

Child Death, Near Death, and Stillbirth Commission (CDNDSC)

Policy and Procedure Review of Deaths and Near Deaths due to Child Abuse/Neglect

Purpose:

The primary purpose of conducting retrospective investigations and reviews of child deaths and near deaths due to abuse and/or neglect is to safeguard the health and safety of the children of the State by providing timely system-wide recommendations regarding practices or conditions which impact the mortality of children. This purpose is accomplished by conducting:

- An initial investigation and review of the relevant¹ facts and circumstances of the near death or death, while protecting the integrity of any criminal prosecution of the case.
- A final review of the facts and circumstances surrounding the death or near death which were not available at the initial review, including a review of the criminal prosecution of the case.

Policy:

Delaware Code requires the Child Death, Near Death and Stillbirth Commission (hereinafter referred to as “the Commission”) to investigate and review the facts and circumstances of all cases of child death or near death due to abuse and/or neglect within six months of the death or near death. Near death is defined as a child determined by a physician to be in serious or critical condition due to abuse or neglect.

A case of child death or near death will be assigned to a panel for initial review. Following release of the case by the Attorney General’s Office, the same panel will conduct the final review.

Legislative Authority:

31 Del. C. § 323 (a) (e)

¹ The term “relevant” is used throughout this policy. As used herein, relevant shall refer to the facts and circumstances surrounding the near death or death, including but not limited to, history regarding the family and initial responses to the near death or death. Facts and circumstances, which arise after the initial response to the near death or death, shall not be deemed “relevant” for the purpose of the review; however, those facts and circumstances may still be addressed with the appropriate agency outside the confines of the review.

Procedures:

INITIAL REVIEW - Preparation

1. Deaths and near deaths due to abuse and/or neglect shall be reviewed within six months of a report to CDNDSC staff.
2. Those responsible for reporting cases to CDNDSC staff are:
 - The Attorney General's Office
 - The Department of Services for Children, Youth and Their Families
 - Any other state or local agency with the responsibility for investigating child deaths or child near deaths (e.g. law enforcement, Office of the Chief Medical Examiner).
3. These agencies have fourteen days to report cases to CDNDSC staff once it is determined that the death or near death is due to abuse and/or neglect.
4. Once reported, CDNDSC staff will promptly coordinate a meeting to include representatives from all investigating agencies, CDNDSC staff, and a representative from the Office of the Child Advocate ("OCA"). The purpose of the meeting is to identify what records and witnesses are needed and/or available for the initial investigation and review.
 - Records should be relevant to the circumstances surrounding the death or near death. Records may include, but are not limited to: medical records, state agency records, relevant records from other involved agencies (e.g. non-profit providers), and witness testimony/affidavits. The Attorney General's Office must authorize any request for mental health records.
 - Witnesses should be relevant to the circumstances surrounding the death or near death, or should provide subject matter expertise to the panel. In compliance with § 323 (f), no person identified by the Attorney General's Office as a potential witness in any criminal prosecution arising from the death or near death of an abused or neglected child shall be questioned, deposed or interviewed by or for the Commission in connection with its investigation and review of such death or near death until the completion of such prosecution.
5. The records and witnesses will be requested from the appropriate agencies or entities by CDNDSC staff.
 - Records from governmental agencies represented on the Commission will be obtained via the completion of datasheets (to include a narrative section with dates). Records summarized in the datasheets must be relevant to the circumstances surrounding the death or near death. Datasheets must be electronically sent to CDNDSC staff within one month of the request. If necessary, a subpoena may also be issued.
 - Records from governmental agencies not represented on the Commission or from non-governmental entities will be obtained via subpoena. CDNDSC Staff will promptly request the Attorney General's Office to issue such subpoenas.

- Witness participation will be coordinated by CDNDSC staff. If necessary, a subpoena may be issued.
6. CDNDSC staff will:
 - Review records received;
 - Determine the need for additional records;
 - Request any and all additional records; and
 - At the discretion of the Executive Director, a timeline may be completed of all submitted records for the purpose of assessing system issues.
 7. These cases are primarily assigned to the Child Abuse and Neglect Panel (“CAN Panel”) for review. For good cause shown to the Commission, any panel may be assigned to review any death or near death case.
 8. Once all relevant records and witnesses are obtained, CDNDSC staff will schedule the case for the next available CAN Panel agenda unless otherwise assigned.
 9. If a case will not be ready for review within the statutory timeframes, an extension will be requested from the Commission.

