THE SECOND LOOK COMMISSION

ANNUAL REPORT HIGHLIGHTS 2023

The Second Look Commission (SLC) reviews cases of children across Tennessee who have experienced a second or subsequent incidence of severe abuse to identify ways to improve the system and help other children avoid a similar fate. The SLC publishes an annual report of their findings. This document outlines key information primarily contained in the 2023 annual report. The full report can be found at tn.gov/tccy.

Included Highlights

- Purpose of The Second Look Commission
- Economic Impact of Child Abuse
- FY2022 Case Data
- Findings & Recommendations
- Abuse Death Data

Purpose of The Second Look Commission

The Second Look Commission (SLC) was created in response to the need to review and improve how Tennessee handles severe child abuse cases, including child fatalities that are the result of a second or subsequent incident of severe abuse. The SLC was created in 2010 by Public Chapter 1060 (codified as TCA §37-3-801 et seq.) as a unique entity with a single purpose: to "review an appropriate sampling of cases involving a second or subsequent incident of severe child abuse in order to provide recommendations and findings to the general assembly regarding whether or not severe child abuse cases are handled in a manner that provides adequate protection to the children of this state."

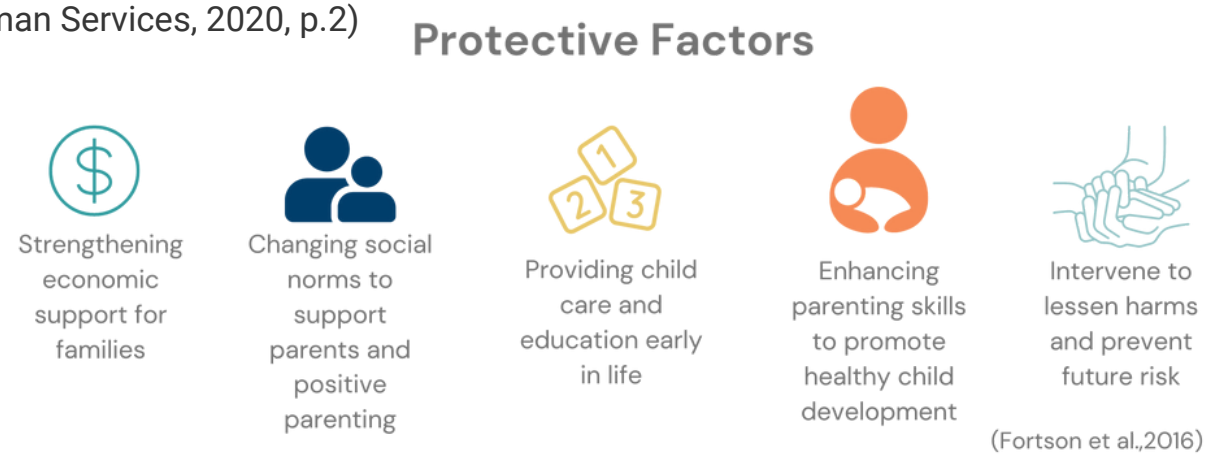
Economic Cost of Child Abuse and Neglect

This year the Second Look Commission and Tennessee Commission on Children and Youth partnered with The Boyd Center for Business and Economic Research at the University of Tennessee, Knoxville to study the economic cost of child abuse and neglect across Tennessee. In the study, published June 2023, the Boyd Center for Business and Economic Research found that the economic impact of substantiated claims of child abuse and neglect in Tennessee is between $3.33 and $4.97 billion annually. The report found each year there are an average of 11,668 children who were first-time substantiated victims of abuse or neglect. This equates to a one-in-eight chance that a child in Tennessee is a substantiated victim of child abuse by the time they reach adulthood.

Protective Factors

"A protective factors approach to the prevention of child maltreatment focuses on positive ways to engage families by emphasizing their strengths and what parents and caregivers are doing well, as well as identifying areas where families have room to grow with support.

