Second Look Commission
2016 Annual Report

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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 with representatives from all three branches of state government: members of the General Assembly, Department of Children's Services (DCS), the Administrative Office of the Courts (AOC), law enforcement (including the Tennessee Bureau of Investigation and officers from urban and rural areas), district attorneys general, public defenders, 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. Child development is important for community and economic development. 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 wise investment in children and families becomes the basis of a prosperous and sustainable society.

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 sturdy foundation in the early years increases the probability of positive outcomes. A fragile 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 of children 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.

When a young child experiences excessive stress, such as Adverse Childhood Experiences, extreme poverty, abuse or severe maternal depression – what scientists now call "toxic stress" –

it can disrupt the architecture of the developing brain. This can lead to lifelong difficulties in learning, memory and self-regulation. Severe or chronic stress releases harmful chemicals in the brain that impair cell growth and make it harder for neurons to form healthy connections, damage the brain's developing architecture and increasing the probability of poor outcomes. Intervention in the lives of children who are experiencing toxic stress should not be delayed.

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 in 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.

Science tells us that many children's futures are undermined when stress damages the early brain architecture. Trying to change behavior or build new skills on a foundation of brain circuits that were not wired properly when they were first formed requires more work and is less effective. Later interventions are more costly and produce less desirable outcomes than the provision of nurturing, protective relationships and appropriate experiences earlier in life. We know that children who are exposed to serious early stress develop an exaggerated stress response that, over time, weakens their defense system against diseases from heart disease to diabetes and depression.

In what is reportedly the first major study of child abuse and neglect in 20 years, Petersen, A. (2012), *New directions in child abuse and neglect research*, 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. "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." (Petersen, 2012, p. 155).

> 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).
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> 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.* (p. 4, 5). (2012). Tennessee Commission on Children and Youth.

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 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.

As Tennesseans understand the impact of Adverse Childhood Experiences, they will realize the future economic development and prosperity of the state depends on what we do to prevent these experiences whenever possible and to wrap services around children and families when they cannot be prevented. There will be better collaboration across disciplines, departments, agencies and communities, and focus on the infrastructure of services and supports that make a difference. When child abuse and domestic violence prevention, home visiting, mental health and substance abuse services for parents, and a variety of other services and supports are available for early intervention, they put in place a preventive system that catches children before they fall. This kind of sound investment in our society's future is confirmed by brain science. It improves outcomes for children now and is a significant foundation for solutions to many of the long-standing and nagging challenges we face as a state in our health, mental health, social services, child protection, and juvenile and criminal justice systems.

In 2012, Tennessee included an ACEs module in the Behavioral Risk Factor Surveillance System, a telephone survey conducted by the Centers for Disease Control and Prevention. The ACEs module was included to get a better understanding of how ACEs affect Tennessee's general population. The Tennessee Department of Health analyzed data from 7,056 adults. The data indicates ACEs are found throughout Tennessee. Of the 7,056 adults, 6,918 answered at least one question on the ACEs module. Statistical weights were applied to make the sample representative of all adult Tennesseans, resulting in a weighted total sample of 4.8 million (4,789,134) with an answer to at least one of the ACEs questions. Using weighted values, 33.1% percent of Tennesseans experienced two or more ACEs, a weighted n of 1,587,714 (unweighted n=2,038). The report, *Adverse Childhood Experiences in Tennessee*, is available on the Tennessee Department of Health's website at https://tn.gov/health/topic/MCH-reports.

Studies have found abused and neglected children to be at least 25 percent more likely to experience problems such as delinquency, teen pregnancy and low academic achievement. (Kelley et al. 1997). Children who experience maltreatment are at increased risk for smoking, alcoholism and drug abuse as adults. (Felitti et al., 1998; Runyan et al., 2002.)

2016 FINDINGS AND RECOMMENDATIONS

This is the third year the list of cases provided by DCS contains cases involving abuse and neglect deaths. The SLC decided to review all the abuse and neglect death cases on the FY 2015 list, as well as a sampling of cases representative of the higher maltreatment type percentages, sexual abuse and drug exposure. The SLC also considered the time between the first and second incident of abuse. To maximize its efforts and make the case reviews more relevant, the SLC

decided to review only cases in which the first and second incident of abuse occurred within three years of FY 2015.

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 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. Members of the SLC read the summaries prior to the investigatory meetings and arrive at the meetings prepared to analyze each case thoroughly.

The list of cases provided by DCS for fiscal year 2014-2015 (FY 2015) reported 643 children experienced a second or subsequent incident of severe child abuse. Similar to previous years, sexual abuse was the most prevalent type of listed severe child abuse. Sexual abuse accounted for approximately 73 percent of the severe abuse that occurred in FY 2015. However, sexual abuse only accounted for approximately 22 percent of the prior maltreatment type set forth in the FY 2015 list of cases. The second most prevalent type of severe abuse was drug exposed child/infant. Drug exposure accounted for approximately 13 percent of the severe abuse that occurred in FY 2015. However, drug exposure accounted for approximately 36 percent of the prior maltreatment type set forth in the FY 2015 list of cases. Accordingly, sexual abuse accounted for approximately 48 percent of all of the maltreatment types set forth in the FY 2015 list of cases. Drug exposure accounted for approximately 25 percent of all of the maltreatment types set forth in the FY 2015 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 might have prevented repeat abuse. Although there continues to be opportunities to improve the manner in which severe child abuse cases are handled in Tennessee, changes continue to occur that will likely have a positive impact on reducing the rate and consequences of severe child abuse.

The following findings and recommendations are based on the child death and severe abuse cases reviewed by the SLC during the 2016 calendar year. The recommendations recommend specific action steps to help resolve a finding in some instances and further research and investigation in other instances. The findings and recommendations are discussed below and grouped by the following broad categories: Child Deaths, Courts and Legal, Collaboration, and Training.

Child Death Cases

- Law enforcement should treat all child death investigations as homicide investigations until the evidence dictates otherwise.
    - In 2005, the United States Department of Justice produced a document titled, "Investigating Child Deaths." The document acknowledges most sudden and unexpected child deaths are not caused by abuse or neglect. Despite this fact, the document goes on to state all child death investigations should be approached with the thought that the child may have been a victim of abuse or neglect. The investigation should continue with the hypothesis that the child may have been a victim of abuse or neglect until the investigation is completed and the evidence conclusively proves otherwise. This approach helps preserve evidence and witness statements. https://www.ncjrs.gov/pdffiles1/ojjdp/209764.pdf
    - The SLC recommends training for law enforcement focused on how to investigate child death cases to address this finding. The SLC acknowledges some jurisdictions already treat all child death investigations as homicide investigations until the evidence dictates otherwise.

