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CHAIR

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EXECUTIVE DIRECTOR

August 18, 2021

The Honorable John Carney
Office of the Governor
820 N. French Street, 12th Floor
Wilmington, DE 19801

RE: Reviews of Child Deaths and Near Deaths due to Abuse or Neglect

Dear Governor Carney:

As one of its many statutory duties, the Child Protection Accountability Commission ("CPAC") is responsible for the review of child deaths and near deaths due to abuse or neglect. As required by law, CPAC approved findings from 20 cases at its August 18, 2021 meeting.[1]

Thus far in 2021, there have been 3 deaths and 35 near deaths due to child abuse or neglect. In June alone, there were 8 near deaths and 1 death. As you are aware, despite the pandemic, the Child Abuse and Neglect (CAN) Panel met conscientiously to assure that child abuse deaths and near deaths were timely reviewed. The volume of deaths and near deaths to children continues to overwhelm the panel. With 38 new cases in 2021 thus far, the impact on the front lines and on the CAN Panel is significant. These numbers are troubling both in terms of child safety as well as in timely caseload management and retrospective review.

With respect to the 20 cases that were approved by CPAC today, here are the strengths and system breakdowns. Two of the near death cases approved had been previously reviewed and was awaiting the completion of the criminal investigation. Both cases resolved – one as an Assault 2nd with community supervision and one as a

[1] 16 Del. C. § 932.

misdemeanor endangering with probation. No additional findings were made – two strengths were noted.

The eighteen remaining cases were from deaths or near deaths that occurred between September of 2020 and January of 2021. Of these cases, nine will have no further review as there are no criminal charges. Six of the nine remaining cases have pending charges and will be reviewed again once prosecution is completed. The remaining three cases are still being investigated. The children in these cases range in age from two weeks to eleven years of age with four deaths and fourteen near deaths. The children were victims of abusive head trauma, poisoning via drug ingestion, bone and skull fractures, medical neglect and unsafe sleep. These eighteen cases resulted in 34 strengths and 68 current findings across system areas.

For these September 2020 through January of 2021 cases, 16 strengths and 15 findings were noted for the Multidisciplinary Team Response. The Office of the Child Advocate (OCA) has now contracted with a MDT Training and Policy Administrator with significant law enforcement expertise who is working with individual law enforcement jurisdictions on best practices, resources and compliance with the MOU. The Joint Action Plan delineates the further steps this contracted position and CPAC must take to further best practices and MOU compliance by team members. The Office of the Investigation Coordinator (IC) has also instituted MDT meetings within 48-72 hours of every child abuse death, serious injury or drug ingestion. These steps by CPAC have shown a significant positive impact this quarter on the multidisciplinary investigations as only 15 findings were made and more strengths were noted.

The medical response had 8 findings together with 2 strengths. Five of the findings surround reporting of child abuse and neglect. The medical response to child abuse and neglect cases was a significant focus in the retreat and resulting Joint Action Plan. Significant recommendations for improvement have been delineated that focus on more tailored education, coaching and support for various aspects of the medical profession, particularly hospitals and walk in care, as well as pediatric, family medicine and obstetrics/gynecological practices. The Joint Action Plan also focuses on getting specialized medical child abuse expertise downstate. CPAC has created a workgroup chaired by medical professionals to tackle these significant tasks, and will be utilizing funds from mandatory reporting training to accomplish these goals. While this take time and resources to accomplish, CPAC is hopeful with this targeted focus and the

additional resources, it can begin to make a substantive impact on all aspects of Delaware's medical response to child abuse and neglect, as well as continue to empower the medical community to utilize Plans of Safe Care to assure supports for infants with prenatal substance exposure.

The Division of Family Services (DFS) had 16 strengths and 45 findings this quarter. Sixteen of those findings were regarding high caseloads. The rest of the findings continue to focus on timely and appropriate completion of safety agreements, inappropriate safety agreements and parental risk factors. In the Joint Action Plan, CPAC and CDRC, with full partnership by DSCYF, have recommended the following steps to improve worker and supervisory responses: develop and provide initial and ongoing training on the Structured Decision Making Safety and Risk Assessment tools; provide regular coaching and monitoring to DFS staff on child safety agreements; intensify DFS supervisory training and support on child safety agreements; develop an abbreviated DFS training for MDT partners; and utilize quarterly meetings to address findings from these cases with DFS staff. CPAC is hopeful that as these measures are implemented, improvements to these areas will be reflected in these retrospective reviews.