Protective factors approaches also help children, youth, and families build resilience and develop skills, characteristics, knowledge, and relationships that offset risk exposure and contribute to both short- and long-term positive outcomes." (U.S. Dept. of Health and Human Services, 2020, p.2)



US Department of Health and Human Services. (2020). Protective factors approaches in child welfare. Child Welfare Information Gateway, March.Retrieved from: https://www.childwelfare.gov/pubpdfs/protective_factors.pdf

Fortson, B. L., Klevens, J., Merrick, M. T., Gilbert, L. K., & Alexander, S. P. (2016). Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

2021-2022 CASE DATA

The Department of Children's Services reported 599 children experienced a second or subsequent incident of severe child abuse in FY 2022.

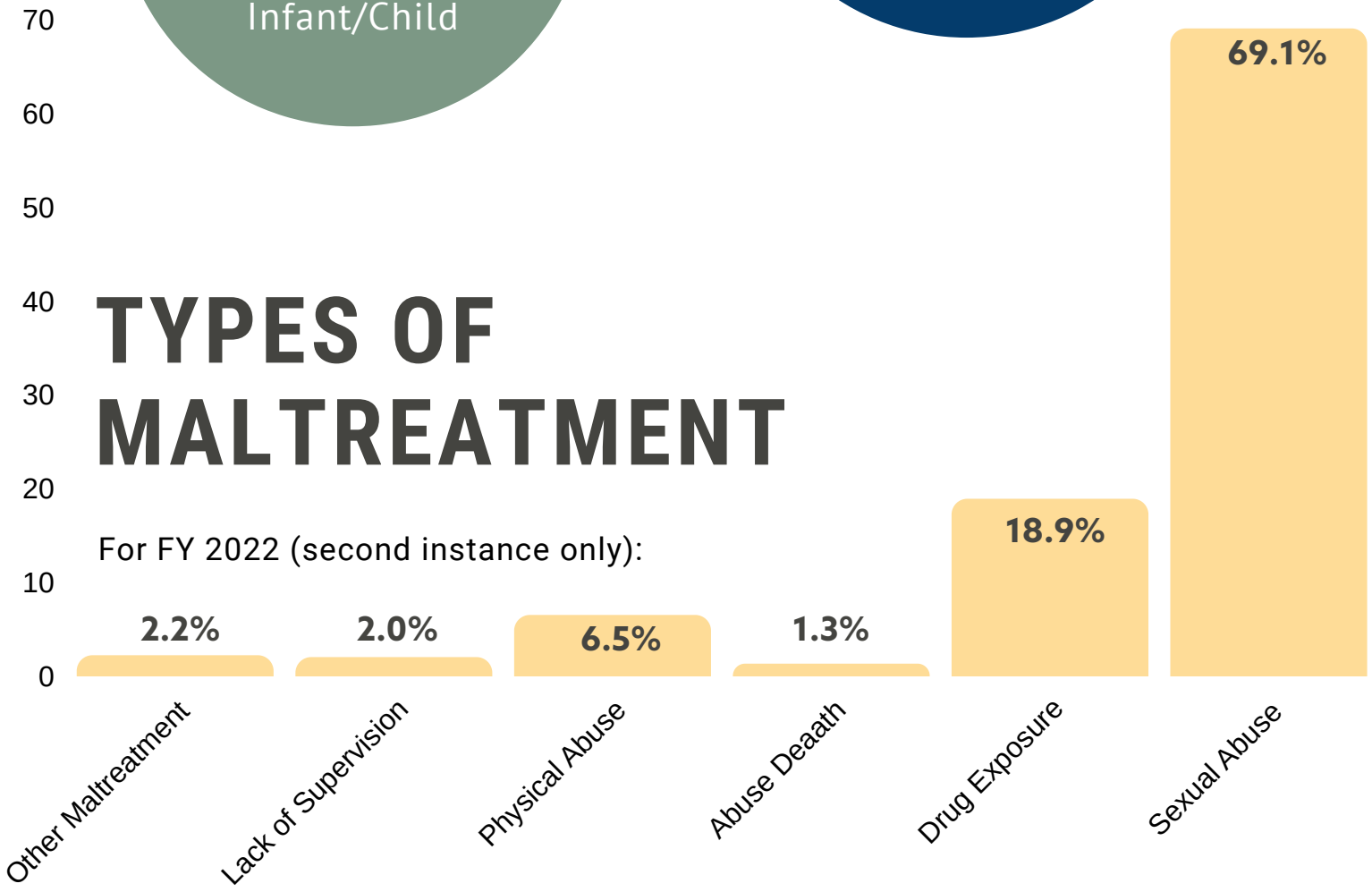
5.3%
increase in cases from FY2021.