- In child death investigations, DCS needs to receive autopsy reports as soon as reasonably possible. A delay in receiving autopsy reports is a recurring issue.
    - In some instances, a DCS child death investigation cannot be classified until the autopsy report is provided to DCS. When this is the case and other children are involved, permanency is delayed and safety may be compromised until the autopsy report is provided. The SLC recommends the SLC, DCS and other identified stakeholders work together to determine the average length of time it takes DCS to receive an autopsy report in a child death case. The stakeholders involved should also determine whether there are regional differences in the time it takes DCS to receive autopsy reports in child death cases. The stakeholders should develop action steps to address any factors causing an unnecessary delay in DCS receiving autopsy reports in child death cases, which may also impact juvenile court cases and criminal prosecution.

Courts and Legal

- Kinship/Family placements continue to fail to comply with No Contact orders. In a case reviewed this year, a child died at the hands of a person who was prohibited from having contact with the child.
    - Courts must clearly explain to those designated as supervisors their responsibilities and encourage non-supervisors to report violations of No Contact and Supervised Visitation Orders; DCS must bring violations to the attention of

the Court; and Courts should take such violations very seriously and enforce the provisions of these Orders with the full weight of the law.

- In an effort to improve the enforcement of Juvenile Court No Contact orders, the SLC will explore including No Contact orders from juvenile courts in the State of Tennessee Integrated Criminal Justice Portal (Portal). Currently, Juvenile Court orders are not included in the Portal. The Portal is a browser-based application that allows Criminal Justice agencies to search multiple agency information without the need to log-in to different systems.
- In additional efforts to identify potential solutions, the SLC Director presented this finding, and the finding set forth next in this report, to the Administrative Office of Courts, Court Improvement Program (CIP) during a CIP meeting. Members of the CIP determined a collaborative effort including the juvenile courts, DCS and law enforcement may be the best way to address this finding and the finding set forth next in this report. In August 2016, the SLC Director presented this finding, and the finding set forth next in this report, to juvenile court judges at the Joint Conference on Juvenile Justice. The SLC will continue to engage stakeholders regarding this finding.

- The lack of consequences for failing to report child abuse continues to be an issue.
  - 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. The SLC will share its concerns with appropriate child abuse prevention stakeholders to include DCS, law enforcement, district attorneys, service providers, healthcare professionals and hospitals.
  - In part, TCA § 37-1-402(a) states, "The purpose of this part is to protect children whose physical or mental health and welfare are adversely affected by brutality, abuse or neglect by requiring reporting of suspected cases by any person having cause to believe that such case exists. It is intended that, **as a result of such reports, the protective services of the state shall be brought to bear on the situation** to prevent further abuses, to safeguard and enhance the welfare of children, and to preserve family life." Emphasis added. Individuals who suspect abuse are required to report the abuse, not investigate it. TCA § 37-1-401 *et seq.* is a mandatory report statute, not a mandatory investigate statute. Child abuse prevention stakeholders must make sure children are being interviewed by the

appropriate individuals. Additional training for professionals and services providers, and public information for the community regarding mandatory child abuse reporting would enhance child safety.

- The report by the district attorney mandated by TCA § 37-1-607(a)(1)(A) and (B) should contain specific information and be easily accessible.
    - TCA § 37-1-607(a)(1)(A)and (B) states,
        - The department shall coordinate the services of child protective teams. At least one (1) child protective team shall be organized in each county. The district attorney general of each judicial district shall, by January 15 of each year, report to the judiciary committee of the senate and the civil justice committee of the house of representatives on the status of the teams in the district attorney general's district as required by this section, and the progress of the child protective teams that have been organized in the district attorney general's district. The department shall, with the cooperation of all statutorily authorized members of the child protective team, establish a procedure and format for data collection. The procedure and format developed shall include at a minimum the following information:

(i) The number of reports received for investigation by type (i.e., sexual abuse, serious physical abuse, life-threatening neglect);

(ii) The number of investigations initiated by type;

(iii) The number of final dispositions of cases obtained in the current reporting year by type of disposition as follows:

(a) Unsubstantiated, closed, no service;

(b) Unsubstantiated, referred for non-custodial support services;

(c) Substantiated, closed, no service;

(d) Substantiated, service provided, no prosecution;

(e) Substantiated, service provided, prosecution, acquittal; or

(f) Substantiated, service provided, prosecution, conviction;

(iv) Age, race, gender, and relationship to the victim of perpetrators identified in cases that are included in subdivisions (a)(1)(A)(iii)(c)-(f); and

(v) The type and amount of community-based support received by child protective teams through linkages with other local agencies and organizations and through monetary or in-kind, or both, donations.

(B) Such data shall be reported by January 15 of each year to the judiciary committee of the Senate and the civil justice committee of the House of Representatives, along with a progress report on the teams and any recommendations for enhancement of the child sexual abuse plan and program.

- The requirements of the statute are not being fulfilled. Based on reports the SLC received from the Judiciary Committee of the Senate, 19 out of 31 district attorneys submitted reports referenced by TCA §37-1-607(a)(1)(A) and (B) in 2016. Of the 19 reports submitted, four of them appeared to substantially comply with the statute. Creating a form to capture the requirements of the statute may help with compliance. The SLC will annually review the reports submitted to the Judiciary Committee of the Senate.

- When a court other than juvenile court enters an order that may impact the safety of a child under the jurisdiction of a juvenile court, DCS and other child abuse prevention stakeholders involved in the juvenile court matter need to know about the order from the other court.
  - Sometimes, alleged perpetrators of child abuse are under the jurisdiction of several courts during the pendency of the juvenile court matter. These alleged perpetrators do not always share important information about activity that may negatively impact their juvenile court matter. In fact, they are generally under no obligation to do so. An alleged perpetrator of child abuse could have a judgment entered against him/her for domestic assault in criminal court and DCS and other stakeholders involved in the juvenile court matter would not know unless they took action to discover it, especially in larger counties. DCS, law enforcement and other child abuse prevention stakeholders should explore ways to obtain orders from courts other than the juvenile court.