CPAC only brings you the most horrific of Delaware's child abuse cases; however, for every one of these cases, there are countless more cases where DFS case workers are under the same pressures with children at risk of serious harm. Young children with sentinel injuries are often the victims of serious abuse just months later. Prompt identification of these cases, and thorough investigation thereafter could decrease serious harm. For your information we have included the strengths, findings and the details behind all of the cases presented in this letter. CPAC stands ready as a partner as well as to answer any further questions you may have.

Respectfully,

Tania M. Culley, Esquire
Executive Director
Child Protection Accountability Commission
Enclosures

cc: CPAC Commissioners
General Assembly

Child Protection Accountability Commission

Child Abuse and Neglect (CAN) Panel

Current Caseload

AUGUST 18, 2021

Total Open CAN Cases	**99**
Initials	*56*
Finals	*43*

INITIALS	**56**
Preparation	**47**
Within Compliance	*47*
Out of Compliance	*0*
Pending Review	**0**
Within Compliance	*0*
Out of Compliance	*0*
Reports	**9**
Initial Report Not Written	*0*
Initial Report Written	*9*

FINALS	**43**
Preparation	**0**
Pending Prosecution	**38**
Pending Review	**3**
Reports	**2**
Final Report Not Written	*0*
Final Report Written	*2*

2015-2020 Child Abuse & Neglect Case Summaries			
Year	**Near Deaths**	**Deaths**	**Total**
2015	21	11	**32**
2016	22	5	**27**
2017	31	13	**44**
2018	34	14	**48**
2019	29	13	**42**
2020	43	9	**52**

2021 Child Abuse & Neglect Case Summaries[1]		
Month	**Near Deaths**	**Deaths**
January	2	0
February	6	1
March	5	0
April	8	0
May	4	0
June	8	1
July	2	1
August	0	0
September	0	0
October	0	0
November	0	0
December	0	0
Total	**35**	**3**
	Total	**38**

[1]This summary only includes cases screened in and accepted by the CAN Panel for review. Cases that are pending a decision will not be in until a screening decision has been made.

Office of the Child Advocate
900 King Street, Ste 350
Wilmington, DE 19801

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Summary

AUGUST 18, 2021

INITIAL REVIEWS

	*Current	Grand Total
MDT Response	**16**	**16**
Communication	2	2
General - Civil Investigation	3	3
General - Criminal/Civil Investigation	9	9
Interviews - Child	1	1
Medical Exam	1	1
Medical	**2**	**2**
Documentation	1	1
Medical Exam/Standard of Care - ED	1	1
Risk Assessment/ Caseloads	**3**	**3**
Collaterals	2	2
Reporting	1	1
Safety/ Use of History/ Supervisory Oversight	**12**	**12**
Completed Correctly/On Time	10	10
Oversight of Agreement	2	2
Unresolved Risk	**1**	**1**
Parental Risk Factors	1	1
Grand Total	**34**	**34**

FINAL REVIEWS

	*Current	Grand Total
Unresolved Risk	**2**	**2**
Legal Guardian	1	1
Parental Risk Factors	1	1
Grand Total	**2**	**2**

TOTAL CAN PANEL STRENGTHS **36**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

Office of the Child Advocate
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Child Protection Accountability Commission

