Second Look Commission
2014 Annual Report

Tennessee Commission on Children and Youth

502 Deaderick Street

Nashville, TN 37243-0800

Tennessee Commission on Children and Youth authorization number 316627. December 2014. 300 copies. This public document was promulgated at a cost of $1.89 each.

Introduction

The Second Look Commission (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 make findings and recommendations regarding whether severe abuse cases are handled in a manner that provides adequate protection for the children of Tennessee. The SLC is the only entity designed by statute to bring together representatives of all key stakeholders in the child protection system in Tennessee: members of the General Assembly, Department of Children's Services (DCS), law enforcement (including the Tennessee Bureau of Investigation and officers from urban and rural areas), district attorneys general, public defenders, courts, child advocacy centers, a physician who specializes in child abuse detection, and other children's advocates. The SLC is the only entity with statutory authority to hold closed meetings to critically analyze confidential information in individual cases, and also to compel participants in the investigation and disposition of the cases reviewed to appear before it to discuss issues and answer questions. The SLC is the vehicle for representatives of these key groups to meet together to review cases and identify strategies for improving child protection in Tennessee.

The SLC reviews some of the worst incidents of child abuse and neglect in Tennessee. Only the Second Look Commission reviews cases of children from all 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. Special, concentrated efforts must also be devoted to analyzing and responding to the tragedy of child abuse. The SLC was created as a catalyst to facilitate improved response to child abuse. The composition of the SLC includes representatives of all key stakeholders and disciplines and members of the General Assembly, and it has facilitated much needed communication and collaboration.

Many departments, agencies, entities and community members are involved in a wide range of efforts to protect Tennessee's children from child abuse and neglect and properly respond to such abuse when it occurs. In various degrees and manners, all these child advocates collaborate to provide better protection for our children. Despite their ongoing efforts, Tennessee's children are still traumatized by the horrific experiences of repeated incidents of severe child abuse. The issues regarding severe child abuse cannot be adequately addressed by DCS, TCCY, Child Advocacy Centers, law enforcement or any one organization, or community agency or individual. All stakeholders must come together to address this societal problem in a coordinated and concerted manner. The 1980s brought a dramatic increase in acknowledgement of child sexual abuse and a growing awareness that child protective services, law enforcement, and the criminal justice system were not working together in response to child abuse allegations. In 1985, the Tennessee General Assembly recognized the complex nature of these cases and enacted legislation that established Child Protective Investigative Teams (CPIT). CPITs across the state are composed of professionals who bring a diversity of skills, backgrounds and training

to the investigation. Team members include representatives of child protective services, law enforcement, child advocacy center staff, district attorneys, mental health and juvenile court. In 1990, Children's Advocacy Centers (CACs) developed in Tennessee as child-focused, facility based programs where representatives from CPITs work together to conduct investigations and make team decisions regarding severe child abuse cases.

As a result of these reforms, most sexually and severely abused children are interviewed in child-friendly environments by professionals skilled in conducting these interviews. The investigation and prosecution of these cases has also improved tremendously in recent decades. Despite these and other reforms, more remains to be done. It is our hope that the proposed recommendations of the SLC will be embraced and implemented and will spur child protection professionals to engage in meaningful dialogue that will produce additional ideas for reducing repeat abuse of our children.

Impact of Child Abuse

The future prosperity of any society depends on its ability to foster the health and well-being of the next generation. When a society invests wisely in children and families, the next generation will pay that back through a lifetime of productivity and responsible citizenship.

The basic architecture of the human brain is constructed through an ongoing process that begins before birth and continues into adulthood. Like the construction of a home, the building process begins with laying the foundation, framing the rooms and wiring the electrical system in a predictable sequence. Early experiences literally shape how the brain gets built; a strong foundation in the early years increases the probability of positive outcomes. A weak foundation increases the odds of later difficulties. The interactive influences of genes and experience shape the developing brain. The active ingredient is the "serve and return" relationships with their parents and other caregivers in their family or community. Like the process of serve and return in games such as tennis and volleyball, young children naturally reach out for interaction through babbling and facial expressions. If adults do not respond by getting in sync and doing the same kind of vocalizing and gesturing back at them, the child's learning process is incomplete. This has negative implications for later learning.

Chronic stressful conditions such as extreme poverty, child abuse or maternal depression – what some scientists call "toxic stress" – can also disrupt the architecture of the developing brain. This can lead to lifelong difficulties in learning, memory and self-regulation.

Children who experience the trauma of child abuse are more likely to have difficulty developing trusting relationships. They are less likely to be successful in school and more likely to exhibit behavior problems. They are more likely to have mental health and substance abuse treatment needs. Even in adulthood, they are more likely to experience challenges maintaining stable

relationships and employment. Too frequently, child abuse is intergenerational, and effective responses to first instances of abuse are more likely to reduce future abuse not only to that individual child, but to future generations.

In what is reportedly the first major study of child abuse and neglect in 20 years (http://www.iom.edu/reports/2013/new-directions-in-child-abuse-and-neglect-research.aspx), researchers with the National Academy of Sciences reported on September 12, 2013, the damaging consequences of abuse can not only reshape a child's brain but also last a lifetime. "What the committee sees as hopeful is the evidence of changing environments can change brain development, health, and behavioral outcomes. There is a window of opportunity, with developmental tasks becoming increasingly more challenging to negotiate with continued abuse and neglect over time." (pg 4-37).

> As reported by the Centers for Disease Control and Prevention in "The Effects of Childhood Stress Across the Lifespan," researchers have identified a link between Adverse Childhood Experiences (ACE) and adult health. Research identified particularly strong links between exposure to violence, especially child abuse, neglect and domestic violence, with risky behaviors and health problems in adulthood (Middlebrooks, 2008).
>
> The study demonstrated that Adverse Childhood Experiences are common, with two-thirds of the over 17,000 participants reporting at least one ACE, and one in five reporting three or more. ACEs were associated with increased risky health behaviors in childhood and adolescence, including increased sexual activity and unintended pregnancies, suicide attempts, smoking and illicit drug and underage alcohol abuse. As the number of ACEs increased, so did the likelihood of adult health problems, such as alcoholism and drug abuse, depression, chronic obstructive pulmonary disease, heart disease, liver disease, as well as increased risk of intimate partner violence, multiple sexual partners, sexually transmitted diseases and unintended pregnancies. Smoking and suicide attempts also went up.
>
> Those experiencing child sexual abuse were more likely to experience multiple other ACEs, increasing as the severity, duration and frequency of the sexual abuse increased or as the age of first occurrence decreased. Both men (one in six) and women (one in four) experiencing child sexual abuse were twice as likely to report suicide attempts. Female victims who reported four or more types of abuse were one and a half times more likely to have an unintended pregnancy, and men experiencing physical abuse, sexual abuse or domestic violence were more likely to be involved in a teenage pregnancy.
>
> Additionally, the authors of the study found that adverse childhood experiences affected health throughout the lifespan, first in health risks during childhood and

adolescence, then in disease during young adulthood and then in death. Over a lifetime, across the population, medical visits generally fall into a pattern of fewer visits by younger adults in their 20s and 30s, increasing proportionally with age, with the most medical visits occurring in the over 65 age group. That was the pattern of the study among those with an ACE score of 0. Among those with an ACE score of two, the pattern is reversed: the youngest age group had the most medical visits, decreasing proportionally with age, and those in the over 65 age group, the least. At an ACE score of four, those over 65, who would be expected to have greatest number of visits, had almost disappeared. Although research is ongoing, the investigators believe that those participants with two or more ACEs die at a younger age.

Clearly the ACE study demonstrates the importance of prevention and early intervention and support for children suffering adverse childhood experiences in order for them to live longer, healthier, happier, more productive lives.

KIDS COUNT – The State of the Child in Tennessee 2012 (pp. 4, 5)

Preventing child abuse and intervening effectively when it first occurs are keys to avoiding lifelong negative consequences from child abuse. Cases reviewed by the Second Look Commission make it abundantly clear that there are gaping holes in the systems responding to child maltreatment in Tennessee. As a state, we can and we must identify and implement strategies to ensure children who experience severe abuse, who are among the most vulnerable Tennesseans, receive the protection and remediation assistance they deserve. It will take a concerted and sustained effort to peel away the many layers of this complex issue to get to the core. Additional time and effort are required to competently and adequately address the issues and problems.