Collaboration

- The difficulty of protecting abused children when a perpetrator cannot be identified is a recurring issue.

- As identified in the SLC 2015 Report, sometimes despite the best efforts of DCS, law enforcement and other stakeholders, the perpetrator cannot be identified in a child abuse case. When the perpetrator cannot be identified in these cases, the result may be no prosecution, return the child to an abusing or non-protective parent, etc. The inability to identify a perpetrator should not force DCS or the courts to potentially put the child in an abusive environment. In an effort to identify potential solutions, the SLC Director presented this issue to the CIP and the juvenile court judges at the Joint Conference on Juvenile Justice. The SLC will continue to engage stakeholders regarding this finding, including identifying appropriate strategies such as thorough investigations, effective collaboration, etc.

- DCS representatives often spend considerable time attempting to locate the abused child and the child's caregivers, who may be the alleged perpetrators of the child abuse. When a child is potentially in danger, time is of the essence.
  - If a designated DCS representative had the ability to directly access the Department of Human Services (DHS) benefits databases, DCS may be able to locate children and family members faster. The SLC recommends DCS and DHS work together to develop an agreement to give designated DCS employees limited access to the appropriate DHS benefits databases.

- Appropriate communication and collaboration between child abuse prevention and investigations stakeholders continues to be an issue.
  - Families in which severe child abuse occurs will often benefit from a variety of agencies and the coordination of services. The collaboration of agencies and services must be a priority of all child abuse prevention stakeholders. Appropriate communication and collaboration enhances the delivery of services to the child and family and helps child abuse prevention stakeholders make better informed decisions about the safety of children. DCS and others making decisions that will impact the safety of a child need to know as much pertinent information as possible. Information about prior child endangerment, no matter how minor it may seem, could make a substantial difference in the course of an investigation and the child's safety. Joint DCS and law enforcement investigations enhance child safety.
  - The 2012 SLC report recommends the establishment of additional family justice centers in Tennessee. The 2013 SLC report renewed the SLC's support of existing and future family justice centers. Again, the SLC supports efforts to maintain and improve existing family justice centers and the establishment of additional family justice centers in Tennessee. Family justice centers provide an excellent infrastructure for effective collaboration between child abuse prevention and investigation stakeholders.

- The SLC supports additional funding, resources and training for the proper use of extended forensic interviews.
    - Extended forensic interviews are a valuable tool. In child sexual abuse cases, the absence of physical evidence and witnesses is common. Abused children do not disclose child abuse during the first interview for a variety of reasons. If a child does not disclose during a forensic interview, the first interview may be the only interview regarding that particular allegation of abuse. On its website, the National Children's Advocacy Center states extended forensic interviews are "appropriate for children where the results of a single interview are inconclusive or where there are serious concerns about the child's ability to participate in a single-session interview. Such children might be the very young child, a child with developmental delays or cognitive disabilities, or an extremely traumatized child." http://www.nationalcac.org/extended-forensic-interview-training/

Training

- Despite DCS training and noticeable improvement, improper documentation continues to be an issue.
    - Proper documentation of all case activity is essential to making informed decisions regarding the safety of a child. Proper documentation provides an accurate picture of the investigation and DCS' involvement with the child and family. Proper documentation captures what formed the basis of actions taken or not taken by DCS. Moreover, proper case file documentation may help district attorneys prosecute perpetrators of child abuse. New case managers, supervisors and others who review a child abuse investigation file need to be able to determine what happened in a case and why by reviewing the file.
    - In cases reviewed this year by the SLC, documentation was sometimes confusing. Multiple names/designations were often used for the same individual. Entering information into TFACTS in a timely manner continues to be an issue, but improvements continue to be 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. The SLC noted improper documentation in 75 percent of the cases reviewed this year.
    - The SLC believes DCS case managers are receiving needed training to address documentation issues. The SLC will monitor this issue as additional DCS employees receive the needed training and DCS continues to address this issue.

- Issue-driven vs. incident-driven investigations continue to be an issue.

- Purely incident-driven investigations may or may not address all the factors that impact a child's safety and well-being. Ensuring the immediate safety of a child is paramount. However, ensuring the safety of the child is usually just the beginning of a long road to well-being, permanence and stability. Moreover, focusing too narrowly on a particular incident as opposed to the underlying issues could have a negative impact on the safety of a child.
- The SLC recommends DCS continue to provide training on this issue through the CPS Training Academy and other appropriate avenues. The SLC Director has completed the CPS Training Academy. He serves as a faculty member of the CPS Training Academy. The SLC Director helped vet portions of the curricula and currently reviews various DCS policy changes and additions. The SLC should continue to participate in and monitor the training at various stages to help determine whether the training addresses this reoccurring finding.

- The lack of consequences for failing to report child abuse continues to be an issue.
  - 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. The SLC will share its concerns with appropriate child abuse prevention stakeholders to include DCS, law enforcement and district attorneys.

- DCS did not always interview potential collateral witnesses of the child abuse.
  - Interviewing potential collateral witnesses is an essential part of conducting a child abuse investigation. Child abuse investigators should make reasonable efforts to identify and interview potential collateral witnesses set forth in referrals and additional witnesses identified during the course of the investigation. These individuals may have information that would help the investigator make an informed decision about the safety of the child. Additionally, finding and interviewing collateral witnesses is also important for trial purposes. Failing to follow-up on identifying and interviewing collateral witnesses could adversely impact the outcome of the case at trial.
  - Through the CPS Training Academy and other appropriate opportunities, DCS should continue to stress the need to interview collateral witness identified in the referral or otherwise identified during the course of the investigation.

- DCS employees cannot always quickly and easily access DCS history for all the alleged perpetrators and victims involved in an investigation.
    - Most, but not all, DCS case history is entered into TFACTS. Of the case history and other information entered into TFACTS, not all of it is easily accessible. The ability of a CPS Investigator to obtain all the DCS history of an alleged perpetrator is crucial to making an informed decision regarding the safety of a child. DCS should explore ways to enhance DCS investigators' ability to obtain previous DCS history of a child and family members.