Child Abuse and Neglect Panel

Strengths Detail

AUGUST 18, 2021

INITIAL REVIEWS

System Area	Strength	Rationale	Count of #
MDT Response			16
	Communication		2
		There was good communication between the medical team, DFS, and the law enforcement agency.	1
		There was good communicaiton between the medical team, DFS, and the law enforcement agency.	1
	General - Civil Investigation		3
		During the prior and current investigations, the DFS caseworkers thoroughly assessed the safety of both children despite concerns being for only one child. The assessments included regular visits, school and medical collaterals, and appropriate follow up to ensure the needs were being met.	1
		Despite the complexity of the case due to the child's legal status, lack of health insurance, complicated injuries, language barriers, and residency status, the DFS caseworker did an excellent job of ensuring the child received all necessary services and medical treatment, and ultimately was reunited safely with his paternal family.	1
		During the course of the multiple investigations, there was good collaboration between the investigation and treatment caseworkers, to include joint responses to the home and quality contact with the family.	1
	General - Criminal/Civil Investigation		9
		There was a good MDT response to the near death investigation by the law enforcement agency and DFS, to include joint responses to the children's hospital and the home, joint interviews, and a child safety agreement during hospitalization despite an initial negative urine drug screen for the child.	1
		There was good MDT communication and collaboration between DFS, the law enforcement agency, the medical team, and the DAG, to include joint responses to the hospital, joint interviews, blood draws, medical evaluations and forensic interviews of the children within both households.	1
		There was a good MDT response to the near death investigation by the law enforcement agency and DFS, which appropriately assessed the needs of all children residing in the home, and included joint responses to the hospital, joint interviews with the parents and the relative, a child safety agreement, medical evaluation of the sibling, and forensic interview of the sibling.	1
		There was a good MDT response to the near death investigation by the law enforcement agency and DFS, which included joint responses to the hospital and to the home, joint interviews with Mother and the maternal relatives, a child safety agreement, medical evaluation of the siblings, and forensic interview of the older sibling.	1
		There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews, an evidentiary blood draw of the child, medical evaluations for the siblings, and forensic interviews of the children.	1
		There was a good MDT response to the death incident, which included a joint response to the hospital, joint interviews, an evidentiary blood draw of Mother, and medical evaluations and forensic interviews of the sibling and the other children residing in the home.	1
		There was a good MDT response to the death incident, which included a joint response to the hospital, joint interviews, an evidentiary blood draw of Mother, and a medical evaluation and forensic interview of the sibling residing in the home.	1

	There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews with the parents, and medical evaluations and forensic interviews of the child and the sibling residing in the home.	1
	There was a good MDT response to the near death incident, which included a joint response to the hospital, joint interviews, forensic interview of the child, and collaboration with outside agencies, as appropriate.	1
Interviews - Child		1
	The DFS caseworker abstained from interviewing the sibling prior to the forensic interview.	1
Medical Exam		1
	The DFS caseworker advocated for the child to be medically evaluated by the children's hospital despite the initial treating hospital determining the child was cleared for medical discharge.	1
Medical		2
Documentation		1
	There was excellent documentation within the local hospital ED medical records relating to the child's presentation and the MDT response to the near death.	1
Medical Exam/ Standard of Care - ED		1
	The initial treating hospital identified and thoroughly documented other non-presenting injuries, which were concerning for child physical abuse.	1
Risk Assessment/ Caseloads		3
Collaterals		2
	Strong collaterals were completed by the DFS caseworker. The contacts included both professional and personal resources.	2
Reporting		1
	A report was made to the Office of Professional Standards, and subsequently to the Office of Child Care Licensing, which resulted in the unlicensed in-home daycare being closed.	1
Safety/ Use of History/ Supervisory Oversight		12
Completed Correctly/On Time		10
	The DFS caseworker immediately implemented a child safety agreement restricting contact with the child while hospitalized. There was consistent review and modification, when necessary, of the safety agreement.	1
	The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. There was consistent review and modification, when necessary, of the safety agreement by the DFS caseworker.	1
	The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. There was consistent review and modification, when necessary, of the safety agreement.	2
	The DFS caseworker was diligent in implementing a child safety agreement for the daycare provider's infant, although neither the provider nor her attorney were agreeable. A medical evaluation was also completed for the infant.	1
	The DFS caseworker immediately implemented a child safety agreement restricting contact with the child while hospitalized. The agreement also included the siblings in the home. There was consistent review and modification, when necessary, of the safety agreement.	1