599
Cases of second or subsequent severe abuse

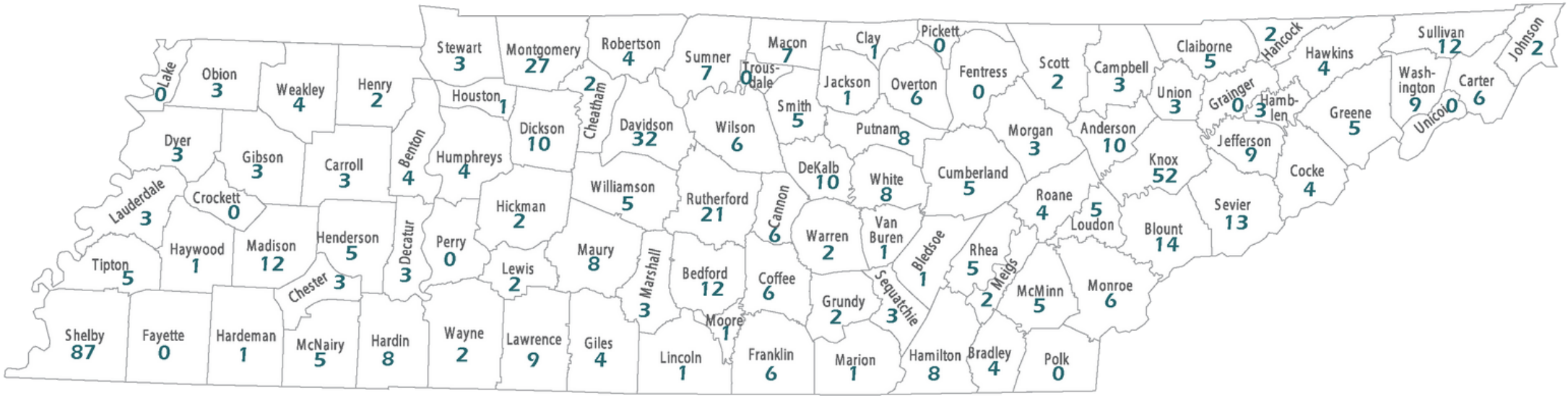
42%
of combined cases were Drug Exposed Infant/Child

TYPES OF MALTREATMENT

For FY 2022 (second instance only):



Reported cases in FY 2022 by county



Findings

Safety of Placements

Members expressed concerns with the safety conditions at several contracted providers.

Findings related to this include:

- In one case, a foster home was initially approved for two placements, yet had six children placed there. Members noted concern about why this exception was made and why the policy was not followed.
- Members noted the opportunity for a more in-depth evaluation of foster homes when allegations of abuse or inappropriate discipline arise.
- In one abuse death instance, members noted that the children were the foster parents' first placement and were a complex placement for the first time. Members questioned what resources, services, and supports were provided to the foster parents.
- Members noted concerns regarding how the foster mother and case worker spoke about the alleged child victim in their care. Members noted the opportunity for additional training for both the placement and worker.
- Members noted that the description of the bruising appeared to resemble a slap mark, not matching the explanation for the marks provided by the foster parents.
- Members were concerned with allegations of abuse at a residential treatment center. In one case, there was staff sexual abuse at a facility.
- Allegations of contraband being provided by staff at a facility did not result in a law enforcement investigation or criminal charges.

In some cases, visitation or custody was granted to caregivers who had unresolved criminal charges or substantiations placing the children at risk of harm.

