseudonyms to refer to the juvenile and we use them to protect the juvenile's privacy and for ease of reading. *See* N.C. R. App. P. 42(b).

[2] Respondent does not argue that there was any error in the trial court's order on disposition. Issues related to that order are therefore abandoned. *See* N.C. R. App. P. 28(b)(6)

I. Background

¶ 2 Victoria was born on 18 September 2018 with multiple medical issues including atrial septal defect, feeding problems, gastroesophageal reflux, and neonatal encephalopathy. As a result, Victoria was admitted to the Neonatal Intensive Care Unit ("NICU") at Novant Health Forsyth Medical Center and placed on oxygen and therapeutic hypothermia. Respondent was discharged on 22 September 2018 while Victoria remained in the NICU.

¶ 3 The Davidson County Department of Social Services ("DSS") became involved with the family after receiving a Child Protective Services ("CPS") report on 24 September 2018 that Respondent and Victoria's father had intellectual impairment issues and were not capable of caring for the minor child. DSS performed an investigation and determined that services were needed. Specifically, DSS identified concerns regarding Respondent's mental and emotional wellbeing, instability of housing, intellectual delays, and Respondent's ability to care for herself and Victoria. The safety plan developed by DSS as a result of the investigation required live-in support and 24/7 line-of-sight supervision by a relative or fictive kin temporary service provider to ensure that Respondent was able to provide adequate care for Victoria. Respondent agreed to comply with this safety plan.

("Issues not presented in a party's brief, or in support of which no reason or argument is stated, will be taken as abandoned.").

¶ 4 On 10 October 2018, Victoria was transferred to Wake Forest Baptist Medical Center NICU due to poor oral feeding, for speech and feeding therapy, and surgical placement of a feeding tube. Victoria was eventually discharged from the hospital on 1 November 2018. Immediately after her discharge from the hospital, Respondent moved with Victoria to Mecklenburg County to reside with a relative approved by DSS. However, Respondent subsequently moved to the home of a family friend. Because the family did not intend to return to Davidson County, the case was transferred to Mecklenburg County Youth Family Services ("YFS"). Victoria's father moved to Minnesota shortly after the case was transferred to YFS.

¶ 5 On 27 December 2018, Victoria was admitted to the Levine Children's Hospital Emergency Department for poor weight gain and failure to thrive. Victoria's poor weight gain was suspected to be a result of Respondent's non-compliance with the child's feeding pump regimen and mixing routine. Victoria's physician had prescribed continuous feeds around the clock, but Respondent had been following a different regimen. Respondent was re-trained on the use of Victoria's feeding tube, schedule, and mixing routine. After the correct feeding regimen was implemented at the hospital, Victoria began to gain weight appropriately. By the time of Victoria's discharge on 4 January 2019, the home of the family friend with whom she had been living with Respondent had been assessed and approved by YFS.

¶ 6 Victoria was hospitalized again three days later, on 7 January 2019. Her

feeding tube had come out. After the feeding tube was placed again, Victoria was discharged into Respondent's care to live in the home of the family friend approved by YFS.

¶ 7 After Victoria was discharged from the hospital in January 2019, Children's Developmental Services Agency Case Manager M. Gnyp ("Case Manager Gnyp") made multiple attempts to begin feeding services for Victoria. After several unsuccessful attempts to reach Respondent by phone or text message, Case Manager Gnyp met with Respondent on 1 February 2019 to initiate services. However, Respondent stated that she felt the services were no longer needed and that she did not want a therapist coming to the home.

¶ 8 On 4 February 2019, Respondent participated in a child and family case team meeting. Pursuant to the case plan established at the meeting, Respondent was required to (1) keep up with Victoria's appointments; (2) work with the Child Development Services Agency; (3) address her own mental health needs; and (4) comply with the safety plan. As part of the case plan, Respondent also participated in and completed Intensive Family Preservation Services ("IFPS"). Respondent completed the program in March 2019. YFS then relaxed the safety plan to no longer require 24/7 supervision of Respondent because of her successful completion of IFPS.

¶ 9 On 4 March 2019, Victoria was hospitalized for a leaking feeding tube. Respondent told medical staff that Victoria had an appointment to exchange her

feeding tube for a new, larger tube in late February 2019, but that she did not attend the appointment. Victoria's feeding tube was replaced during the visit.

¶ 10 On 15 March 2019, Victoria was hospitalized for a fever and cough. After being admitted, Victoria was diagnosed with failure to thrive and poor weight gain. During the visit, Respondent was unable to describe Victoria's feeding regimen and became frustrated when hospital personnel asked her questions about it. Hospital personnel also observed that Respondent needed frequent reminders of appropriate times to start feedings, stopped feedings too early, administered oral feedings instead of using the feeding tube despite being instructed to do otherwise, and on one occasion gave Victoria Diet Coke from a bottle. Victoria was discharged on 21 March 2019. Before she was discharged, Respondent confirmed that she would follow up with Victoria's feeding therapy, as instructed—the feeding therapy Case Manager Gnyp had been attempting to contact Respondent about, which Respondent thought was unnecessary.