		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement also included the siblings in the home. There was consistent review and modification, when necessary, of the safety agreement.	1
		During the prior investigations, the DFS caseworker thoroughly assessed the safety of both children. The assessments included regular visits, and school and medical collaterals.	1
		The DFS caseworker immediately implemented a child safety agreement for the siblings in the home. There was consistent review and modification, when necessary, of the safety agreement. Medical evaluations were also completed for the siblings expeditiously.	1
		The DFS caseworker immediately implemented a child safety agreement while the child was hospitalized. The agreement also included the children residing in the non-relative caregiver's home. There was consistent review and modification, when necessary, of the safety agreement.	1
	Oversight of Agreement		2
		Following Mother's violation of the child safety agreement, a TDM was held, and as a result, a new child safety agreement was implemented for the child and a custody petition was filed for the sibling.	2
Unresolved Risk			1
	Parental Risk Factors		1
		The DFS investigation and treatment caseworkers made timely, appropriate referrals for the family, which included an early intervention program, home visiting services, alcohol or drug (AOD) liaison, Purchase of Care, and the family interventionist.	1
Grand Total			**34**

FINAL REVIEWS

System Area	Strength	Rationale	Count of #
Unresolved Risk			2
	Parental Risk Factors		1
		The parents were offered case plans to be able to reunify with their children after DFS is no longer involved.	1
	Legal Guardian		1
		Despite the relatives filing for guardianship, the case was transferred to treatment for ongoing services.	1
Grand Total			**2**

TOTAL CAN PANEL STRENGTHS **36**

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Summary

AUGUST 18, 2021

INITIAL REVIEWS		
Sum of #	**Column Labels**	
	***Current**	**Grand Total**
MDT Response	**15**	**15**
Crime Scene	3	3
General - Civil Investigation	1	1
General - Criminal Investigation	1	1
General - Criminal Investigation / Civil Investigation	1	1
Intake with DOJ	1	1
Interviews - Adult	3	3
Interviews - Child	1	1
Medical Exam	3	3
Reporting	1	1
Medical	**8**	**8**
Medical Exam/ Standard of Care - ED	3	3
Reporting	5	5
Risk Assessment/ Caseloads	**26**	**26**
Caseloads	16	16
Collaterals	6	6
Risk Assessment - Closed Despite Risk Level	1	1
Risk Assessment - Screen Out	3	3
Safety/ Use of History/ Supervisory Oversight	**11**	**11**
Oversight of Agreement	1	1
Safety - Completed Incorrectly/ Late	5	5
Safety - Inappropriate Parent/ Relative Component	3	3
Safety - No Safety Assessment of Non-Victims	1	1
Supervisory Oversight	1	1
Unresolved Risk	**8**	**8**
Child Risk Factors	1	1
Contacts with Family	2	2
Parental Risk Factors	4	4
Substance-Exposed Infant	1	1
Grand Total	**68**	**68**

TOTAL CAN PANEL FINDINGS **68**

*Current - within 1 year of incident

**Prior - 1 year or more prior to incident

Office of the Child Advocate
900 King Street, Ste 350
Wilmington, DE 19801

Child Protection Accountability Commission

Child Abuse and Neglect Panel

Findings Detail

AUGUST 18, 2021

INITIALS REVIEWS

System Area	Finding	PUBLIC Rationale	Sum of #
MDT Response			15
	Crime Scene		3
		No scene investigation was completed by the law enforcement agency. As a result, the scene was not photographed and no evidence was collected.	1
		No scene investigation was completed by the law enforcement agency at the parents' home. As a result, the scene was not photographed and no evidence was collected.	1
		The scene investigation by the law enforcement agency was delayed.	1
	General - Civil Investigation		1
		For the prior investigation, the DFS caseworker did not initiate a multidisciplinary team response upon receipt of the physical injury report. In addition, the caseworker did not conduct a thorough investigation and made a finding of no evidence to substantiate versus unsubstantiated.	1
	General - Criminal Investigation		1
		The initial responding officer concluded the victim's injuries were not serious in nature, and as a result, it initially impacted the assignment to the Criminal Investigations Unit. However, the DFS caseworker provided photographs and additional information.	1
	General - Criminal Investigation / Civil Investigation		1
		There was not an initial MDT response to the near death incident in compliance with the MOU and statute. Law Enforcement declined to send a detective to the hospital.	1
	Intake with DOJ		1
		The law enforcement agency did not notify the DOJ Special Victims Unit of the near death incident. As a result, the evidentiary blood draws of the victim and the suspect were not completed.	1