- Continued efforts to improve drug exposed children/infants investigations are appropriate.
    - Substance abuse of caregivers was a major contributing factor of child abuse in the FY 2015 cases reviewed by the SLC. Although drug exposure accounted for approximately 25 percent of all of the maltreatment types set forth in the FY 2015 list of cases, that percentage may be misleading. The list of cases provided by DCS only contains the maltreatment type for two investigations. The family may have been the subject of other investigations reviewed by the SLC, but not set forth in the list of cases provided by DCS. Several investigations could have occurred during the time between the two investigations set forth on the list of cases. Moreover, the family could have been the subject of child abuse investigations that did not involve severe child abuse. Substance abuse was present in 75 percent of the cases reviewed by the SLC this year. Moreover, substance abuse or mental health issues were present in all but one case reviewed this year.
    - DCS should make and document additional efforts to determine whether a caregiver is exposing a child to drugs when the caregiver refuses to submit to a drug screen.
    - DCS has experienced an increase in all Drug Exposed Child (DEC) CPS cases (investigations and assessments) involving children of all ages. During federal FY 2014, DCS worked 23,270 cases reported to DCS involving at least one DEC allegation; 5,647 of those cases involved infants (children less than one year old at case opening). During federal FY 2015, DCS worked 24,225 cases reported to DCS involving at least one DEC allegation; 5,810 of those cases involved infants. During federal FY 2016, DCS worked 26,031 cases reported to DCS involving at least one DEC allegation; 6,094 of those cases involved infants. Infants are approximately 24 percent of the DEC cases from federal FY 14 through federal FY 16. However, during that time period infants were approximately 5 percent of the child population in the state. Additional or different approaches to address drug abuse must be employed by Tennessee.

The SLC recommends training, practice improvements and resources to address drug abuse using a public health approach. A public health response to drug abuse would involve a coordinated collaborative strategy involving various agencies, departments and communities to provide treatment as opposed to punishment. Community health and safety are priorities in a public health approach to addressing drug abuse.

- As set forth in the Courts and Legal section of this report, the SLC recommends additional training for professionals and services providers, and public information for the community regarding mandatory child abuse reporting to enhance child safety.

ACTION TAKEN ON SLC RECOMMENDATIONS

- From the beginning of the SLC, the core of many of the recommendations has involved strengthening relationships, interactions and investigations of stakeholders, and improving communication and collaboration. To address these issues, the SLC recommended the development of improved joint and collaborative training for all child abuse investigation stakeholders based on the identification of opportunities to improve practices. In part based on recommendations from the SLC, DCS created the CPS Investigations Training Academy (Investigations Academy) in 2013 to help address SLC findings and recommendations and improve the overall quality of CPS investigations and child safety. The Investigations Academy has the potential to strengthen relationships, interaction and investigation, and to improve communication and collaboration to reduce the incidents and impact of severe child abuse in Tennessee. Not only will DCS CPS investigators be required to attend the Investigations Academy, but TBI agents, CPIT partners and community partners are also invited and encouraged to participate in the Investigations Academy at no cost to their agency, with the exception of staff time and travel expenses.

  DCS Child Protective Services Assessment (CPSA) workers identified areas of need for CPSA workers which led to the establishment of the CPSA Training Academy. The CPS Investigations Academy and the Assessment Academy will be merged in order to maximize resources and to provide comprehensive training opportunities for all CPS and Family Support Services staff with an estimated implementation in 2017.

- The SLC has emphasized the need for DCS to conduct issue-driven investigations as opposed to incident-driven investigations, and while there are still opportunities for improvement, DCS has made strides in this arena. The Academy has the potential and was partly designed to address the practices and strengths of issue-driven investigations over incident-driven investigations.

- The Investigations Academy includes the following courses that help address various SLC findings and recommendations:
    - Medical Evaluation of Child Sexual Abuse;
    - Medical Evaluation of Child Abuse and Neglect;
    - John E. Reid Child Abuse Investigations;
    - John E. Reid Physical Neglect and Child Abuse Reconstruction Techniques;
    - John E. Reid Emerging Trends in Child Sex Abuse;
    - Drug Identification;
    - Recognizing and Documenting Impairment/Drug Use;
    - Meth, Meth Labs and Drug Trucks;
    - CPS Investigations Policy and Effective Use of Work Aids;
    - Juvenile Court Systems;
    - Case Presentation; and
    - Case File Documentation.

- In addition to the training received in the Investigations Academy, proper case file documentation training is included in DCS pre-service and specialty training. Tablets have been distributed to frontline CPS staff to ensure information can be documented and recalled with greater ease and accuracy. Improvements to TFACTS have allowed for increased efficiency in documentation for staff.

- The 2012 SLC Annual Report found a more consistent best practices model for Child Protective Investigation Teams (CPIT) should be developed and implemented across the state to reduce inconsistent CPIT practices and poor outcomes for children in Tennessee. The report recommended creating a Statewide Child Protective Investigation Teams (CPIT) Coordinator and a CPIT Advisory Board. In 2013, DCS appointed a Director of Community Partnerships within the Office of Child Safety. The Director serves as the Statewide CPIT Coordinator. DCS also developed a statewide CPIT Advisory Board. The Statewide CPIT Advisory Board developed by DCS in response to the recommendation by the SLC recently developed a Data and Practice Analysis Workgroup which has been tasked with reviewing the recommendations contained in SLC reports, in addition to other reports that contain recommendations for DCS.

- The 2011, 2012 and 2015 SLC Annual Reports all had findings and recommendations related to the need for improved supervision of frontline staff. Additional supervisors have been added by DCS to reduce the number of staff per team and to allow for more opportunities to provide intensive supervision and coaching. The Office of Child Safety Internal Quality Control Division developed an internal quality review process for CPS Investigations, Special Investigations and the Child Abuse Hotline. Evaluation methods and tools are used to standardize and assist supervisors in assessing performance by

gathering quantitative and qualitative data, which is then used for individual and team performance improvements.

- The 2014 SLC Annual Report found Tennessee should provide even more education regarding safe sleeping. In partnership with the Tennessee Department of Health, all 12 DCS regions have implemented a Safe Sleep initiative that involves home visitation, information sharing with parents about safe sleep, distribution of Pack and Plays as needed, and coordinated efforts with community partners to ensure caregivers are properly informed.