Findings related to this include:

- Members questioned why a grandmother had supervised visitation with a child when she has pending criminal charges and a severe abuse substantiation by DCS.
- Members had concerns that the mother had been substantiated and charged with severe abuse, yet the children were returned to her while she was on probation for the severe abuse charges.

In several cases, members noted that custody determinations or relative caregiver placements allowed contact with caregivers that presented an ongoing risk to the child's safety or stability.

Findings related to this include:

- In one instance, the child was allowed to remain in the home of someone who resided with a person convicted of sexual offenses against a child and was a registered violent sex offender.
- Members stated concerns about the children remaining in the grandmother's home after multiple allegations of abuse.
- In one instance, the mother was deemed to be protective of the child, but was sending the child to her grandparent’s house anytime the alleged perpetrator would come over. Members questioned how sustainable and protective that is.

Recommendations

Safety of Placements

Establish in the Department of Children's Services Policy that if a Special Investigations Unit investigation leads to the substantiation of an abuse death or near death at a licensed provider, the Office of Child Welfare Licensing and Office of Continuous Quality Improvement will conduct a review of the provider's practices to ensure compliance and safety. Upon completion, the review will be provided to the Commissioner of the Department of Children’s Services.

Members noted that first-time foster parents are experiencing a significant change and may need additional support during the transition. Currently, all new placements (regardless of the foster parent's tenure) are to receive a case worker visit within 3 days. New foster parents will receive a call and visit with the Foster Parent Support Worker and be connected to a Foster Parent Mentor. Considering the challenges that may arise as a first-time foster parent, members recommended requiring more frequent in-home caseworker visits for both DCS foster homes and third-party providers to ease the transition over the first 3 months.

Allegations of contraband being provided by staff to children at residential facilities should be investigated by law enforcement.

While custody is determined through the court, the judges make that determination based on the information provided to them through the various parties. Ensuring that the court has all of the available information to make the best decision possible regarding custody and visitation is critical to ensuring the best and safest outcomes for children.

Findings

Investigations

In several of the abuse death cases, members noted the need for additional communication regarding autopsies and the challenges that arise when that does not happen.

Findings related to this include:

- Investigators were unable to get a preliminary autopsy finding in one case. If law enforcement had known smothering could have been a potential cause of death, they may have approached the investigation differently.
- Members noted the challenges that come when the investigating officer changes, particularly when there is not yet a preliminary or final autopsy available.
- In one abuse death case, the autopsy took three and a half years.
- Members noted these significant autopsy delays appear to be regional/location-specific. DCS has established a system to reach out to the medical examiner's office in the event of a delay.
- There is an opportunity for better communication from the medical examiner's office as autopsy results are pending.
- Members noted law enforcement in smaller counties often are not able to attend autopsies, making communication critical.

In several cases, members found opportunities for a more thorough investigation into the alleged abuse.

Findings related to this include:

- In one case, it appears that the former foster mother of the alleged perpetrator may have babysat the alleged child victim shortly before the child's death. It does not appear that the former foster mother was contacted as a part of the investigation into the death of the child.
- During the course of an investigation, the child disclosed sexual advances and grooming behaviors from their stepfather, but this was not followed up on. A year later, when they disclosed again there was an investigation, resulting in him being substantiated and charged criminally.
- Members had concerns that a hotline call alleging methamphetamine use and concerns of postpartum depression with psychotic features was screened in as a P2 Assessment.
- Upon review of case notes and findings, members expressed concern that decisions made and interpretation of evidence may have been impacted by confirmation bias in favor of the foster parents.
- Members questioned why there was not a hair follicle test done on the alleged child victim after several allegations of a drug-exposed child.
- Members noted concerns that the sibling in the home was not interviewed regarding sexual abuse after a disclosure from another sibling.
- Members noted the case had multiple allegations that were Unsubstantiated or No Services Needed. Members wondered if these multiple cases contributed to alarm fatigue.
- Members noted in one case there were repeated allegations of drug exposure that were not properly investigated.
- Members noted concerns that the grandmother would not allow the child to participate in a forensic interview. It does not appear that there was an effort made to court order the forensic interview.
- There was concern that a detective didn't act with enough urgency to interview the alleged perpetrator, members thought this two-month delay may have given the family members time to work out a consistent story.