	Interviews - Adult	3
	DFS was not contacted by the law enforcement agency to observe the suspect/witness interviews.	2
	During the home visit, there was no attempt by the DFS caseworker to gather information or interview the unknown male in the babysitter's home.	1
	Interviews - Child	1
	During the prior investigation, the children reported having an older sister, but there was no attempt by the caseworker to identify this child or interview her.	1
	Medical Exam	3
	During the prior investigation, the sibling was medically examined for vaginal bleeding and bruising and a CT scan was recommended. However, there was no follow up by the caseworker to ensure the imaging occurred.	1
	The two half-siblings who were present in the home during the near death incident were not medically evaluated.	1
	The sibling, who resided part-time in the residence, was not medially evaluated.	1
	Reporting	1
	The law enforcement agency delayed making a report to the DFS Report Line for a prior domestic violence incident.	1
Medical		8
	Medical Exam/ Standard of Care - ED	3
	The children's hospital does not test for Fentanyl in its urine drug screen. As a result, the initial urine drug screen came back as negative, and this impacted the investigation.	1
	For the near death investigation, the emergency department physician opined that the child's fracture was more likely due to an accidental injury, and the physician had no concerns about the infant's safety.	1

	For the near death investigation, the emergency department physician had no plans to transfer the infant to the children's hospital for further assessment and evaluation despite bilateral subconjunctival hemorrhages, petechia and bruising. Rib fractures were later identified on the follow up skeletal survey.	1
Reporting		5
	There was no report to the DFS Report Line by the PCP after mother called the office reporting bruising to a 10-week-old infant and the mechanism of injury is unknown.	1
	There was no report to the DFS Report Line by the hospital emergency department for the near death incident, and the child was released prior to the x-rays being read.	1
	Prior to the near death incident, concern for bruising was noted by the PCP and bloodwork was ordered. However, there was no report to the DFS Report Line once the bloodwork came back normal.	1
	The hospital emergency department failed to make a report to the DFS Report Line for a prior injury that is highly suspicious for abuse to a child under age 4, despite lack of an adequate explanation from parents for the injury.	1
	The attending hospital nurses did not make a report to the DFS Report Line for the near death incident which occurred in the hospital. The treating hospital physician did not feel that DFS should be conducting an investigation and would not share information relevant to the case with the DFS caseworker.	1
Risk Assessment/ Caseloads		26
Caseloads		16
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	5

	The caseworkers were over the investigation caseload statutory standards during the current and prior investigations. However, it does not appear that the caseload negatively impacted the DFS response to the cases.	1
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open. However, it does not appear that the caseload negatively impacted the DFS response to the case.	6
	The DFS caseworker was over the investigation caseload statutory standards during the prior investigation. However, it does not appear that the caseload negatively impacted the DFS response to the case.	1
	The DFS caseworker was over the investigation caseload statutory standards the entire time the case was open, and the caseload appears to have had a negative impact on the DFS response to the case.	1
	The caseworkers were over the investigation caseload statutory standards during the current and prior investigations. The caseload appears to have had a negative impact on the response in one of the prior investigations. However, it does not appear that the caseload negatively impacted the DFS response in a subsequent investigation or in the near death investigation.	1
	The DFS caseworkers were over the investigation caseload statutory standards during the prior, current, and subsequent investigations. The caseload appears to have had a negative impact on the response in the prior investigation. However, it does not appear that the caseload negatively impacted the DFS response in the near death investigation or in the subsequent investigation.	1
Collaterals		6
	During the near death incident, a collateral contact was not completed with non-professional sources close to the family.	1

	During the prior investigation, a collateral contact was not completed with the specialist who mother claimed had examined the child.	1
	During the prior investigation, the DFS caseworker did not request the child's medical records and medical neglect was suspected.	1
	During the prior investigation, a collateral contact was not completed with non-professional sources close to the family.	1
	DFS investigated multiple reports alleging medical neglect but there was not an attempt to communicate with all the medical providers and specialists for the medically complex child or to obtain an assessment by the child abuse medical experts to allow for an earlier intervention.	1
	During a prior investigation, a collateral contact was not completed with a relative caregiver, with whom the child had previously resided.	1
Risk Assessment - Closed Despite Risk Level		1
	The SDM Risk Assessment identified the risk as high in the prior investigation. Ongoing service was recommended; however, the case disposition was overridden to close the investigation after a Framework was completed. This was a medically complex child with a history of medical neglect allegations and appointments were not being kept and feeding issues were unresolved.	1
Risk Assessment - Screen Out		3
	The call by hospital emergency department to the DFS Report Line was written as a hotline progress note rather than a new report.	1
	The call by the Division of Forensic Science to the DFS Report Line was written as a hotline progress note rather than a new report.	1