- When DCS is investigating harm to child and the child has been hospitalized, DCS should receive notice before the child is discharged from the hospital. Although the failure to notify DCS appears to be an anomaly, the need to notify DCS should be reemphasized. CPS investigators should remind hospital representatives of the importance of notifying DCS before a child subject to a DCS investigation is discharged from the hospital. DCS developed a Hospital Protocol to ensure hospital staff who are involved with children and families supported by DCS are considered team members and therefore should be included in the planning and decision making process. The purpose of the protocol is to promote effective communication and enhance and strengthen relationships between DCS and the medical community. The Hospital Protocol was effective as of December 1, 2016.

- The 2011 SLC Annual Report noted the terms used by DCS in its policies to classify the results of their investigations are not consistent with the classifications set forth in TCA §37-1-607 ("indicated" and "unfounded" vs. "substantiated" and "unsubstantiated"). DCS made significant terminology changes in efforts to align language with state law and nationally recognized and accepted language used by other child welfare agencies, law enforcement, disability and adult protective services. The term "substantiated" replaced the term "indicated" and the term "unsubstantiated" replaced the term "unfounded." The change was effective January 1, 2014.

Repeat Child Abuse Data

The reported number of children who experienced a second or subsequent incident of severe child abuse for fiscal year 2014-2015 is 643.

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

- Female: 72 percent;
- Male: 28 percent.

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

- White: 72 percent;
- Black: 22 percent;
- Unable to determine: 6 percent.

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

- 0-4 years old: 15 percent;
- 5-9 years old: 23 percent;
- 10-13 years old: 30 percent;
- 14-17 years old: 32 percent.

The types of maltreatment for FY 2015 are as follows:

- Abandonment: less than 1 percent;
- Abuse Death: less than 1 percent;
- Drug Exposed Infant: 3 percent;
- Drug Exposed Child: 10 percent;
- Lack of Supervision: 3 percent;
- Medical Maltreatment: 1 percent;
- Neglect Death: less than 1 percent;
- Nutritional Neglect: less than 1 percent;
- Physical Abuse: 9 percent;
- Sexual Abuse: 73 percent.

Number of individual children who experienced a second or subsequent incident of severe child abuse for fiscal year 2014-2015 reported in each county by judicial districts:

1st Judicial District

Carter	3
Johnson	1
Unicoi	2
Washington	7

2nd Judicial District

Sullivan	16

3rd Judicial District

Greene	7
Hamblen	2
Hancock	1
Hawkins	6

4th Judicial District

Cocke	8
Grainger	5
Jefferson	11
Sevier	13

5th Judicial District

Blount	7

6th Judicial District

Knox	36

7th Judicial District

Anderson	10

8th Judicial District

Campbell	4
Claiborne	6
Fentress	2
Scott	3
Union	1

9th Judicial District

Loudon	5
Meigs	1
Morgan	1
Roane	15

10th Judicial District

Bradley	10
McMinn	6
Monroe	5
Polk	1

11th Judicial District

Hamilton	14

12th Judicial District

Bledsoe	1
Franklin	4
Grundy	2
Marion	2
Rhea	3
Sequatchie	0

13th Judicial District

Clay	0
Cumberland	8
DeKalb	7
Overton	6
Pickett	0
Putnam	10
White	3

14th Judicial District

Coffee	10

15th Judicial District

Jackson	3
Macon	3
Smith	1
Trousdale	0
Wilson	12

16th Judicial District

Cannon	2
Rutherford	13

17th Judicial District

Bedford	7
Lincoln	4
Marshall	2
Moore	0

18th Judicial District

Sumner	21

19th Judicial District

Montgomery	22
Robertson	10

20th Judicial District

Davidson	39

21st Judicial District

Hickman	4
Lewis	1
Perry	3
Williamson	0

22nd Judicial District

Giles	1
Lawrence	7
Maury	4
Wayne	2

23rd Judicial District

Cheatham	6
Dickson	7
Houston	0
Humphreys	2
Stewart	1

24th Judicial District

Benton	2
Carroll	9
Decatur	1
Hardin	2
Henry	2

25th Judicial District

Fayette	7
Hardeman	2
Lauderdale	2
McNairy	5
Tipton	10

26th Judicial District

Chester	0
Henderson	4
Madison	11

27th Judicial District

Obion	9
Weakley	5

28th Judicial District

Crockett	1
Gibson	7
Haywood	4

29th Judicial District

Dyer	2
Lake	0

30th Judicial District

Shelby	104

31st Judicial District

Van Buren	1
Warren	11

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

The Tennessee General Assembly should be commended for its proactive stance regarding protecting the children of Tennessee. The SLC continues to work 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.

The General Assembly should continue the existence of the SLC through the Sunset Review Process. The SLC is a viable and an efficient mechanism to identify weaknesses in how severe child abuse cases are handled in Tennessee and to identify strategies to improve responses to severe child abuse. During the Sunset hearing on December 14, 2016, the Education, Health and General Welfare Joint Subcommittee of Government Operations recommended to continue the SLC for four years.

The SLC has consistently demonstrated the ability, willingness and desire to fulfill its statutory obligations. The SLC submits its reports containing findings and recommendations in a timely manner. Even more than simply fulfilling its statutory obligations, the SLC has gone above and beyond its statutory obligations in attempting to function with excellence. The governing statute requires the SLC to meet at least quarterly. The SLC generally meets every other month. The meetings are productive and the investigatory meetings always produce preliminary findings and recommendations that serve as a basis for the annual report. However, the meetings are just a portion of the time and effort put forth by the members of the SLC. SLC members read and review investigatory summaries before coming to the meetings. The investigatory summaries during 2016 averaged approximately 35 pages. The summary page numbers range from a low of eight to a high of 70. SLC members sometimes conduct their own research into matters being reviewed and share the information with the SLC during investigatory meetings. SLC members work hard to comprehensively understand the issues identified in the cases to improve how Tennessee handles severe child abuse cases. The SLC is a viable Commission.

Not only is the SLC viable, it is also efficient. The SLC is statutorily comprised of seventeen members. The SLC only has one paid position, the director. The director performs a substantial portion of the administrative tasks of the SLC so the members can devote their expertise and

limited time to addressing the more substantive aspects of the SLC's purpose. Moreover, thanks to the support of the Tennessee Administrative Office of the Courts, the SLC minimizes travel expenses by making teleconferencing and videoconferencing available in east and west Tennessee to its members for all meetings.