Recommendations

Investigations

Ensure that medical examiners understand the importance of a preliminary autopsy finding and the benefits it provides to the investigation process.

Evaluate current Child Protective Services (CPS) caseloads to determine the number of workers with over 20 open cases. Examine if the current policy of determining caseloads by a regional monthly average allows caseworkers enough time and capacity to conduct their investigations to the best of their abilities. In addition, while CPS and Foster Care, Juvenile Justice, Family Support Services, and Family Crisis Intervention Program caseworkers are to have no more than a regional monthly average of 20 cases, CPS worker's cases are counted by the family while all others are by the child. Considering this, DCS should evaluate if the number of cases for CPS workers should be decreased.

Findings

Multi-Disciplinary Investigations

Members noted concerns with the consistency regarding the availability of forensic interview recordings.

Members questioned if the Department of Children's Services ever partners with law enforcement investigators to search through cell phones or other devices for potentially sexually explicit materials or communication.

Members expressed a significant need for additional training on the complexities of abuse, particularly sexual abuse, among Child Protective Investigation Team members.

Findings related to this include:

- Members expressed significant concerns with members participating in CPIT and making determinations on substantiations without adequate training on abuse, particularly sexual abuse.
- Members had concerns about detectives not being adequately trained on the complexities of sexual abuse cases and disclosures from children.
- Members noted a need for additional training regarding all types of abuse, particularly sexual abuse and domestic violence.

While members felt the need for in-depth training for CPIT partners as mentioned above, they also expressed the need for additional or enhanced broad training available for patrol law enforcement who might respond to a domestic violence or runaway situation.

Recommendations

Multi-Disciplinary Investigations

The Child Advocacy Centers have begun using a digital evidence software, VidaNyx for forensic interviews. Members are hopeful that the implementation of this software will make forensic interviews more accessible for parties that need access while maintaining their security.

Considering the large number of stakeholders involved with children who have experienced maltreatment or victimization, the sharing of data and information is critical. Tennessee should evaluate how to best share data across stakeholders while maintaining appropriate privacy and protection.

The Department of Children's Services Office of General Counsel should establish a policy on when and how investigators can partner with law enforcement to extract evidence from phones or other devices.

Individuals investigating child abuse or participating in CPIT should receive annual training provided by the Child Advocacy Centers focused on the function of CPIT, changes to statutes, and the complexities of child abuse. In previous years, members noted the need to evaluate the state's current capacity to implement such training. The training should be developed in consultation with child abuse prevention stakeholders and approved by the Joint Taskforce on Children's Justice.

Even law enforcement who do not typically investigate instances of child abuse may be called to a scene with a child who has experienced abuse or significant trauma. Members recommended the Second Look Commission and The Joint Task Force on Children's Justice review the training material provided in P.O.S.T and provide recommendations.

Findings

No Contact Orders & Medical

In multiple cases reviewed by the commission, an existing No Contact Order was violated placing the child in danger.

Findings related to this include:

- **In one case, the alleged perpetrator was substantiated for a near-death case with the alleged child victim. A No Contact Order between the alleged perpetrator and alleged child victim was court ordered. The order was violated and led to the abuse death of the alleged child victim.**
- **Members have reviewed several cases where the mothers are not appropriately protective of their daughters who have been sexually abused, even violating court orders. This is particularly common when the alleged perpetrator is their spouse, boyfriend, or paramour.**

Members found that when law enforcement or the Department of Children's Services are addressing a situation, they are often not aware of or able to easily access information regarding existing No Contact Orders between the caregiver and child.

An alleged child victim presented to a pediatrician's office once for being difficult to arouse or potential sedation and once for bruising on their ear. Both situations are concerning for abuse, but do not appear to have been reported.