2014 FINDINGS AND RECOMMENDATIONS

The 2013 fiscal year list of cases contained maltreatment types not included in previous lists. Most notably, the 2013 fiscal year list of cases contained abuse and neglect deaths. The SLC does not believe this is the first time cases containing these maltreatment types satisfied the statutory definition for the types of cases to be reviewed by the SLC. DCS used a different and more accurate formula to create the list of cases mandated by statute.

After reviewing the list of cases, the SLC decided to review all five of the abuse and neglect death cases as well as focusing a sampling of cases representative of the higher maltreatment type percentages. Additionally, The SLC also considered when the incidents of abuse occurred. In the past, SLC members have reviewed cases in which DCS indicated the first incident of abuse as many as seven years before the second incident of abuse. Many of the laws, policies, procedures and practices in place and prevalent during the first incident of abuse were no longer applicable during the time of the SLC review. Accordingly, excluding death cases, the SLC decided to limit its review to cases in which the first and second incident of abuse occurred within three years of the previous fiscal year.

For each case reviewed, the SLC gathers information from various individuals, departments and agencies. The documentation gathered by the SLC typically includes records from the following, when applicable: DCS, medical service providers, juvenile courts, law enforcement, criminal courts, educational systems, child advocacy centers and various service provider records. In addition to gathering documentation, the SLC obtains additional information through email requests, telephone calls and site visits. The director of the SLC reviews all of the gathered information and provides a written case summary of the cases the SLC will review one week prior to the investigatory meeting of the SLC. The average number of pages of the summaries for the cases reviewed by the SLC during 2014 is approximately 32. Members of the SLC read the summaries prior to the investigatory meetings and arrive at the meetings prepared to thoroughly analyze each case.

The list of cases provided by DCS for fiscal year 2012-2013 (FY 2013) reported 605 children experienced a second or subsequent incident of severe child abuse. Similar to last year, sexual abuse was the most prevalent type of severe child abuse. Sexual abuse accounted for approximately 75 percent of the severe abuse represented in the FY 2013 list of cases. The second most prevalent type of severe abuse was drug exposed child. Drug exposed child maltreatment accounted for approximately 15 percent of the severe abuse represented in the FY 2013 list of cases.

As in previous years, the review process was often painful as members considered the horrific experiences endured by the children whose cases were reviewed, and through the review process could see missed opportunities that could have prevented repeat abuse. Although there continues to be opportunities to improve the manner in which severe child abuse cases are being handled in Tennessee, changes continue to occur which will likely have a positive impact on reducing the rate and consequences of severe child abuse.

2014 Findings and Recommendations

The following findings and recommendations are primarily based on the cases reviewed during the 2014 calendar year:

- Tennessee, through the Office of the Chief Medical Examiner, should implement a statewide medical examiner system;
- Amend TCA § 37-1-403(d) to make it clear a person who has reasonable cause to suspect a child died as a result of child abuse must report their reasonable suspicion to the appropriate medical examiner *and DCS*;
- DCS should provide training to help DCS child protective service (CPS) investigators and assessors fully appreciate the potential impact drug abuse has on a child being cared for by someone abusing drugs;

- Parents, caregivers and other appropriate parties should be drug screened when a child is potentially the victim of severe child abuse and the parent, caregiver and other appropriate parties have a history of drug abuse;

- DCS is encouraged, through training and other appropriate measures, to continue to equip its CPS investigators and assessors with the knowledge to determine when parents, caregivers and other appropriate parties should be drug screened, especially in child death cases;

- Professionals must stress the need to evaluate children who may have been exposed to methamphetamines or the manufacturing process, at any phase of the process;

- The opportunity to improve communication within DCS and between DCS and various stakeholders continues;

- The Administrative Office of the Courts should incorporate clarifying prohibitions of "No Unsupervised Contact Orders" in the training it provides to Juvenile Court Judges and Magistrates;

- There is a continued need to stress the importance of issue-driven investigations as opposed to incident-driven investigations;

- Proper DCS documentation continues to be an issue;

    - DCS should conduct and document all appropriate collateral interviews;

    - DCS training must emphasize the necessity of including a closing summary in TFACTS recordings;

- Failure to report child abuse continues to be an issue;

- Tennessee should provide even more education regarding safe sleeping;

- District attorneys and assistant district attorneys (collectively referred to as DAs) need to collect data on the number of and handling of crimes against children cases;

- Each county, or at least each judicial district, should have a DA dedicated to handling cases involving crimes against children; and

- The General Assembly should form a committee to research what additional resources DAs may need to appropriately address crimes against children.

The report will now address these findings and recommendations in greater detail.

Child Fatality Matters

This is the first year the list of cases provided to the SLC contained child death cases. In the past, the SLC reviewed a stratified random sampling of cases. This year the SLC incorporated a two-pronged approach. The SLC reviewed all the child death cases as well as a stratified random sampling of other types of severe child abuse cases.

Through its Child Fatality Review Teams, Tennessee investigates the deaths of all children in the state of Tennessee. However, deaths from abuse or neglect can be more difficult to investigate than deaths from accidents and illness. The need to timely and accurately obtain data in these cases cannot be understated.

In 2014, the Child Welfare Information Gateway published a report entitled *Child Abuse and Neglect Fatalities 2012:Statistics and Interventions* (Gateway Report). In part, the Gateway Report stated:

> Many researchers and practitioners believe that child fatalities due to abuse and neglect are still underreported. A recent report on national child abuse and neglect deaths in the United States estimates that approximately 50 percent of deaths reported as "unintentional injury deaths" are reclassified after further investigation by medical and forensic experts as deaths due to maltreatment (Every Child Matters Education Fund, 2012). It also is often more difficult to establish whether a fatality was caused by neglect than it is to establish a physical abuse fatality. The different agencies that come into contact with a case of a possible child neglect fatality may have differing definitions of what constitutes neglect, and these definitions may be influenced by the laws, regulations, and standards of each agency (Schnitzer, Gulino, & Yuan, in press).

The Gateway Report also identified several issues affecting the accuracy and consistency of child death data, some of which the SLC found applicable in Tennessee based on information provided to the SLC. They are as follows: variations in death investigation systems and training, variations in reporting processes, the length of time it may take to establish abuse or neglect as the cause of death and the lack of coordination or cooperation among different agencies and jurisdictions. *Child Abuse and Neglect Fatalities 2012:Statistics and Interventions, Child Welfare Information Gateway*. Available online at https://www.childwelfare.gov/pubs/factsheets/fatality.cfm. For example, in one case reviewed by the SLC, the investigation of the case had to remain open approximately 30 days past the time period set forth pursuant to DCS policy to close the case because the final autopsy report had not been received by DCS. Documentation indicated the report was available approximately two months before DCS received it. The timely provision of autopsy reports will likely improve child death investigations and protect other children in the home from potential abusive harm or trauma experienced due to removal from the home. This case highlighted a great opportunity to not only improve the way Tennessee handles severe child abuse cases, but also improve death investigations in Tennessee.

The SLC recommends Tennessee implement a statewide medical examiner system. Tennessee has five regional autopsy centers. The five regional autopsy centers perform autopsies in a manner consistent with the National Association of Medical Examiners (NAME) accreditation. The NAME "Accreditation Standards have been prepared and revised by NAME for the purpose of improving the quality of the medicolegal investigation of death in this country. Accreditation applies to offices and systems, not individual practitioners. The standards emphasize policies and procedures, not professional work product. The standards represent minimum standards for an adequate medicolegal system, not guidelines. NAME accreditation is an endorsement by NAME that the office or system provides an adequate environment for a medical examiner in which to practice his or her profession and provides reasonable assurances that the office or system well serves its jurisdiction. It is the objective of NAME that the application of these standards will aid materially in developing and maintaining a high caliber of medicolegal investigation of death for the communities and jurisdictions in which they operate." https://netforum.avectra.com/eweb/DynamicPage.aspx?Site=NAME&WebCode=Accred.