INITIAL REVIEW – Process

1. Once the case is prepared and authorized for review, the CDNDSC staff will at least one month prior to the review:
 - Provide the panel members agency datasheets;
 - Request a medical professional on the panel to review any relevant medical records and summarize them at the review.
 - Request the National Association of Social Worker’s representative or mental health professional on the panel to review any relevant mental health records and summarize them at the review.
2. At each panel meeting, all those present must comply with and sign the confidentiality statement for the review process. Confidentiality sheets are collected and maintained by CDNDSC staff. Specific identifying case information will remain confidential and restricted to panel and Commission members.
3. Witnesses and invited professionals will only be present for the discussion of facts relevant to their involvement in the case.
4. Panel members will orally summarize their agencies’ interaction with the child and/or family when applicable.
5. If a panel member has been directly involved with the case, they may participate in the discussion but must abstain from voting. Likewise, panel members not present for the entire initial review shall abstain from voting.
6. Each statutorily appointed agency/individual will have one vote regardless of the number of representatives at the meeting.
7. Following presentations of information and discussion, the process to be followed by the panel chair is as follows:
 - All invited individuals/witnesses shall be excused.

- The chair asks the panel:
 - A. Were reasonable standards of practice met by the systems involved?
 - B. What system practices or conditions, if any, impacted the death or near death?
 - C. What, if any, system practices or conditions related to the death or near death were ancillary to the incident but present opportunities for system-wide improvement?
 - Ancillary factors identified by the panel shall be compiled and tracked by CDNDSC staff, and presented at least annually to the Commission for possible action.
 - These ancillary factors will not be identified in the initial review letter to the Governor.
 - D. System or case specific concerns that may impact the safety or mortality of children, but which occurred after the death or near death may be raised during the review. Prior to the conclusion of the review, the panel will identify the appropriate agency or entity to address the concerns. A response by said agency or entity to the panel is not required but is recommended. The response or lack thereof will be reported by the panel chair at the next CDNDSC meeting. This does not preclude the reporting of:
 - Current suspected child abuse and neglect. In which case, the panel will determine the most appropriate person to make the report and what it should include;
 - Circumstances of suspected medical malpractice. This issue will be referred to the Commission for further action.
 - E. Are there recommendations for change to community behaviors, technologies, agency systems and/or laws that could improve system practices or conditions that impacted the death or near death? ²
If yes, the panel should move the discussion to developing recommendations.
If not, the initial review is concluded.
8. Recommendations should focus on opportunities for improvement, should be action-oriented and should be written so that others not involved in the review understand how they logically relate to the death or near death. A recommendation put forth must meet the following criteria:
- The recommendation is clearly related to the case and is regarding those practices or conditions which impact the safety and mortality of children.

² Community behaviors would include public prevention or education such as co-sleeping, aggressive teenage driving, etc. Technologies would include any device that could possibly prevent a child's death such as defibrillators, pool alarms, etc.

- There is enough expertise around the table to ensure the recommendation is appropriate.
 - No further research is needed to make the recommendation.
 - An entity to take the lead on implementing the recommendation is identified.
9. An affirmative vote of sixty percent of those present is needed to adopt any recommendation.
 10. Once a vote on the recommendations is taken, there will be no additional discussion regarding the recommendations.
 11. CDNDSC staff in partnership with the Panel Chair will draft the panel report to include recommendations voted upon by the panel. This report will then be submitted to the Recommendation Subcommittee (this subcommittee is comprised of Commissioners who voluntarily participate). After the subcommittee's review of the recommendations and initial report, the Recommendation Subcommittee will either edit the recommendations and the initial report or ask additional questions of the Child Death Specialist to research for the report. If the Child Death Specialist is unable to answer the subcommittee's questions or concerns, the case will be sent back to the panel for further clarification.
 12. The Child Death Specialist will draft panel minutes, to include circumstances of the case, panel discussion, ancillary issues, and recommendations for panel approval prior to the chair's use at the next scheduled Commission meeting.
 13. The initial review is not concluded until the Commission has approved the findings of the panel. The panel chair will report back to the panel the outcome of the Commission meeting.
 14. The panel may create a list of records and witnesses to be subpoenaed and/or requested for the final review of the case.
 15. All data will be entered into a secured computerized database, which will be maintained by the CDNDSC staff.