¶ 11 On 28 March 2019, a week later, Respondent and Victoria were not home for a scheduled home visit with Case Manager Gnyp at the time agreed upon. On 8 April 2019, Respondent and Victoria again were not home for a scheduled visit at the time agreed upon.

¶ 12 On 18 April 2019, Victoria was hospitalized again because her feeding tube was leaking. The feeding tube was replaced again and Victoria was discharged.

¶ 13 Finally, on 3 May 2019, Respondent indicated to Case Manager Gnyp that she was willing to begin Victoria's feeding therapy. Victoria's first feeding therapy session took place on 10 June 2019. A feeding schedule was created for Respondent to record the amount and time Victoria was fed during the week.

¶ 14 On 20 June 2019, the second feeding therapy session took place. However, Respondent had not completed the feeding log from the week before.

¶ 15 On 28 June 2019, at the time scheduled for the third feeding therapy session, Respondent answered the door after ten minutes and cancelled the appointment, stating that Victoria had already eaten and was sleeping.

¶ 16 On 5 July 2019, despite the appointment being confirmed by text message that day, Respondent and Victoria were not at home at the time scheduled for the next feeding therapy session. Respondent did not respond to other text messages or phone calls that day. Case Manager Gnyp again attempted to contact Respondent on 9 July 2019 to reschedule the appointment but received no response.

¶ 17 On 19 July 2019, despite the visit being confirmed by text message that day, Respondent and Victoria were again not home at the time agreed upon for a home visit. Respondent did not respond to Case Manager Gnyp's calls or text messages that day.

¶ 18 On 22 July 2019, Social Worker T. Jackson-McLendon met with Respondent. YFS had been advised that Respondent was not consistently staying in overnight to

ensure that Victoria was receiving her overnight feedings and that Respondent had moved in with her boyfriend without the home being approved by YFS. Social Worker Jackson-McLendon informed Respondent that the safety plan was being amended to return to 24/7 supervision. Respondent did not agree to the change.

¶ 19 On 26 July 2019, Respondent participated in another child and family case team meeting. She did not bring Victoria to the meeting; instead, she left Victoria at her boyfriend's home. Social Worker Jackson-McLendon informed Respondent that YFS needed to assess the boyfriend's home as a placement for Victoria and run background checks on the adults residing there based on Respondent's history of domestic violence and failure to engage in domestic violence services.

¶ 20 Social Worker Jackson-McLendon met Respondent at her boyfriend's home immediately following the meeting. She asked Respondent to return with her to the home of her family friend where she had been residing, which would provide YFS with time to complete the home assessment and conduct the background checks, but Respondent refused. Respondent agreed to allow Victoria to return to the approved placement, but she refused to return with Social Worker Jackson-McLendon to demonstrate how to properly mix Victoria's feeds and use the feeding tube. As a result, YFS took 12-hour emergency custody of Victoria and took her to the hospital to be evaluated. Victoria was diagnosed again that day with failure to thrive.

¶ 21 On 29 July 2019, a juvenile petition was filed alleging that Victoria was

neglected. The matter came on for hearing on 14 July 2020 in Mecklenburg County District Court before the Honorable Faith Fickling-Alvarez. The trial court presided over a three-day adjudication and a one-day disposition. On 13 November 2020, the court entered an order adjudicating Victoria neglected. On 16 December 2020, the court entered an order on disposition.

¶ 22 Respondent noticed appeal from the trial court's order on adjudication on 14 December 2020 and from the court's order on disposition on 7 January 2021.

II. Analysis

¶ 23 "The allegations in a petition alleging abuse, neglect, or dependency shall be proved by clear and convincing evidence." N.C. Gen. Stat. § 7B-805 (2019). The role of our Court in reviewing a district court's adjudication is to determine

> (1) whether the findings of fact are supported by clear and convincing evidence, and (2) whether the legal conclusions are supported by the findings of fact. If such evidence exists, the findings of the trial court are binding on appeal, even if the evidence would support a finding to the contrary.

In re T.H.T., 185 N.C. App. 337, 343, 648 S.E.2d 519, 523 (2007) (internal marks and citations omitted). Unchallenged findings of fact are binding on appeal. *Koufman v. Koufman*, 330 N.C. 93, 97, 408 S.E.2d 729, 731 (1991).

A. Findings of Fact

¶ 24 Respondent challenges four of the trial court's findings. We address each in turn.