Although these five regional autopsy centers perform autopsies in a manner consistent with NAME accreditation, Tennessee lacks consistency in the manner and quality in death investigations, in part, because we do not have a statewide medical examiner system. In general, a County Medical Examiner must have the degree of doctor of medicine (M.D.) and be duly licensed in Tennessee. Each county has a medical examiner and the medical examiner answers to the examiner's respective county. Counties function independently resulting in chaotic practices that often do not meet minimum standards. Additionally, the regional autopsy centers are not funded by the state. There is no accountability to the state. The current medical examiner system does not provide accountability or oversight for the quality of death investigations throughout Tennessee.

Members of the SLC recommend the Office of the Chief Medical Examiner implement a statewide medical examiner system to provide high standards and uniform practices throughout the state. An appropriate starting point is to give the Chief Medical Examiner the authority to mandate compliance with appropriate standards in completing death investigations and autopsies.

The SLC is also concerned about the timely reporting of child deaths to DCS. The delay in notification potentially places other children in danger and increases the difficulty to obtain valuable information due to the passage of time. Pursuant to Tennessee Code Annotated (TCA) § 68-142-107(a)(2), child fatality reviews teams must review all deaths of children seventeen years of age or younger. Accordingly, every child death is reported to a child fatality review team. However, all child deaths are not reported to DCS for investigation. TCA § 37-1-403(a)(1) states, "Any person who has knowledge of or is called upon to render aid to any child who is suffering from or has sustained any wound, injury, disability, or physical or mental condition shall report such harm immediately if the harm is of such a nature as to reasonably indicate that it has been caused by brutality, abuse or neglect or that, on the basis of available

information, reasonably appears to have been caused by brutality, abuse or neglect." Accordingly, only those child deaths in which the death reasonably appears to have been caused by brutality, abuse or neglect must be reported to DCS. Any unnecessary delay in determining whether there is reason to believe a child death was caused by brutality, abuse or neglect unnecessarily delays an investigation by DCS. Justice delayed is justice denied. In one case reviewed by the SLC, DCS did not receive a referral in a child death matter until 22 days after the child's death.

In the same child death matter referenced above, the child who was the subject of the review (John) had a sibling (Jane) who died approximately four months prior John's death. DCS did not learn of Jane's death until DCS received the referral for John's death (22 days after John died). Although CPIT subsequently classified Jane's death as Unsubstantiated for Neglect Death, reporting the death to DCS approximately four months after the death is still concerning.

These delays in reporting appropriate child deaths to DCS may also be caused by statutory language. TCA § 37-1-403(d) states, "Any person required to report or investigate cases of suspected child abuse who has reasonable cause to suspect that a child died as a result of child abuse shall report such suspicion to the appropriate medical examiner. The medical examiner shall accept the report for investigation and shall report the medical examiner's findings, in writing, to the local law enforcement agency, the appropriate district attorney general, and the department. Autopsy reports maintained by the medical examiner shall not be subject to the confidentiality requirements provided for in § 37-1-409." This language may cause individuals to report "suspicious" child deaths to the medical examiner to the exclusion of DCS. ***The SLC recommends amending TCA § 37-1-403(d) so the first sentence reads as follows, "Any person required to report or investigate cases of suspected child abuse who has reasonable cause to suspect that a child died as a result of child abuse shall report such suspicion to the appropriate medical examiner <u>and the department</u>."*** *Underline added.*

Based on matter referenced above, other matters and information obtained by the SLC, the SLC will continue to pay particular attention when and how child deaths are reported to DCS.

<u>Drug Related Matters</u>

Parental substance abuse and dependence has a significant impact on children. According to the 2007 National Survey on Drug Use and Health, 8.3 million children lived with a parent who abused or was dependent on alcohol or an illegal drug. The greatest percentage of children living with a parent who abused or was dependent on alcohol or an illegal drug were two years of age or younger. As the age of the children increased the percentage who lived with a parent who abused or was dependent on alcohol or an illegal drug decreased. Parental substance abuse and dependence may impact the parent's ability to bond with the child, which is arguably more important the younger the child is. Children who experience drug exposure are at risk for a range of problems, including emotional, academic and developmental problems. Lack of

supervision is also an issue when a child's caretaker abuses alcohol and illegal substances. https://www.childwelfare.gov/pubs/usermanuals/substanceuse/chapterthree.cfm.

Unfortunately, Tennessee is all too familiar with the impact of illegal drug usage. In 2011, Tennessee ranked 49th highest in the country for the number of prescriptions filled per capita at 17.6 prescriptions filled per person. The national average at the time was 12.1. http://health.state.tn.us/MCH/PDFs/NAS/NAS_Reporting_Webinar_031913.pdf. According to the report titled "Hospital-Based Surveillance for Neonatal Abstinence Syndrome (NAS) in Tennessee, 2013," the statewide rate for NAS cases in Tennessee in 2013 was 11.6 cases per 1,000 live births. NAS is a condition in which a baby has withdrawal symptoms after being exposed to certain substances in utero. The exposure can involve prescribed and/or illicit drugs. After delivery the baby experiences withdrawal because the substances are no longer being received through the umbilical cord. NAS is a clinical syndrome; the diagnosis typically involves (1) a history of exposure to substances that may precipitate a withdrawal, (2) evidence of the substance in the baby's system and, (3) symptoms consistent with a state of withdrawal. http://health.tn.gov/mch/PDFs/NAS/NAS%20FAQs_63014L.pdf. In an article in web-based newsletter *the fix,* Tommy Farmer, assistant special agent in charge of the Tennessee Bureau of Investigation, is quoted saying, "We're in jeopardy of losing an entire generation of our youth to addiction if we don't get a grip on this."

In one matter reviewed by the SLC, the mother of a three year old child tested positive for benzodiazepines in December 2011, opiates in February 2012 and marijuana in May 2012. During an investigation initiated around April 2012, the mother admitted to using methamphetamine. The mother gave birth to another child in July 2012 (Child # 2). Fortunately, the meconium of Child # 2 tested negative for all substances. Although Child # 2 did not test positive for drugs, ***the SLC recommends training to help DCS CPS investigators and assessors fully appreciate the potential impact drug abuse has on a child being cared for by someone abusing drugs***.

The SLC also recommends parents, caregivers and other appropriate parties should be drug screened when a child is potentially the victim of severe child abuse and the parent, caregiver and other appropriate parties have a history of drug abuse. The SLC members agree all parents, caregivers and other appropriate parties who are being investigated for severe child abuse should not have to submit to a drug screen. However, when the parent, caregiver or other appropriate party has a history of drug abuse, the SLC believes a drug screen is warranted. Drug abuse manifests itself in many ways. Although DCS and other providers may address the immediate problem through a myriad of services, the failure to discover and address an underlying substance abuse problem would likely lead to continued abuse.
The SLC encourages DCS, through training and other appropriate measures, to continue to equip its child protective services investigators and assessors with the knowledge to determine when parents, caregivers and other appropriate parties should be drug screened, especially in

child deaths. Data set forth in the "Child Fatalities in Tennessee Review of 2012 Deaths" produced by the Tennessee Department of Health, Division of Family Health and Wellness, provides alcohol or drugs were noted to be contributing factors in sleep-related infant deaths as follows:

- Adult drug-impaired sleeping with infant: 5 cases
- Adult alcohol-impaired sleeping with infant: 3 cases.

More than one contributing factor may have been present in a single death, so there may be some overlap in the counts listed above. The training should also address the need to drug test parents, caregivers and other appropriate parties when a child tested positive for drugs. The SLC notes DCS currently provides courses in its CPS Training Academy titled "Drug Identification;" "Recognizing and Documenting Impairment/Drug Use;" and "Meth, Meth Labs and Drug Trucks." DCS is also in the process of reviewing its drug screening policies.