INITIAL REVIEW - Commission Responsibilities

1. The Commission members will attend scheduled meetings to review and consider the activities, findings and recommendations of the panel as reported by the panel chair.
2. The Commission will respond to requests by the panel chair for an extension from the Commission when it appears that a case will not be ready for review within the statutorily set timeframe.
3. The Commission or executive committee shall determine whether or not to grant an extension by majority vote.
4. The Commission will consider a de-identified case report of the facts and circumstances of the death or near death, any recommendations, and any ancillary factors presented by the panel chair.
5. Following the presentation and discussion, the Commission will consider the recommendations for approval.

6. The Commission will vote on the recommendations. A 60% or greater vote of the Commission is required to approve the recommendations.
7. If the Commission has additional questions or concerns regarding any aspect of a case, those questions or concerns will be directed to the appropriate agency/entity in the meeting or through CDNDSC staff.
8. Following the outcome of the review and approval of the Commission, CDNDSC staff will:
 - Prepare and send the letter to the Governor [see attachment 1],
 - Prepare and send the letter to the specific agency or entity named in the recommendation, and
 - Provide copies of the letters to the Child Protection Accountability Commission, CDNDSC Commissioners, General Assembly, and panel members.
9. The Commission shall monitor agency progress on action steps for each recommendation via a process developed and implemented by CDNDSC staff. The Commission shall at least annually review all tracked ancillary factors to examine emerging trends, address critical findings and make recommendations for action as appropriate.
10. Progress on action steps will be shared with the panel by the panel chair during meetings when available. Action steps will be documented in the CDNDSC annual report.

FINAL REVIEW - Preparation

1. CDNDSC staff will monitor cases following completion of the initial review. Every six months, the CDNDSC staff will communicate with the Attorney General's Office panel representative to establish if any cases are ready to be released for a final review.
2. Upon release of a case for final review, CDNDSC staff will coordinate a meeting to include representatives from all investigating agencies, CDNDSC staff, and a representative from the OCA. The purpose of this meeting is to identify what previously unavailable records and/or witnesses are needed for the final review. The meeting shall include a review of any list of records or witnesses made by the panel during the initial review.
3. The records and witnesses will be requested from the appropriate agencies or entities by CDNDSC staff.
 - CDNDSC staff will provide the datasheets from the initial review to all involved governmental agencies represented on the Commission and request any relevant records that were previously unavailable. This information must be electronically sent to CDNDSC staff within one month of the request. If necessary, a subpoena may also be issued.
 - Records from governmental agencies represented on the Commission will be obtained via the completion of datasheets (to include a narrative section with dates). Records summarized in the datasheets must be relevant to the circumstances surrounding the death or near death.

- Datasheets must be electronically sent to CDNDSC staff within one month of the request. If necessary, a subpoena may also be issued.
- Records from governmental agencies not represented on the Commission or from non-governmental entities will be obtained via subpoena. CDNDSC Staff will promptly request the Attorney General's Office to issue such subpoenas.
 - Witness participation will be coordinated by CDNDSC staff. If necessary, a subpoena may be issued.
4. CDNDSC staff will:
 - Review original records and datasheets
 - Review previously unavailable records received;
 - Determine the need for additional records;
 - Request any and all additional records;
 - At the discretion of the Executive Director, a timeline may be completed of all submitted records for the purpose of assessing system issues.
 - Organize any materials received after the initial review including but not limited to letters to the Governor, Commission reports and past minutes pertaining to the case.
 5. Once all relevant records and witnesses are obtained, CDNDSC staff will schedule the case for the next available CAN Panel agenda unless otherwise assigned.