Members noted that although a cause of death was found to be undetermined, pediatricians treating the child's injuries reiterated that while the level of injury could be caused by an adult falling, it would not be possible for that to occur by a child of that size falling.

Recommendations

No Contact Orders & Medical

For many years, the Second Look Commission has noted violations of No Contact Orders placing children in danger. The Commission continues to reiterate the importance of courts clearly explaining, orally and in written word, the scope and duration of No Contact Orders. The courts should reiterate that the No Contact Order does not expire at the conclusion of the Department of Children's Service's case.

TCA 37-4-414 (e)(2)(b)(i) establishes a criminal offense specific to the violation of a No Contact Order by a Kinship Foster Placement. Since this is newly passed legislation, ensuring Kinship Foster Care placements are aware of the consequences they face if they knowingly allow the parent to violate a No Contact Order should be a high priority during the onboarding process.

The SLC recommends the creation of a database of No Contact Orders, from both General Sessions and Juvenile Court, to be accessed by law enforcement and DCS investigators. The members discussed the Tennessee Fusion Center as a potential partner. Members stressed the importance of the database staying up to date, both for the implementation of a new order and amendments to an existing order. This can either be achieved through an automatic system such as Quest in the juvenile courts or through legislation requiring courts to input the information within a given time.

Training and reminders on the typical injuries or signs associated with child abuse should be provided to all professionals working in medical facilities, especially pediatrician's offices.

Communication and mutual understanding between medical examiners and medical providers is critical in determining the appropriate cause of death.

Findings

Services

Members found wrap-around services provided to families during challenging times to be a strength and potentially mitigate further abuse from occurring.

Findings related to this include:

- In one case, when the child was placed with another caregiver following the death of their sibling, the caregiver was given extensive family support services to ease the transition. Members noted this as a strength that likely prevented further challenges.
- Members were encouraged that the ACV had intensive in-home services from youth villages considering the trauma they had experienced.
- Members noted that when the mother had access to support from a Multi-Agency Collaboration things seemed to be going well.

Members felt parties in several cases would have benefited from additional services.

- Members noted one of the greatest challenges across cases reviewed is a lack of available and appropriate services across the state.
- In one case, members questioned if the mother had gone through enough services and treatment prior to the children returning home. Members noted anger management classes were not on the alleged perpetrator's permanency plan, but strongly felt they should be.
- Members noted concerns about not increasing services for a child. Upon review of the case information, members felt some of the behaviors being exhibited might have been stemming from mental health concerns, but services were not increased.
- Members noted that there is a continued need for more support and counseling for family members/caregivers.
- Members noted that it is not surprising that a child with multiple disclosures of sexual abuse ends up being sexually reactive.

For several years, members have noted the importance of engaging fathers in the custody process. Members noted that paternal extended family can be an important potential placement or support system.

Recommendations

Services

Members were encouraged by the improvements seen when wrap-around support services were provided to caregivers. Members would like to see these programs expanded with a focus on evaluating the best way to safely and successfully transition caregivers out of services.

Access to appropriate services continues to be a need for children in the child welfare system. The General Assembly should commission a study to aggregate and analyze the existing reports regarding the service needs and availability across the state. The study should include input from stakeholders such as the Department of Children's Services and other state agencies, juvenile courts, Child Advocacy Centers, children's hospitals, residential mental health providers, outpatient mental health providers, and children/families with lived experience in the child welfare system.

The Administrative Office of the Courts develops Bench Cards each year. These cards are provided to the courts and outline the services and providers available in the community. Although these are designed to be a service and support to the court, they are publicly available and can be a resource for others in the community looking for information regarding service availability.