In part, the U.S. Department of Justice states the following regarding dangers to children living in methamphetamine labs:

> A child living at a clandestine methamphetamine laboratory is exposed to immediate dangers and to the ongoing effects of chemical contamination. In addition, the child may be subjected to fires and explosions, abuse and neglect, a hazardous lifestyle (including the presence of firearms), social problems, and other risks.
>
> **Chemical contamination.** The chemicals used to cook meth and the toxic compounds and byproducts resulting from its manufacture produce toxic fumes, vapors, and spills. A child living at a meth lab may inhale or swallow toxic substances or inhale the secondhand smoke of adults who are using meth; receive an injection or an accidental skin prick from discarded needles or other drug paraphernalia; absorb methamphetamine and other toxic substances through the skin following contact with contaminated surfaces, clothing, or food; or become ill after directly ingesting chemicals or an intermediate product. Exposure to low levels of some meth ingredients may produce headache, nausea, dizziness, and fatigue; exposure to high levels can produce shortness of breath, coughing, chest pain, dizziness, lack of coordination, eye and tissue irritation, chemical burns (to the skin, eyes, mouth, and nose), and death. Corrosive substances may cause injury through inhalation or contact with the skin. Solvents can irritate the skin, mucous membranes, and respiratory tract and affect the central nervous system. Chronic exposure to the chemicals typically used in meth manufacture may cause cancer; damage the brain, liver, kidney, spleen, and immunologic system; and result in birth defects.[6] Normal cleaning will not remove methamphetamine and some of the chemicals used to produce it. They may remain on eating and cooking utensils, floors, countertops, and absorbent materials. Toxic byproducts of meth manufacturing are often improperly disposed outdoors, endangering children and others who live, eat, play, or walk at or near the site.[7]

Hazardous lifestyle. Hazardous living conditions and filth are common in meth lab homes. Explosives and booby traps (including trip wires, hidden sticks with nails or spikes, and light switches or electrical appliances wired to explosive devices) have been found at some meth lab sites. Loaded guns and other weapons are usually present and often found in easy-to-reach locations. Code violations and substandard housing structures may also endanger children. They may be shocked or electrocuted by exposed wires or as a result of unsafe electrical equipment or practices. Poor ventilation, sometimes the result of windows sealed or covered with aluminum foil to prevent telltale odors from escaping, increases the possibility of combustion and the dangers of inhaling toxic fumes. Meth homes also often lack heating, cooling, legally provided electricity, running water, or refrigeration. Living and play areas may be infested with rodents and insects, including cockroaches, fleas, ticks, and lice. Individuals responding to some lab sites have found hazardous waste products and rotten food on the ground, used needles and condoms strewn about, and dirty clothes, dishes, and garbage piled on floors and countertops. Toilets and bathtubs may be backed up or unusable, sometimes because the cook has dumped corrosive byproducts into the plumbing. (See Children Found in Meth Lab Homes - http://ojp.gov/ovc/publications/bulletins/children/pg5.html#methlab.)

The inability of meth-dependent and meth-manufacturing parents to function as competent caregivers increases the likelihood that a child will be accidentally injured or will ingest drugs and poisonous substances. Baby bottles may be stored among toxic chemicals. Hazardous meth components may be stored in 2-liter soft drink bottles, fruit juice bottles, and pitchers in food preparation areas or the refrigerator. Ashtrays and drug paraphernalia (such as razor blades, syringes, and pipes) are often found scattered within a child's reach, sometimes even in cribs. Infants are found with meth powder on their clothes, bare feet, and toys. The health hazards in meth homes from unhygienic conditions, needle sharing, and unprotected sexual activity may include hepatitis A and C, *E. coli*, syphilis, and HIV.

http://ojp.gov/ovc/publications/bulletins/children/pg5.html.

Professionals, including law enforcement, DCS, hospital staff and courts, must stress the need to evaluate children who may have been exposed to methamphetamines or the manufacturing process, at any phase of the process. In several cases in the current and previous years of review, the SLC identified cases in which parents have admitted to using methamphetamine but the children were not tested for exposure.

Coordination of Stakeholders' Efforts

The opportunity to improve communication within DCS and between DCS and various stakeholders, particularly law enforcement, continues. One case in particular highlighted this opportunity. The case involved allegations of abuse of the same child in at least three different jurisdictions. Based on documentation provided to the SLC, it did not appear the jurisdictions were effectively sharing information.

DCS has taken steps to address the need for improved coordination. DCS centralized its investigations in the Office of Child Safety. DCS created the Division of Community Partnerships, which has aided in identifying community partners to participate in the CPS Training Academy. This gives key community partners the opportunity to train alongside DCS CPS investigators.

Courts sometimes need to further clarify the prohibitions of "No Unsupervised Contact Orders" and provide relatives and other appropriate parties copies of the order. Due to confidentiality issues, some of the order may need to be redacted. In one of the co-sleeping deaths reviewed by the SLC, the mother should not have been left alone with the child. The court in this matter placed the child with the paternal grandparents and ordered supervised contact between the child and her parents. Both the parents and paternal grandparents stated they did not think they were violating the court's order by allowing the parents to spend the night with the child in the home of the paternal grandparents. The parties stated they believed the paternal grandparents were providing supervised visitation as long as they were in the same house. The typical supervised contact order assumes line-of-sight supervision. ***The SLC recommends the Administrative Office of the Courts incorporate this issue in the training it provides to Juvenile Court Judges and Magistrates.***

The case mentioned above, also raises another concern of the SLC noted in previous years. The SLC understands and agrees placing a child with a relative when the child must be removed from his caregiver is usually in the child's best interest when it can be done safely. However, relative placements appear to ignore or misinterpret court orders regarding supervised visitation more often than non-relative placements. The SLC is not suggesting the court use fewer relative placements. We are suggesting the courts should be extremely clear with the appropriate gravitas when entering these orders. The courts should not assume the parents, caregivers, foster parents and other appropriate parties understand what the court means when the court issues an order allowing only supervised contact between a child and a parent, caregiver and other appropriate parties. If the court means the parent, caregiver or other appropriate party may be in the same room only when the supervisor is in the room with them, the court should state it open court and make sure the appropriate language is included in the order. Additionally, relative placements and other appropriate individuals should understand the potential repercussions for failing to abide by the court's order.

Investigations

There is a continued need to stress the importance of issue-driven investigations as opposed to incident-driven investigations. In addition to the courses provided in the CPS Investigator Training Academy (Academy), DCS is also addressing this issue in its newly-developed DCS post CPS academy. Specifically, DCS is providing training to aid investigators distinguish between risk issues and safety issues, and how to address each.

In the 2013 annual report, the SLC recommended including aspects of record maintenance and building a file in the Academy training. The Academy dedicates an entire day to case file documentation, organization and presentation. Of particular interest to the SLC, the documentation course is designed to teach the critical considerations of case file documentation.

Properly documenting, organizing and presenting an investigation are critical areas for an investigator to master. Proper file documentation and organization provide a current and accurate picture of the Department's involvement with the child and family, and ultimately provides the basis for many of the decisions made during the course of a matter. Effective documentation can provide accountability for DCS by setting forth reasonable efforts and services provided or made available. Proper file maintenance may also aid in the prosecution of the perpetrators of severe child abuse. "Quality record-keeping is an integral part of professional CPS practice." https://www.childwelfare.gov/pubs/usermanuals/cps/cps.pdf.

Although DCS has shown improvement from previous years, proper documentation continues to be an issue. Some DCS records provided to the SLC continue to lack documentation necessary to make informed decisions regarding the safety of the child. Additionally, documentation is often confusing. Multiple names/designations are often used for the same individual. Entering information into TFACTS in a timely manner continues to be an issue, but improvements have been made. Additional areas of the suggested file documentation training include reducing duplication in TFACTS entries and providing full names, addresses, numbers and agency identification for people referenced in TFACTS entries. For example, when collateral contacts are made, providing the telephone number and address of a collateral contact may make it easier for other DCS representatives and child abuse prevention stakeholders to contact that individual if necessary.

The SLC recommends all appropriate collateral interviews are conducted and documented by DCS. During this and previous years, some DCS files did not contain documentation of interviews with key collateral resources. Based on the documentation, the SLC cannot determine whether this presents an opportunity to improve documentation or interviewing practices.

DCS is in the process of providing tablets for all its investigators. This should help with documentation as well. CPS investigators will be able to document conditions of homes and injuries by taking pictures. Moreover, they will be able to work on TFACTS entries while sitting

in court or waiting in other settings. The Administrative Office of the Courts may need to address DCS's use of tablets in juvenile courts with the judges.