1. Finding of Fact 37

¶ 25 First, Respondent contends that the first sentence of Finding of Fact 37 is not supported by competent evidence. The first sentence of the finding states:

> Following the completion of the IFPS program, the mother was either unwilling to appropriately feed and care for the juvenile's needs, including necessary medical care, or she was unable to do so without the intensive, hands-on assistance from the IFPS therapist that ended on March 6, 2019.

¶ 26 The record reveals that Respondent engaged with hospital staff on several occasions regarding how to properly feed and care for Victoria. During each encounter, hospital staff consistently noted that Respondent was properly mixing Victoria's formula but sometimes required guidance on when to start feedings and how to ensure the feedings were completed properly.

¶ 27 For example, nine days following the completion of IFPS therapy, Victoria was admitted to the hospital due to a fever and diagnosed with failure to thrive. During the visit, hospital staff witnessed Respondent give Victoria Diet Coke from a bottle, which hospital staff believed likely contributed to Victoria's oral aversion. Hospital staff also noted that Respondent gave inconsistent details regarding Victoria's home feedings, which was a cause of concern. During the same hospital visit, Respondent also told hospital personnel that there had been too many formula changes and Victoria's stomach could not tolerate the amount of milk prescribed. When hospital

staff reminded Respondent that Victoria's feeding tube had been upsized several days prior, Respondent seemed to not recall that taking place.

¶ 28 When Victoria was discharged from the hospital, Respondent was instructed to follow up with Victoria's speech/language pathologist due to her significant oral aversion with bottle feeds and Respondent's reluctance to strictly feed Victoria through the feeding tube. Respondent, however, was uncooperative, despite efforts from the Children's Developmental Services Agency staff, and did not attend a feeding therapy session until 10 June 2019—nearly three months after Victoria had been discharged.

¶ 29 This evidence, coupled with the fact that Victoria's weight gain was positive while in the hospital and Respondent was being monitored during feedings and negative when Respondent was solely responsible for feeding and caring for her, was sufficient to support the trial court's finding that Respondent was either unwilling to appropriately feed and care for Victoria's needs, including necessary medical care, or she was unable to do so without the intensive, hands-on assistance from the IFPS therapists.

2. Finding of Fact 39

¶ 30 Next, Respondent argues that Finding of Fact 39 is misleading. Finding of Fact 39 states:

> Even after successful completion of the IFPS program, the

> mother either missed or cancelled several of the juvenile's appointments which were medically necessary to assess and treat the juvenile's feeding and oral aversion issues. These missed/cancelled visits occurred over the course of several months leading up to the filing of the Juvenile Petition.

¶ 31 Respondent acknowledges that she missed several appointments during the months leading up to the filing of the petition but contends that the appointments were not critical. Respondent argues that if the appointments were as critical as the finding suggests, YFS would have intervened. We find this argument unavailing.

¶ 32 As part of Respondent's case plan, she was required to ensure that Victoria, a medically fragile child, received necessary medical care. The record indicates that Respondent cancelled or failed to attend appointments on 28 March, 22 May, 28 June, 5 July, and 19 July 2019. Record evidence also establishes that Respondent failed to start feeding therapy sessions until months after she was directed to do so. We therefore hold that Finding of Fact 39 is supported by the evidence.

3. Finding of Fact 50

¶ 33 Respondent also contends that the last two sentences of Finding of Fact 50 are not supported by the evidence. The last two sentences state:

> 50. . . . Given the mother's past history of domestic violence with a prior intimate partner and her failure to engage in domestic violence services in the past, it was a reasonable safety expectation by YFS that the mother not have [Victoria] at her boyfriend's home without first providing YFS the opportunity to assess the home and

> complete background checks. Because the mother's boyfriend was unknown to YFS and the mother didn't notify YFS in advance of her move, YFS hadn't been able to assess whether he was safe for the medically-needy infant to be around.

¶ 34 Respondent acknowledges that she did have a history of domestic violence but contends that there is no evidence to show concern as to her current boyfriend. Finding of Fact 50 states that YFS was concerned because of its lack of knowledge about Respondent's boyfriend, and in light of Respondent's history of domestic violence. This finding is thus supported by the evidence.

¶ 35 Respondent's history with domestic violence posed a safety concern leading to her losing custody and ultimately her parental rights to her three older children. The finding was also supported by evidence of (1) YFS's concerns about Respondent being in a home that could assist her in caring for Victoria; (2) Respondent's failure to notify YFS about the move; and (3) YFS's inability to perform a background check to ensure Respondent's boyfriend's home was safe. Indeed, there was nothing unusual about YFS wanting to ensure the home was safe, as it had done twice in the past with the homes Respondent and Victoria had resided in.