FINAL REVIEW – Process

1. Once the case is prepared and authorized for review, the CDNDSC staff will at least one month prior to the review:
 - Provide the panel members agency datasheets;
 - Request a medical professional on the panel to review any previously unavailable medical records and summarize them at the review.
 - Request the National Association of Social Worker's representative or mental health professional on the panel to review any previous unavailable mental health records and summarize them at the review.
2. At each panel meeting, all those present must comply with and sign the confidentiality statement for the review process. Confidentiality sheets are collected and maintained by CDNDSC staff. Specific identifying case information will remain confidential and restricted to panel and Commission members.
3. Witnesses and invited professionals will only be present for the discussion of facts relevant to their involvement in the case.
4. Panel members will orally provide and/or update their presentation, when applicable. The Attorney General's Office will provide a review of the criminal prosecution of the case.
5. If a panel member has been directly involved with the case, they may participate in the discussion but must abstain from voting. Likewise, panel members not present for the entire final review shall abstain from voting.

6. Each statutorily appointed agency/individual will have one vote regardless of the number of representatives at the meeting.
7. Following presentations of information and discussion, the process to be followed by the panel chair is as follows:
 - All invited individuals/witnesses shall be excused.
 - The chair asks the panel:
 - A. Were reasonable standards of practice met by the systems involved?
 - B. What recommendations or ancillary factors, if any, from the initial review are no longer appropriate?
 - C. What system practices or conditions, if any, impacted the death or near death?
 - D. What, if any, system practices or conditions related to the death or near death were ancillary to the incident but present opportunities for system-wide improvement?
 - Ancillary factors identified by the panel shall be compiled and tracked by CDNDSC staff, and presented at least annually to the Commission for possible action.
 - These ancillary factors will be identified in the Child Abuse Prevention and Treatment Act (“CAPTA”)³ final report on the case (see attachment 3).
 - E. System or case specific concerns that may impact the safety or mortality of children, but which occurred after the death or near death may be raised during the review. Prior to the conclusion of the review, the panel will identify the appropriate agency or entity to address the concerns. A response by said agency or entity to the panel is not required as it is beyond the purview of the CDNDSC. This does not preclude the reporting of:
 - Current suspected child abuse and neglect. In which case, the panel will determine the most appropriate person to make the report and what it should include;
 - Circumstances of suspected medical malpractice. This issue will be referred to the Commission for further action.
 - F. Are there recommendations for change to community behaviors, technologies, agency systems and/or laws that could improve system practices or conditions that impacted the death or near death?

If yes, the panel should move the discussion to developing recommendations.

If not, the final review is concluded.
8. Recommendations should focus on opportunities for improvement, should be action-oriented and should be written so that others not involved in the

³ The federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child’s near death or death. 42 U.S.C. §5106 a(b)(2)(A)(x). See also, 31 Del. C. § 323(a).

review understand how they logically relate to the death or near death. A recommendation put forth must meet the following criteria:

- The recommendation is clearly related to the case and is regarding those practices or conditions which impact the safety and mortality of children.
 - There is enough expertise around the table to ensure the recommendation is appropriate.
 - No further research is needed to make the recommendation.
 - An entity to take the lead on implementing the recommendation is identified.
9. An affirmative vote of sixty percent of those present is needed to adopt any recommendations.
 10. Once a vote on the recommendations is taken, there will be no additional discussion regarding the recommendations.
 11. CDNDSC staff in partnership with the Panel Chair will draft the final report including recommendations voted upon by the panel, and the CAPTA report [see attachment 3]. These reports will then be submitted to the Recommendation Subcommittee (this subcommittee is comprised of Commissioners who voluntarily participate). After the subcommittee's review of the recommendations and final report the Recommendation Subcommittee will either edit the reports or ask additional questions of the Child Death Specialist to research for the report. If the Child Death Specialist is unable to answer the subcommittee's questions or concerns, the case will be sent back to the panel for further clarification.
 12. The Child Death Specialist will draft panel minutes, to include circumstances of the case, panel discussion, ancillary issues, and recommendations for panel approval prior to the chair's use at the next scheduled Commission meeting.
 13. The final review is not concluded until the Commission has approved the findings of the panel. The panel chair will report back to the panel the outcome of the Commission meeting at which time all case related documents will be collected for shredding by CDNDSC staff.
 14. All data will be entered into a secured computerized database, which will be maintained by the CDNDSC staff.