DCS training must emphasize the necessity of including a closing summary in TFACTS recordings. Finding pertinent information about a case in TFACTS recordings, especially a synopsis of the actions taken in an investigation, continues to be difficult. Members of the SLC noted some of the TFACTS recordings contained an informative and concise closing case summary. A well-written case summary will allow overworked CPS investigators to quickly find key information when reviewing previous investigations of a family. As mentioned above, DCS has a full course in the CPS Training Academy addressing documentation. Part of the course addresses closing summaries. DCS has also incorporated providing quality documentation in its Individual Performance Plan (IPP) for its investigators. Including "closing summaries for all investigations that outline the evidence supporting the classification with the relevant policy cited" is specifically set forth in the IPP.

Prevention

Failure to report child abuse continues to be an issue. In several cases reviewed by the SLC, people, usually family members, knew about the abuse but failed to report it. Tennessee has one of the strongest mandatory child abuse reporting statutes in the nation. TCA § 37-1-403(a)(1) states, "Any person who has knowledge of or is called upon to render aid to any child who is suffering from or has sustained any wound, injury, disability, or physical or mental condition shall report such harm immediately if the harm is of such a nature as to reasonably indicate that it has been caused by brutality, abuse or neglect or that, on the basis of available information, reasonably appears to have been caused by brutality, abuse or neglect." This statute should not be ignored.

Tennessee should provide even more education regarding safe sleeping. In a neglect matter reviewed by the SLC, DCS warned the mother about having too many blankets in the bassinette. The baby was almost level to the side of the bassinette. The baby could roll out of the bassinette. This was a great opportunity to provide additional safe sleep information. Approximately three months later, the baby died in a sleep-related environment. The baby's Certificate of Death stated the immediate cause of death was asphyxia and/or SIDS (associated with co-sleeping). The manner of death was listed as Accident. The baby was sleeping in the same bed with her mother on top of a pillow on her stomach. This was a senseless and preventable death.

According to the "Child Fatalities in Tennessee Review of 2012 Deaths" produced by the Tennessee Department of Health, Division of Family Health and Wellness, "Sixty-six children (8.0% of all deaths) died of asphyxia; forty-two of these children died in a sleep-related environment. This represents an increase of 10% from 2011, when there were 60 asphyxia

deaths, 40 of which occurred in a sleep-related environment." A statewide safe sleep campaign started in the second half of 2012. The State Child Fatality Prevention Review Team recommended aggressively continuing the safe sleep campaign with an expanded emphasis on education for caregivers and health care providers. As a part of this campaign, DCS agreed to provide education to caregivers of children in DCS custody. (http://bit.ly/1wCx0fE)

Based on information provided to the SLC this and previous years, SLC members have a growing concern regarding the investigation and documentation of prenatal care when a child is born with drugs in his/her system. Along with determining the extent of prenatal care obtained in these situations, it is equally important to determine why appropriate prenatal care was not obtained, if applicable. The SLC acknowledges DCS does not have the statutory authority to investigate allegations of abuse against a human embryo or fetus. The SLC is not advocating or suggesting DCS's jurisdiction be expanded to investigate allegations of abuse against a human embryo or fetus.

The collection and maintenance of this data and information would likely be helpful for several reasons. Data and information regarding prenatal care of a child born with drugs in the child's system may help inform decisions made by CPS investigators and CPITs. Children born with drugs in their system who are subsequently subjected to an incident of severe child abuse may fit the statutory requirements of cases reviewed by the SLC, thus providing a more accurate view of the magnitude of the issues to be addressed by the SLC. Additionally, obtaining a complete medical history of a child born with drugs in the child's system may impact services provided to the child as well as provide valuable information to caregivers of the child, to include foster and adoptive parents.

The SLC is not making a finding or recommendation regarding the investigation and documentation of prenatal care when a child is born with drugs in his/her system at this time. The SLC will continue to research this issue and provide findings and recommendations if appropriate.

Data

In the Crime in Tennessee 2013 report prepared by the Tennessee Bureau of Investigation (2013 Crime Report), the Crimes Against Persons category contained the following summarized information regarding the number of victims. See Table 1. The totals represent the number of offenses reported. The Percent of Juvenile Victims column in Table 1 was prepared by the SLC and not included in the 2013 Crime Report.

Crime Against Persons	**Total**	**Under** 18	**Percent of Juvenile Victims**
Murder	333	28	8 percent
Negligent Manslaughter	20	5	25 percent
Kidnapping/Abduction	1,157	398	34 percent
Forcible Rape	1,787	736	41 percent
Forcible Sodomy	416	284	68 percent
Sexual Assault with Object	228	142	62 percent
Forcible Fondling	2,216	1,511	68 percent
Incest	42	39	93 percent
Statutory Rape	510	509	99 percent
Aggravated Assault	28,718	3,558	12 percent
Simple Assault	86,202	12,543	15 percent
Intimidation	27,701	2,169	8 percent
Stalking	1,570	100	6 percent
Commercial Sex Acts	4	4	100 percent
Total	150, 904	22,026	15 percent

Table 1

Based on estimates provided by the United States Census Bureau, the estimated total population in Tennessee in 2013 was 6,495,978. The estimated population in Tennessee of people under the age of 18 in 2013 was 1,491,577. Children were approximately 23 percent of the population of Tennessee in 2013. Children in Tennessee are disproportionately represented in several categories of Crimes Against Persons, and are considerably overrepresented in the following categories: Forcible Rape, Forcible Sodomy, Incest and Commercial Sex Acts. By definition, all victims of Statutory Rape should be under 18 years of age, so children are not overrepresented in the Statutory Rape category. Over the last four years, sexual abuse has accounted for a considerable portion of the cases reported to the SLC: FY 2010 – 77 percent, FY 2011 – 44 percent, FY 2012 – 71 percent, and FY 2013 – 75 percent.

District attorneys and assistant district attorneys (collectively referred to as DAs) need to collect data on the number of severe child abuse cases prosecuted, the number of plea agreements for a crime less serious than the original severe child abuse charge and the number of cases referred to DAs for prosecution from CPIT. The SLC recommends DAs should document when charges involving crimes against children are reduced. DAs should also document why cases involving crimes against children are not prosecuted. The SLC further recommends each county, or at least each district, has a DA dedicated to handling cases involving crimes against children.

The SLC understands collecting and documenting this data and information may require additional resources. The SLC further recognizes volumes of cases may not be prosecuted due to the lack of resources to adequately address these cases. The DAs cannot do their jobs without the proper resources. Accordingly, ***the SLC urges the General Assembly to form a committee to research these issues to provide recommended strategies to address the needs of the DAs.***

Repeat Child Abuse Data

The reported number of children who experienced a second or subsequent incident of severe child abuse for fiscal year 2012-2013 is 605.

The gender composition of the victims of the total population of cases is as follows:

- Female: 74 percent;
- Male: 26 percent.

The racial composition of the victims of the total population of cases is as follows:

- White: 65 percent;
- Black: 20 percent;
- Unable to determine: 15 percent.

The age range composition of the children at the time of the incidents of abuse are as follows:

- 0-4 years old: 11 percent;
- 5-9 years old: 28 percent;
- 10-13 years old: 31 percent;
- 14-17 years old: 31 percent.

The types of abuse in the total population for FY 2013 are as follows:

- Abandonment: less than 1 percent;
- Abuse Death: less than 1 percent;
- Drug Exposed Child: 15 percent;
- Environmental Neglect: 1 percent;
- Lack of Supervision: 3 percent;
- Medical Maltreatment: 1 percent;
- Neglect Death: 1 percent;
- Physical Abuse: 5 percent;
- Psychological Harm: less than 1 percent;
- Sexual Abuse: 75 percent
- Substantial Risk of Physical Injury: less than 1 percent;
- Substantial Risk of Sexual Abuse: less than 1 percent.