The SLC is a unique entity with a unique purpose: to make recommendations and findings regarding whether severe child abuse cases are handled in a manner that provides adequate protection to the children of Tennessee by investigating cases in which children have been the victim of second or subsequent incidents of abuse. Specialized, collaborative and concentrated efforts must be devoted to analyzing and responding to these tragedies. The SLC provides such efforts with minimal costs and maximum expertise.

The SLC is a critical entity because involvement of all groups represented on the SLC is essential for assuring Tennessee responds effectively to child abuse and neglect. Through its knowledgeable and professionally diverse membership and consultative input from various key stakeholders in preventing child abuse, the SLC continues to identify weaknesses and opportunities for improvement in handling severe child abuse cases. However, identifying these opportunities for improvement and making recommendations are just the beginning of improving how severe child abuse cases are handled. The data and various processes must be tracked and evaluated over time. 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. Additionally, the SLC continues to identify ways to increase its impact and better serve Tennessee children and families.

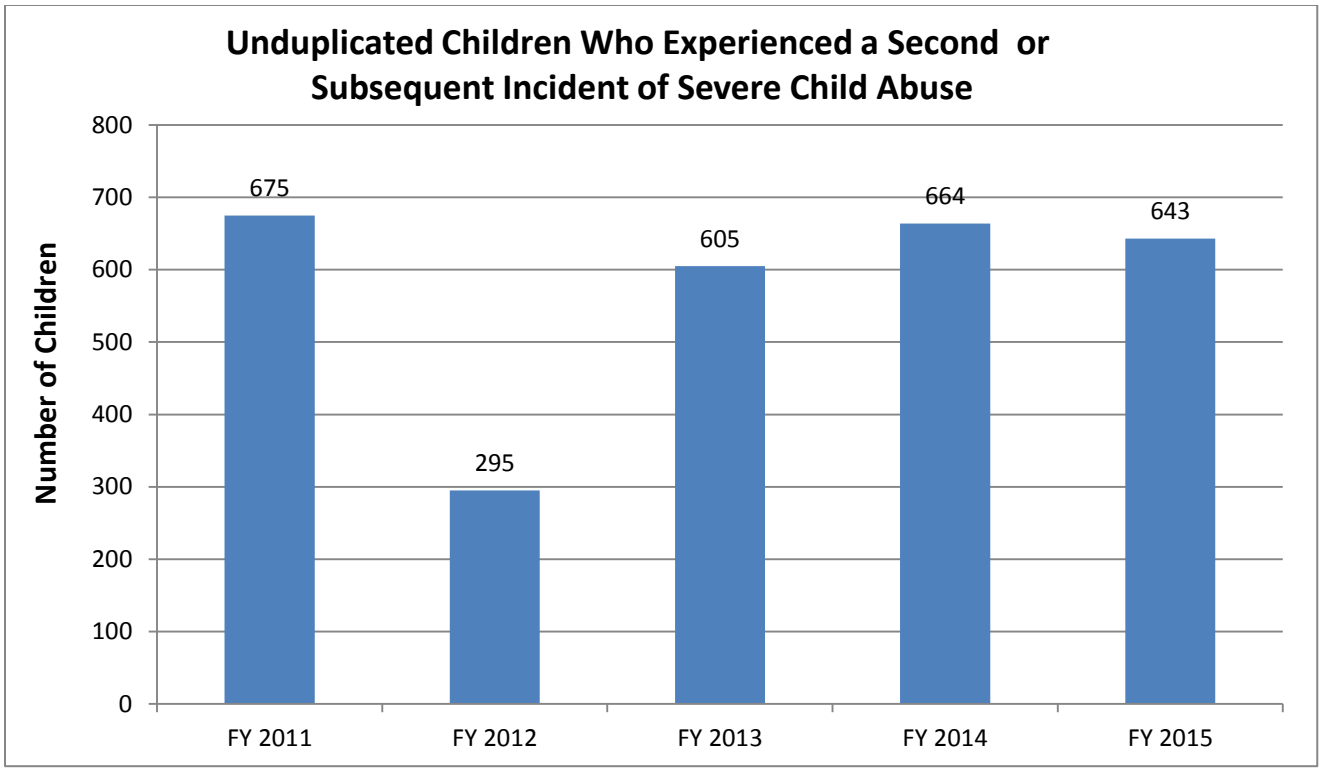


Chart 1

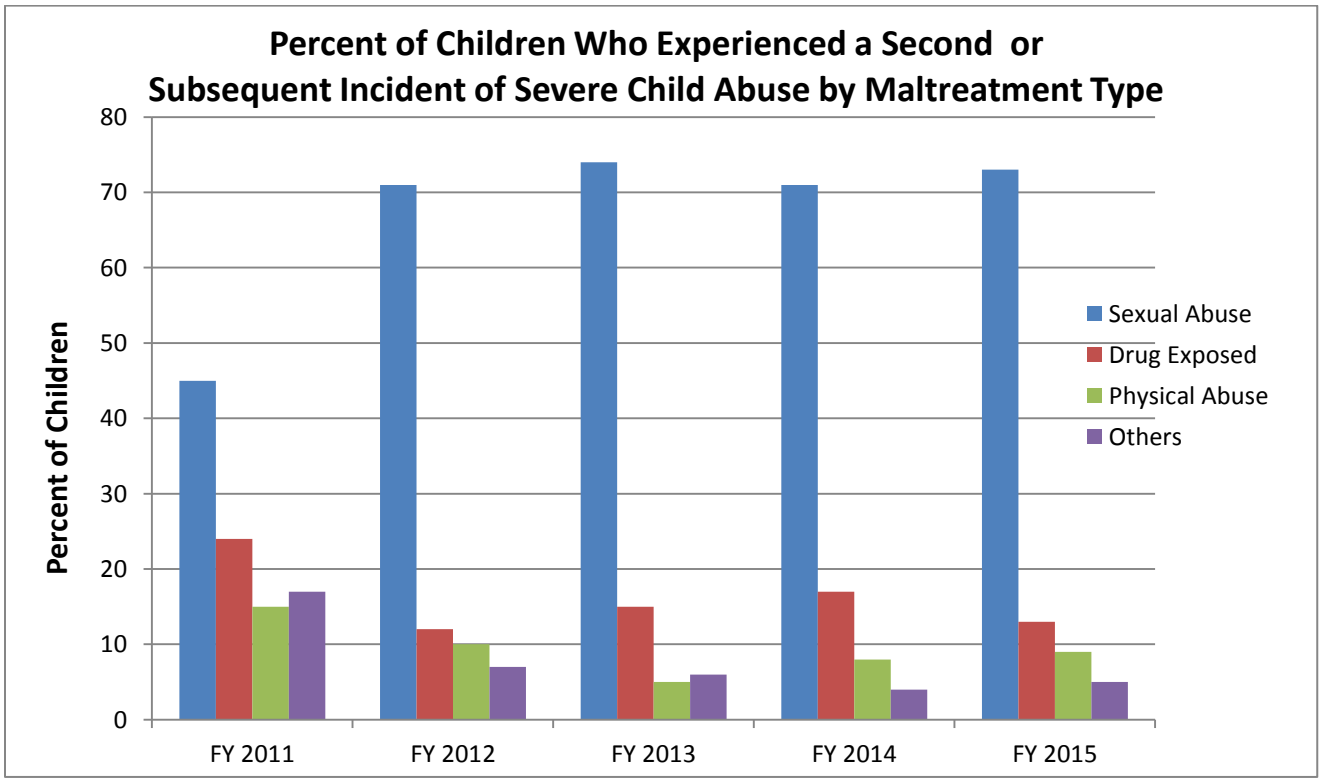


Chart 2

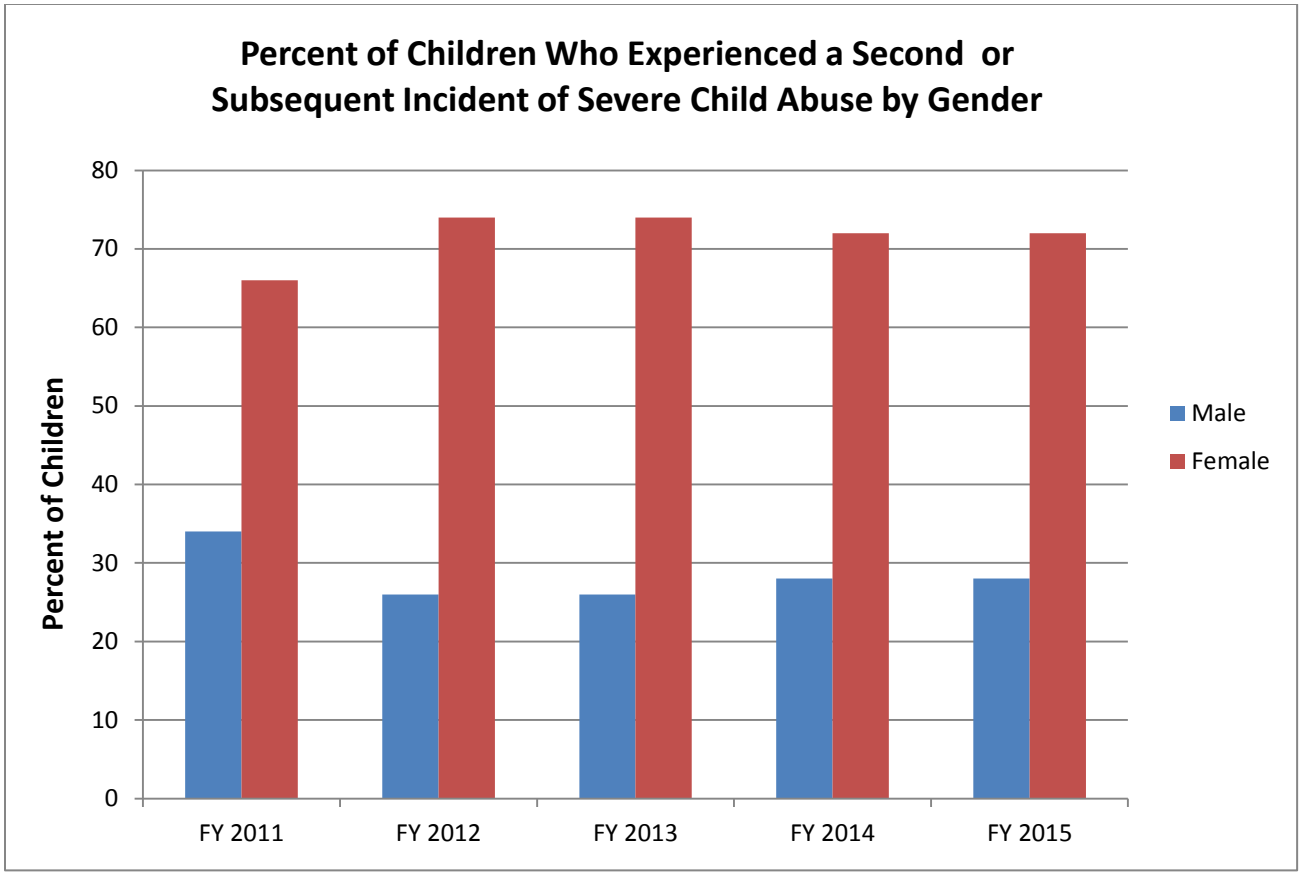


Chart 3

For fiscal years 2011 through 2015, male children were approximately 28 percent and female children were approximately 72 percent of the total population of the children who experienced a second or subsequent incident of severe child abuse in Tennessee based on data provided by DCS. However, for the calendar years 2011 through 2015, male children were approximately 51 percent and female children were approximately 49 percent of the total population of children in Tennessee. Based on the total population of children, female children are disproportionately represented among children who have experienced a second or subsequent incident of severe child abuse.