FINAL REVIEW - Commission Responsibilities

1. The Commission members will attend scheduled meetings to review and consider the activities, findings and recommendations of the panel as reported by the panel chair.
2. The Commission will consider a de-identified case report of the facts and circumstances of the death or near death, any recommendations, any ancillary factors, and the CAPTA final report [see attachment 3] on the case presented by the Panel chair.
3. Following the presentation and discussion the Commission will consider the recommendations for approval.

4. The Commission will vote on the recommendations. A 60% or greater vote of the Commission is required to approve the recommendations.
5. If the Commission has additional questions or concerns regarding any aspect of a case, those questions or concerns will be directed to the appropriate agency/entity in the meeting or through CDNDSC staff.
6. Following the outcome of the review and approval of the Commission, CDNDSC staff will
 - Prepare and send letter to the Governor and the CAPTA report [see attachments 2 and 3],
 - Post the CAPTA report [attachment 3] to the CDNDSC website,
 - Prepare and send the letter to the specific agency named in the recommendation, and
 - Provide copies of the letters and the CAPTA report [see attachments 2 and 3], to the Child Protection Accountability Commission, CDNDSC Commissioners, General Assembly, and panel members.
7. The Commission shall monitor agency progress on action steps for each recommendation via a process developed and implemented by CDNDSC staff. The Commission shall at least annually review tracked ancillary factors to examine emerging trends, address critical findings and make recommendations for action as appropriate.
8. Progress on action steps will be shared with the panel by the panel chair during meetings when available. Action steps will be documented in the CDNDSC annual report.

Attachment 1 [SAMPLE]



STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE 19801-3341

DATE

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

Re: Initial Review of Child Death (or Near Death) due to Abuse/Neglect
CASE #

Dear Governor :

In accordance with 31 Del.C. §323(a), the CDNDSC has conducted an initial review of a child death [or near death, (as certified by a physician)] due to abuse or neglect. Upon completion of criminal prosecution, the Commission will conduct a final review of this case, and may put forth further recommendations at that time. Attached are the recommendations resulting from the initial review.

Thank you for the opportunity to oversee Delaware's Child Death Review Process, and for your commitment to the prevention of child abuse and neglect, and the elimination of child mortality in Delaware.

Sincerely,

Chair
Child Death, Near Death and Stillbirth Commission

cc: Members of the Delaware House of Representatives
Members of the Delaware Senate
Members of Child Death, Near Death and Stillbirth Commission
Members of the Child Protection Accountability Commission
CDNDSC, Correspondence File



STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE 19801-3341

Initial Review
Child Abuse and Neglect Panel Recommendations

CASE #

Manner of Death:

Upon completion of the initial review, it appears that:

all systems did/did not meet current standards of practice.

(If did not)

It appears further review of the () system(s) is required. In addition, CDNDSC offers the following recommendations:

(if "did")

While all systems appeared to have met the current standard or practice, the CDNDSC offers the following recommendation(s):

Attachment 2 [SAMPLE]



STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE 19801-3341

DATE

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

Re: Final Review of Child Death or Near Death due to Abuse/Neglect
CASE #

Dear Governor :

In accordance with 31 Del.C. §323(a), in month, year, the CDNDSC has conducted an initial review of a child death [or near death (as certified by a physician)] due to abuse or neglect. Following conclusion of the criminal proceedings, a final review was conducted and attached are the recommendations resulting from that final review. As a courtesy, the recommendation(s) from the initial review is(are) also attached, together with an update on the progress made on those recommendations. A CAPTA report on the case is also enclosed.

Thank you for the opportunity to oversee Delaware's Child Death Review Process, and for your commitment to the prevention of child abuse and neglect, and the elimination of child mortality in Delaware.

Sincerely,

Chair
Child Death, Near Death and Stillbirth Commission

cc: Members of the Delaware House of Representatives
Members of the Delaware Senate
Members of Child Death, Near Death and Stillbirth Commission
Members of the Child Protection Accountability Commission
CDNDSC, Correspondence File



STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE 19801-3341

Final Review
Child Abuse and Neglect Panel Recommendations

CASE #

Manner of Near Death:

Upon completion of the final review, it appears all systems did/did not meet current standards of practice.