Number of unique cases reported in each county by judicial districts:

1st Judicial District

Carter	3
Johnson	6
Unicoi	1
Washington	4

2nd Judicial District

Sullivan	20

3rd Judicial District

Greene	2
Hamblen	5
Hancock	1
Hawkins	4

4th Judicial District

Cocke	9
Grainger	4
Jefferson	6
Sevier	9

5th Judicial District

Blount	12

6th Judicial District

Knox	26

7th Judicial District

Anderson	16

8th Judicial District

Campbell	7
Clairborne	2
Fentress	1
Scott	3
Union	8

9th Judicial District

Loudon	9
Meigs	2
Morgan	4
Roane	7

10th Judicial District

Bradley	6
McMinn	10
Monroe	3
Polk	3

11th Judicial District

Hamilton	13

12th Judicial District

Bledsoe	2
Franklin	3
Grundy	2
Marion	2
Rhea	5
Sequatchie	3

13th Judicial District

Clay	3
Cumberland	5
DeKalb	4
Overton	2
Pickett	1
Putnam	9
White	9

14th Judicial District

Coffee	11

15th Judicial District

Jackson	0
Macon	7
Smith	3
Trousdale	0
Wilson	5

16th Judicial District

Cannon	3
Rutherford	16

17th Judicial District

Bedford	6
Lincoln	9
Marshall	4
Moore	0

18th Judicial District

Sumner	7

19th Judicial District

Montgomery	16
Robertson	1

20th Judicial District

Davidson	43

21st Judicial District

Hickman	6
Lewis	2
Perry	1
Williamson	3

22nd Judicial District

Giles	7
Lawrence	7
Maury	7
Wayne	2

23rd Judicial District

Cheatham	5
Dickson	4
Houston	0
Humphreys	1
Stewart	3

24th Judicial District

Benton	0
Carroll	2
Decatur	1
Hardin	10
Henry	3

25th Judicial District

Fayette	1
Hardeman	2
Lauderdale	10
McNairy	6
Tipton	4

26th Judicial District

Chester	1
Henderson	6
Madison	8

27th Judicial District

Obion	0
Weakley	5

28th Judicial District

Crockett	1
Gibson	6
Haywood	1

29th Judicial District

Dyer	2
Lake	3

30th Judicial District		31st Judicial District	
Shelby	92	Van Buren	1
		Warren	5

Statute Summary

The Tennessee Second Look Commission is charged with reviewing 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. The Commission's findings and recommendations shall address all stages of investigating and attempting to remedy severe child abuse.

The Department of Children's Services (DCS) has the statutory obligation to submit to the Commission a table of cases meeting the criteria of the cases set forth in TCA §37-3-803 (severe child abuse). The Commission shall review the table of profiled cases submitted by DCS and submit a list of the cases to DCS after such review, setting out specific cases from the table that the Commission selects to review.

Notwithstanding any provision of law to the contrary, the Commission may access confidential information. Investigatory meetings of the Commission shall not be subject to the open meetings requirement and shall be closed to the public. Any minutes or other confidential information generated during an investigatory meeting shall be sealed from public inspection.

The Commission is administratively attached to the Tennessee Commission on Children and Youth (TCCY), but for all purposes other than administration, is an independent commission. Among other things, TCCY is responsible for providing the Commission members with any relevant information and assisting the Commission in the preparation of reports.

Conclusion

As stated in the Introduction, the SLC was created in 2010. The SLC received its first list of cases the same year. Since the first list of cases was provided, the number of unduplicated children on each list provided to the SLC by DCS has dramatically fluctuated. See Chart 1. The SLC has not been able to determine why the number of unduplicated children changed so dramatically every year. Over the years, different DCS representatives have prepared the list of cases for the SLC. The dramatic changes over the years are likely attributable to different DCS representatives using different formulas to generate the lists. Last calendar year, the SLC worked closely with DCS to obtain a more accurate list of FY 2013 cases. Additionally, the same formula will be used to produce subsequent lists of cases. The SLC is looking forward to

having reliable data available to determine whether Tennessee is improving how severe child abuse cases are handled.

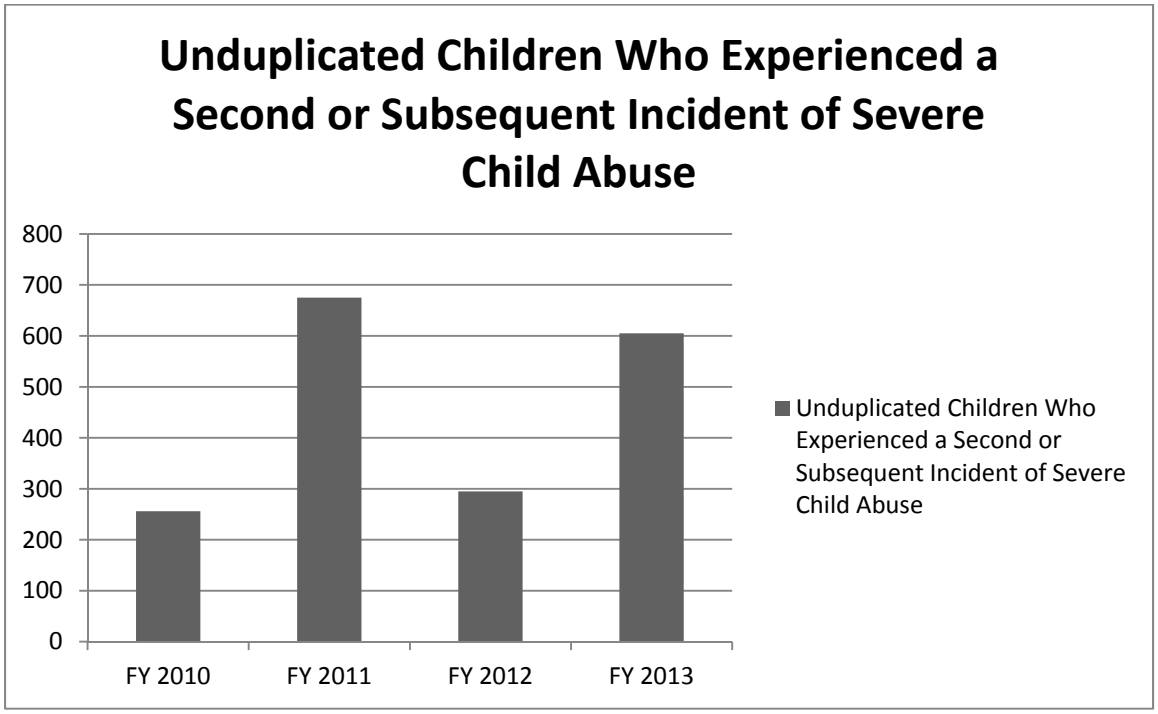

Chart 1

Although the number of unduplicated children on the SLC lists has fluctuated, the demographics and types of abuse have remained relatively constant with a few exceptions. See Charts 2 – 7. On average, Sexual Abuse and Drug Exposure combined represent 83 percent of the cases provided to the SLC. Sexual Abuse alone represents approximately 67 percent of the cases provided to the SLC.