ABOUT SLC ABUSE DEATH REVIEW

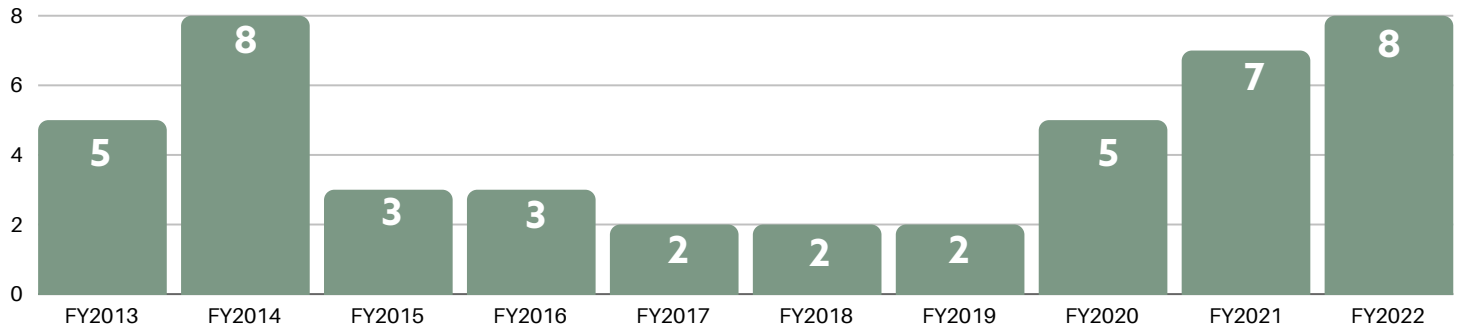
The fiscal years listed throughout the report reflect the disposition date. In many cases, these fall into the same year as the occurrence of abuse, however sometimes with more complicated cases, such as an abuse death, there is a longer timeframe between the occurrence and the disposition.

There were eight instances of a second or subsequent incident of severe child abuse resulting in a death in the SLC's FY 2022 case review. This represents another increase from previous years, matching FY2014 for the highest number reviewed by the SLC.

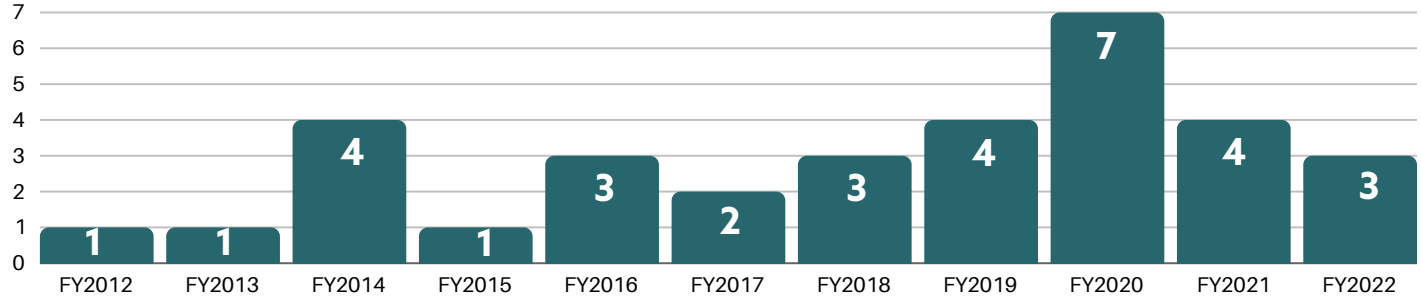
As mentioned earlier, there is often a longer timeframe to reach a disposition in child death cases meaning in many of the cases reviewed by the SLC, the death did not occur in the same fiscal year as the disposition. First chart outlines the number of cases reviewed by SLC (based on the date of disposition) whereas the second chart outlines the trends by date of death.

The number of cases listed here do not reflect all instances of child abuse deaths, just those that meet the Commission's statutory authority, meaning the child had experienced a previous incident of substantiated abuse prior to their death.

Second or Subsequent Incident of Severe Child Abuse Death Cases Based on Date of Disposition



Second or Subsequent Incident of Severe Child Abuse Death Cases Based on Date of Death



The SLC reviews every abuse death that meets the commissions statutory authority. In this year's review of abuse death cases, included eight deaths that occurred between 2018-2022. Based upon the timeframe to reach dispositions in abuse death cases, it is not clear if the decline in 2021 and 2022 is a true decline or if those cases are still being investigated.

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TENNESSEE
COMMISSION ON
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