(If did not)

It appears further review of the () system(s) is required. In addition, CDNDSC offers the following recommendations:

(if "did")

While all systems appeared to have met the current standard or practice, the CDNDSC offers the following recommendation(s):

Attachment 3

State of Delaware

Child Death, Near Death Stillbirth Commission ("CDNDSC")

CAPTA¹ Report

In the Matter of Melissa Wagner Minor Child²

April 18, 2008

¹ The federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child's near death or death. 42 U.S.C. §5106 a(b)(2)(A)(x). See also, 31 Del. C. § 323(a).

² To protect the confidentiality of the family, case workers, and other child protection professionals, pseudonyms have been assigned.

Background and Acknowledgements

The Child Death, Near Death and Stillbirth Commission (“CDNDSC”) was established in 1995. Its mission is to safeguard the health and safety of all Delaware children as set forth in 31 Del. C., Ch.. 3.

Multi-disciplinary Review Panels meet monthly and conduct a retrospective review of the history and circumstances surrounding each child’s death or near death and determine whether system recommendations are necessary to prevent a future death or near death. The Process brings professionals and experts from a variety of disciplines together to conduct retrospective case reviews, create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

Summary of Incident

Melissa, a two month old, was transported by ambulance to the hospital with reported respiratory problems and bleeding from the mouth. Upon arrival, nurses removed Melissa’s clothing and found numerous marks on her body. The forensic nurse reported to the DFS social worker that no head injuries were found but they were sure that Melissa’s injuries were the result of being shaken and slammed on a soft object, probably a bed. An x-ray revealed one of Melissa’s ribs was fractured. Prior to discharge, a parietal skull fracture was found which could have been caused from the birth process or from head trauma.

System Recommendations

At the conclusion of the final review there were no system issues identified that if corrected could have prevented this incident from occurring. No recommendations were made.

Ancillary Factors³

The following ancillary factors were identified and will be evaluated by CDNDSC for possible action:

- *Multi-generational history of abuse/neglect*
 - **Father:** The father has a long history as the victim of child abuse allegedly inflicted by his mother in another state. His mother was reported to have mental health issues and was violent in the home. There was a history of animal cruelty within the family. The father was temporarily placed outside of the home after attacking his mother. It was also stated that the Paternal Grandfather believed that Father was sexually abused by his older half brothers and that he had witnessed his older half brother sexually abuse his sister.

³ In some cases there may be no system practices or conditions that impacted the death or near death of the child; however if the Panel determines that there are ancillary factors which impact the safety or mortality of children, those factors are compiled by CDNDSC staff and presented at least annually to the Commission for possible action.

- Mother: There was past CPS involvement with Mother as a child in another state as Maternal Grandmother had significant mental health issues and financial instability. Maternal Grandmother also had a past history of suicide attempts, two of which were witnessed by her son. A DFS investigation was conducted for allegations of neglect by Maternal Grandmother.
- *Child witnessing domestic violence*
 - Family members reported that Father screamed at Mother every night in Melissa's presence but they did not feel it was appropriate to intervene.
 - Family members reported that they witnessed domestic violence (including while Mother was pregnant with Melissa) but did not want to make Mother mad and therefore did not contact the authorities or the DFS Hotline to make a report. Father has a history of threatening to kill Mother in the past as well as admitted anger and substance abuse issues.
 - Mother often denied domestic violence in the home but upon prompting from Maternal Grandmother admitted incidents where Father threw a lighter at her, had threatened to kill her, and had come after her with a hammer while she held Melissa.
- *Identification of risk factors so appropriate referrals may be made to Smart Start, Home Visiting Programs, etc.*
 - Teenage pregnancy and smoking were identified risk factors. Records indicated that Mother did receive prenatal care and was advised of the risk of cigarette smoking. Records did not reveal any indication that she was offered Home Visiting Services.
- *Mandatory reporting*
 - *Failure to report*
 - Reports indicated that Maternal Grandfather allegedly told Father after observing a bruise on Melissa's left ear and cheek that if Child was ever found with another mark, he would be thrown out of the house. No family members reported this incident to the DFS Child Abuse Hotline.