4. Finding of Fact 54

¶ 36 Lastly, Respondent argues that Finding of Fact 54, even if taken as true, does not establish neglect. Finding of Fact 54 states:

> At the time of the filing of the Juvenile Petition, the

> juvenile's putative father, [Father], was not residing in Mecklenburg County. Shortly after the case was transferred to Mecklenburg County YFS for FIH services, the father moved to Minnesota. He was present multiple times at both Forsyth Medical Center and Wake Forest Medical Center when the juvenile was born and while she required NICU care from September 18, 2018 to November 1, 2018. He was aware of the juvenile's medically-fragile status. There is no evidence that between the time the father moved to Minnesota in early 2019 and the filing of the Juvenile Petition on July 29, 2019 that he was unable to provide care and support for the juvenile, but he failed to do so.

¶ 37 Respondent's argument as to this finding is misplaced. "In determining whether a child is neglected, the determinative factors are the circumstances surrounding the child, not the fault or culpability of the parent." *In re Montgomery*, 311 N.C. 101, 109, 316 S.E.2d 246, 252 (1984). The record demonstrates that Victoria's father was present during Victoria's birth and the time she spent in the NICU and moved to Minnesota prior to the petition filing.

B. Conclusions of Law

¶ 38 Respondent additionally argues that the trial court's findings of fact do not support the court's conclusion that Victoria was neglected. We disagree.

¶ 39 A neglected juvenile is

> [a]ny juvenile less than 18 years of age . . . whose parent, guardian, custodian, or caretaker does not provide proper care, supervision, or discipline; or who has been abandoned; or *who is not provided necessary medical care*; or who is not provided necessary remedial care; or who

lives in an environment injurious to the juvenile's welfare.

N.C. Gen. Stat. § 7B-101(15) (2019) (emphasis added).

¶ 40 "In order to adjudicate a juvenile neglected, our courts have additionally required that there be some physical, mental, or emotional impairment of the juvenile or a substantial risk of such impairment as a consequence of the failure to provide proper care, supervision or discipline." *In re Stumbo*, 357 N.C. 279, 283, 582 S.E.2d 255, 258 (2003) (internal marks and citations omitted). "Where there is no finding that the juvenile has been impaired or is at substantial risk of impairment, there is no error if all the evidence supports such a finding." *In re Padgett*, 156 N.C. App. 644, 648, 577 S.E.2d 337, 340 (2003). "The issue of whether the trial court's findings of fact support its conclusions of law is reviewed de novo." *In re J.S.*, 374 N.C. 811, 814, 845 S.E.2d 66, 71 (2020).

¶ 41 Here, the trial court made the following findings of fact: (1) Victoria was born at 36 weeks gestation with multiple medical issues; (2) after Victoria's birth, Respondent did not demonstrate to the hospital staff that she was able to meet the juvenile's medical needs; (3) Respondent was trained and educated several times as to the needs of Victoria; (4) Victoria was admitted to the hospital from 27 December 2018 to 4 January 2019 for poor weight gain and failure to thrive; (5) Victoria's failure to gain weight was noted to be likely due to maternal noncompliance or confusion with the juvenile's feeding pump regimen and mixing routine; (6) the juvenile gained

weight appropriately while at the hospital; (7) following Victoria's discharge, attempts were made to get Victoria's feeding therapy services started but Respondent indicated she did not want a therapist coming to her home and felt Victoria no longer needed therapy; (8) Victoria was admitted to the hospital again from 15 to 21 March 2019 with fever and cough and diagnosed with failure to thrive and poor weight gain; (9) during her admission, Respondent gave Victoria diet soda from a bottle, which staff noted likely contributed to the juvenile's oral aversion; (10) due to Victoria's significant oral aversions, the hospital recommended that Respondent feed Victoria strictly through the feeding tube and Respondent refused to follow this instruction on several occasions; (11) throughout the duration of the case, Respondent failed to sign up for transportation services and cancelled or missed several of Victoria's medically necessary appointments; and (12) Respondent moved into her boyfriend's home without notifying YFS.

¶ 42 These findings of fact are sufficient to establish that Victoria's physical, emotional, and mental well-being were impaired or in substantial risk of being impaired because of improper care. Specifically, Respondent failed to ensure Victoria was getting the proper assistance she needed by failing to feed her as directed by medical providers and failing to attend and cancelling appointments. Thus, the trial court did not err in adjudicating Victoria neglected.

III. Conclusion

¶ 43 We affirm the order of the trial court because the trial court's findings were supported by competent evidence, and these findings supported the court's conclusion that Victoria was neglected.

AFFIRMED.

Judge INMAN concurs.

Judge WOOD concurs in result.

Report per Rule 30(e).