The call to the DFS Report Line by the law enforcement agency was documented by DFS as a progress note rather than as a new hotline report.	1
Safety/ Use of History/ Supervisory Oversight	**11**
Oversight of Agreement	1
During the treatment case, there was no documentation to suggest the older sibling's safety or the living arrangements had been reassessed since closure of the previous investigation.	1
Safety - Completed Incorrectly/ Late	5
During the near death investigation, no safety agreement was initially completed for the hospitalized victim. Parents should have been permitted no unsupervised contact while at the hospital.	1
The DFS caseworker delayed implementing a safety agreement for the sibling, despite the sibling having been in the care of a relative for several days.	1
During the near death investigation, there was no attempt by the DFS caseworker to contact the sibling's father regarding the safety planning for the child.	1
The DFS caseworker did not consult with law enforcement to determine if the child's relatives had been cleared as suspects prior to implementing a safety agreement which allowed the child to be discharged from the hospital to the relatives' care.	1
During a prior investigation involving the neglect of an older sibling, the initial safety assessment by the DFS caseworker did not accurately reflect family history related to the siblings. The siblings were born substance-exposed and the mother did not express interest in parenting them, which should have prompted implementation of a DFS safety agreement or custody being sought for the older sibling.	1
Safety - Inappropriate Parent/ Relative Component	3

	During the near death investigation, DFS implemented safety agreements allowing relative caregivers to supervise contact between the children and parents. However, contact should have been restricted with all parties until they were ruled out as suspects.	1
	During the death investigation, DFS implemented a safety agreement with a relative caregiver for the surviving sibling, which permitted supervised contact with mother. However, mother should not have been permitted contact since she violated the prior agreement and the sibling was fearful of her, and the caregiver was inappropriate for enabling mother's conduct and not following the prior safety agreement.	1
	For the near death incident, the DFS caseworker amended the safety agreement to include a participant, who resided in the home and was not ruled out as a suspect.	1
	Safety - No Safety Assessment of Non-Victims	1
	During the near death investigation, it was noted that the mother had weekend visits with her other child, and safety was not assessed for this child.	1
	Supervisory Oversight	1
	Prior to the near death incident, a DFS safety agreement was not implemented nor was custody sought for the child despite multiple risk factors, which included the substance-exposed birth, mother's substance abuse impacting her ability to care for the child, mother's lack of bonding with the child, and the prior involuntary termination of mother's parental rights over siblings.	1
Unresolved Risk		8
	Child Risk Factors	1
	During a prior investigation, the DFS caseworker permitted a teen child to continue to reside in the home, which had no running water.	1

Contacts with Family		2
	Upon receiving a report of neglect for the sibling, which was linked to the death investigation, the DFS caseworker delayed response for six weeks.	1
	The DFS caseworker did not complete the standard 30-day contacts with the sibling for a five-month period.	1
Parental Risk Factors		4
	During the prior investigation, DFS received allegations that the parents maintain a secret stash in the home that the children are not permitted to touch, but this was not addressed by the caseworker.	1
	A referral was not made to the DFS domestic violence liaison, and the family had multiple documented incidents of interpersonal violence.	1
	A referral was not made to the DFS domestic violence liaison, and the hotline report and prior investigations noted concerns of intimate partner violence.	1
	DFS did not evaluate substance abuse issues for the parents by requesting that they complete substance abuse evaluations. Concerns of substance abuse were noted in the hotline report and during prior investigations.	1
Substance-Exposed Infant		1
	After birth and prior to the near death incident, a Plan of Safe Care was not implemented for the child who was born substance-exposed.	1
Grand Total		**68**