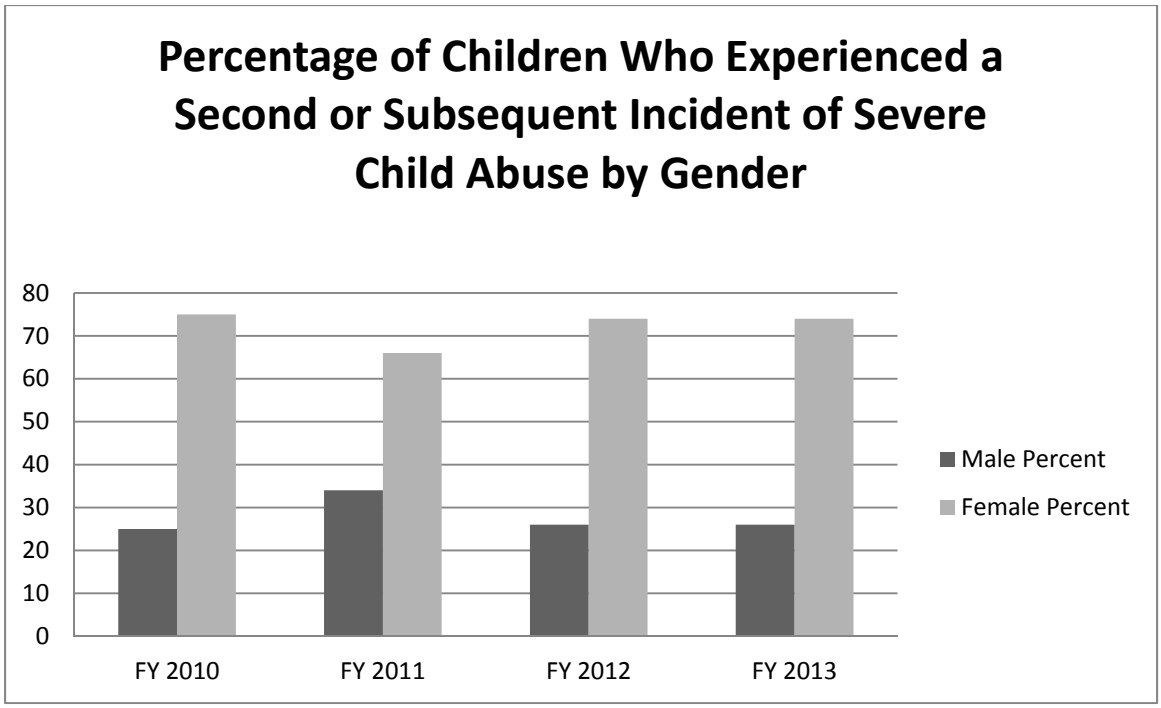

Chart 2

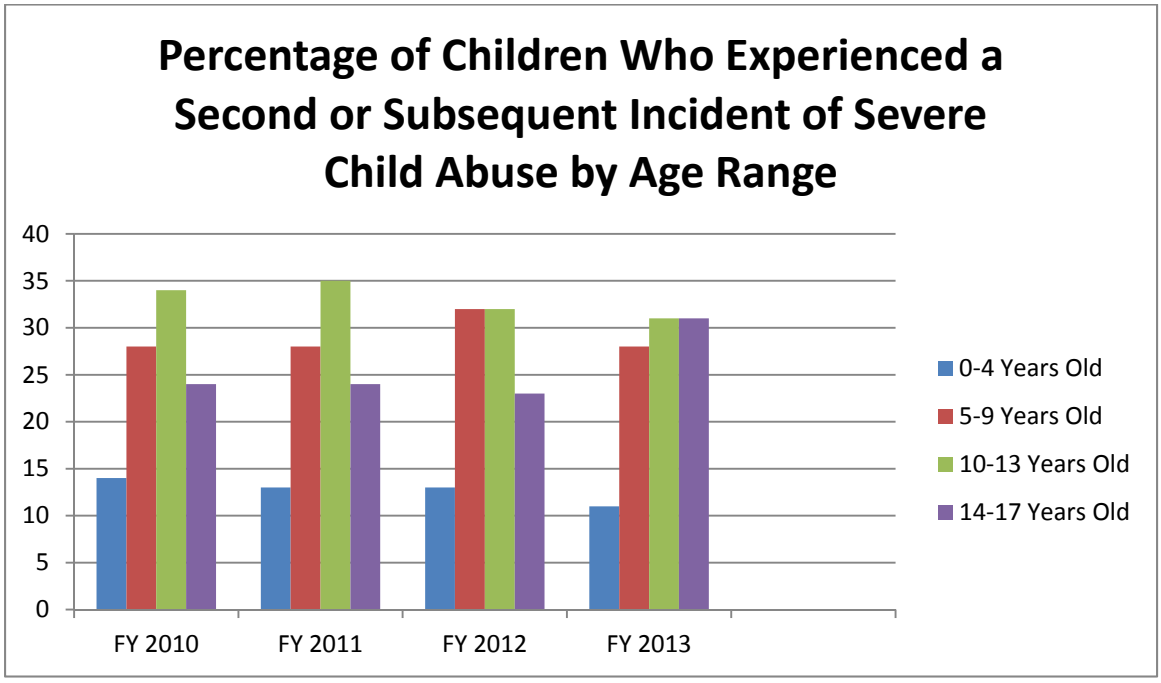

Chart 3

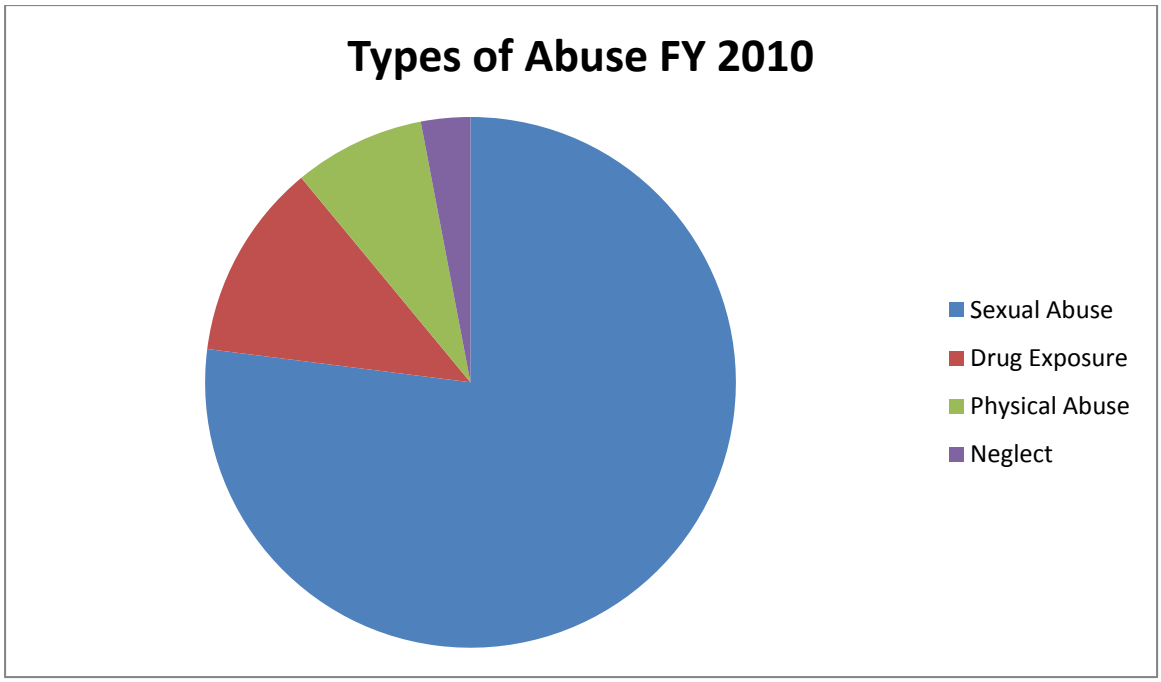

Chart 4

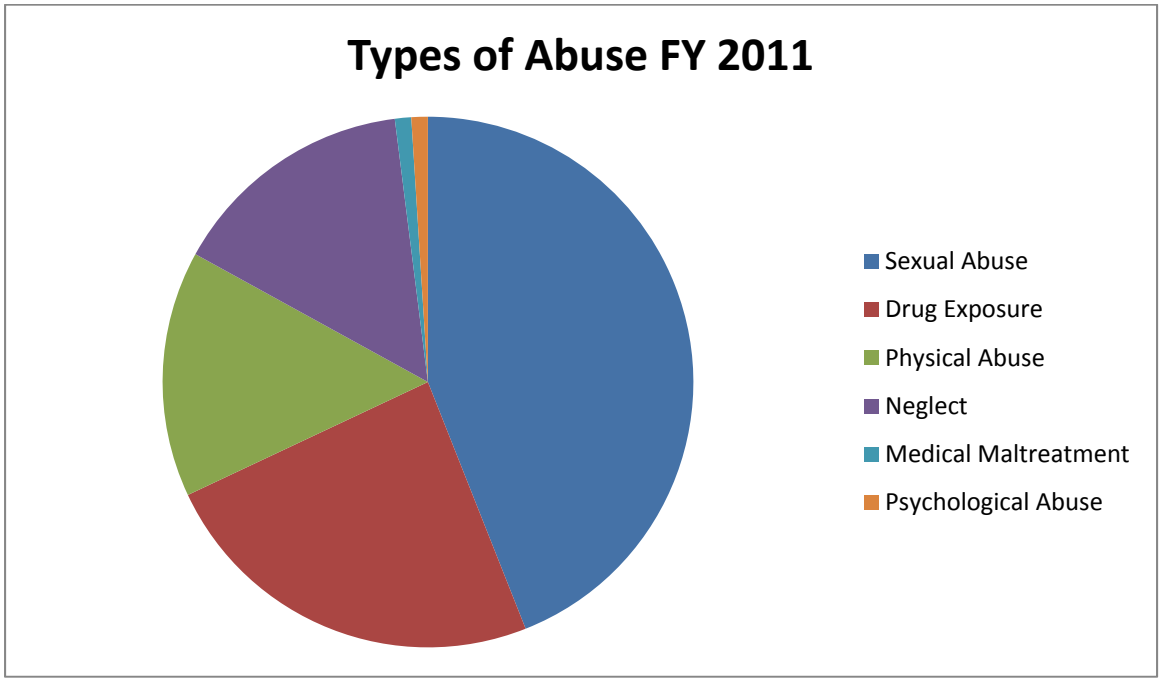

Chart 5

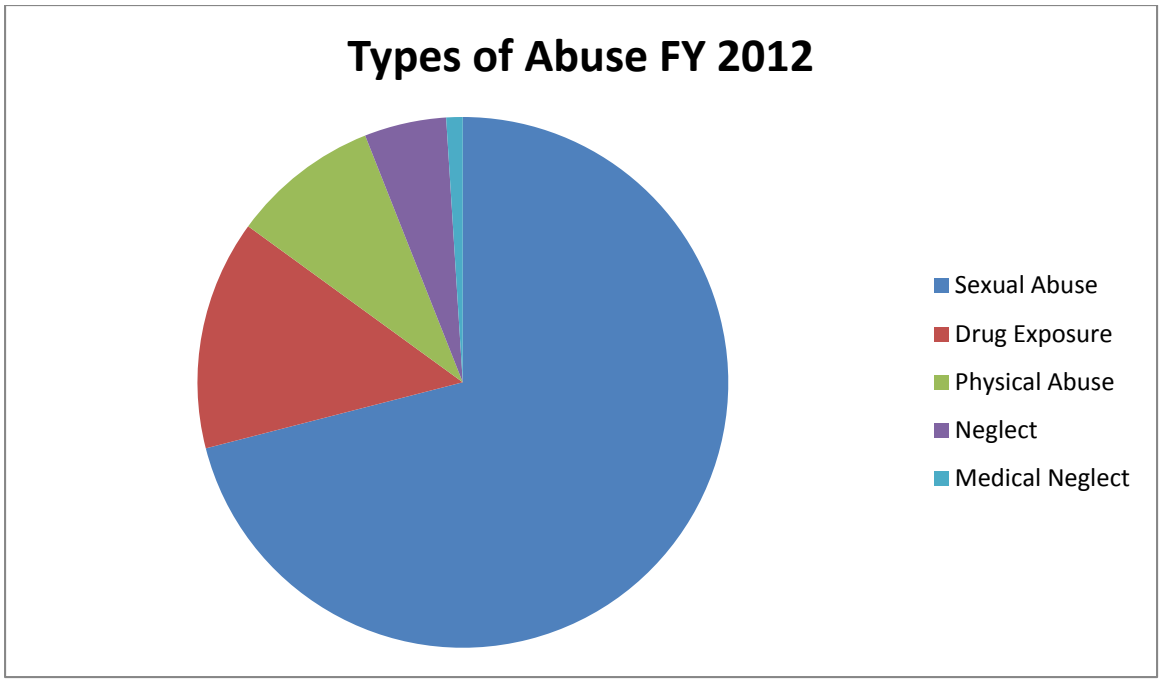

Chart 6

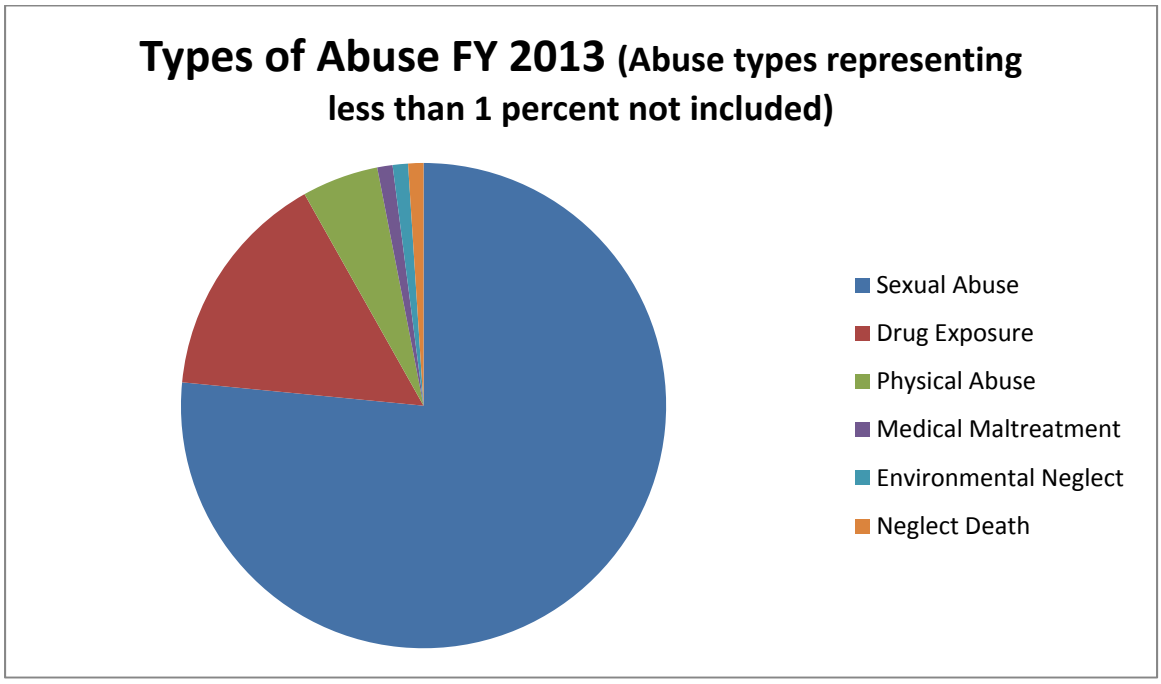

Chart 7

The Tennessee General Assembly should be commended for its proactive stance regarding protecting the children of Tennessee. The SLC has worked with DCS and other stakeholders to provide and help implement findings and recommendations with the goal of Tennessee improving how it handles severe child abuse cases. As recommendations are implemented, the SLC will continue to monitor the impact of the changes over time to determine whether such changes are actually improving how severe child abuse cases are handled in Tennessee.

STATE OF TENNESSEE
SECOND LOOK COMMISSION
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243-0800
(615) 741-2633 (FAX) 741-5956
1-800-264-0904

MEMBERSHIP
December 26, 2014

Senator Doug Overbey, Co-Chair
TN General Assembly

Representative Mark White, Co-Chair
TN General Assembly

Carla Aaron, Executive Director
TN Dept. of Children's Services
Office of Child Safety

Charme Allen
District Attorney General, 6th District
TN District Attorneys General Conference

Representative John J. DeBerry
TN General Assembly

Brenda Davis
Vice Chairperson, Board of Directors
Davis House Child Advocacy Center

David Doyle, Esq.
District Public Defender, 18th Judicial District
District Public Defenders Conference

Senator Dolores R. Gresham
TN General Assembly

David Haines, General Counsel
Administrative Office of the Courts

Donna Hetherington, Lieutenant
Lexington Police Department

David Imhof, East Precinct Commander
Metropolitan Nashville Police Department

Debra Quarles Mills, M.D.
East Tennessee State University
James H. Guillen College of Medicine
Department of Pediatrics

Linda O'Neal, Executive Director
Tennessee Commission on Children and Youth

Mitzi H. Pollard
Private Attorney

Jerri Powell, Special Agent in Charge
Tennessee Bureau of Investigation