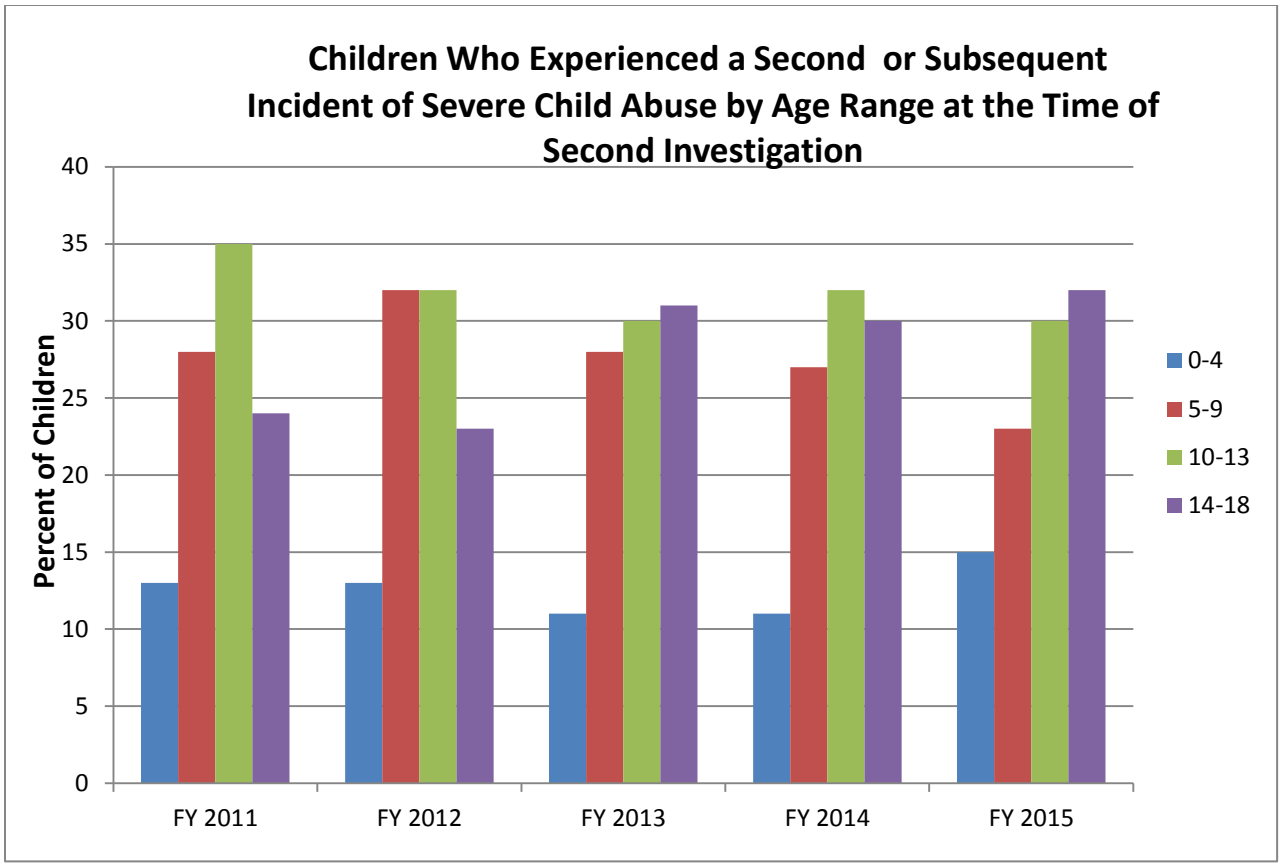


Chart 4

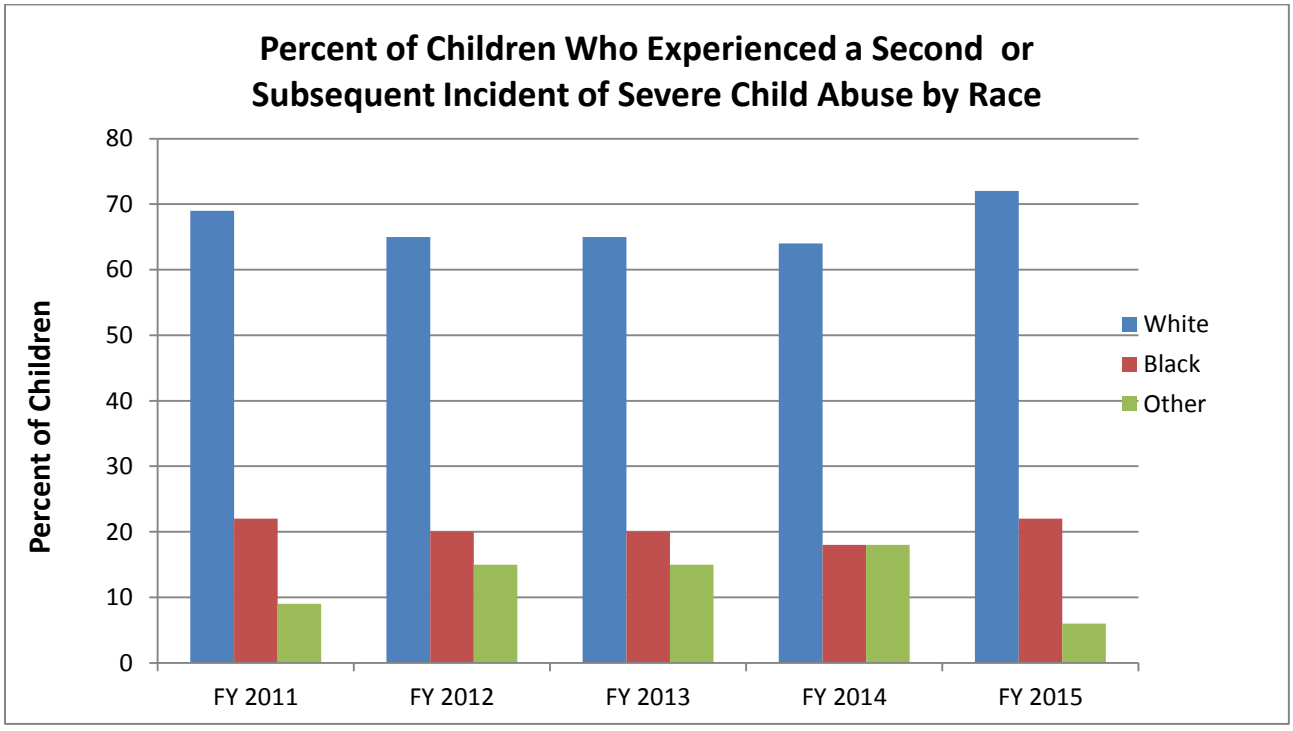
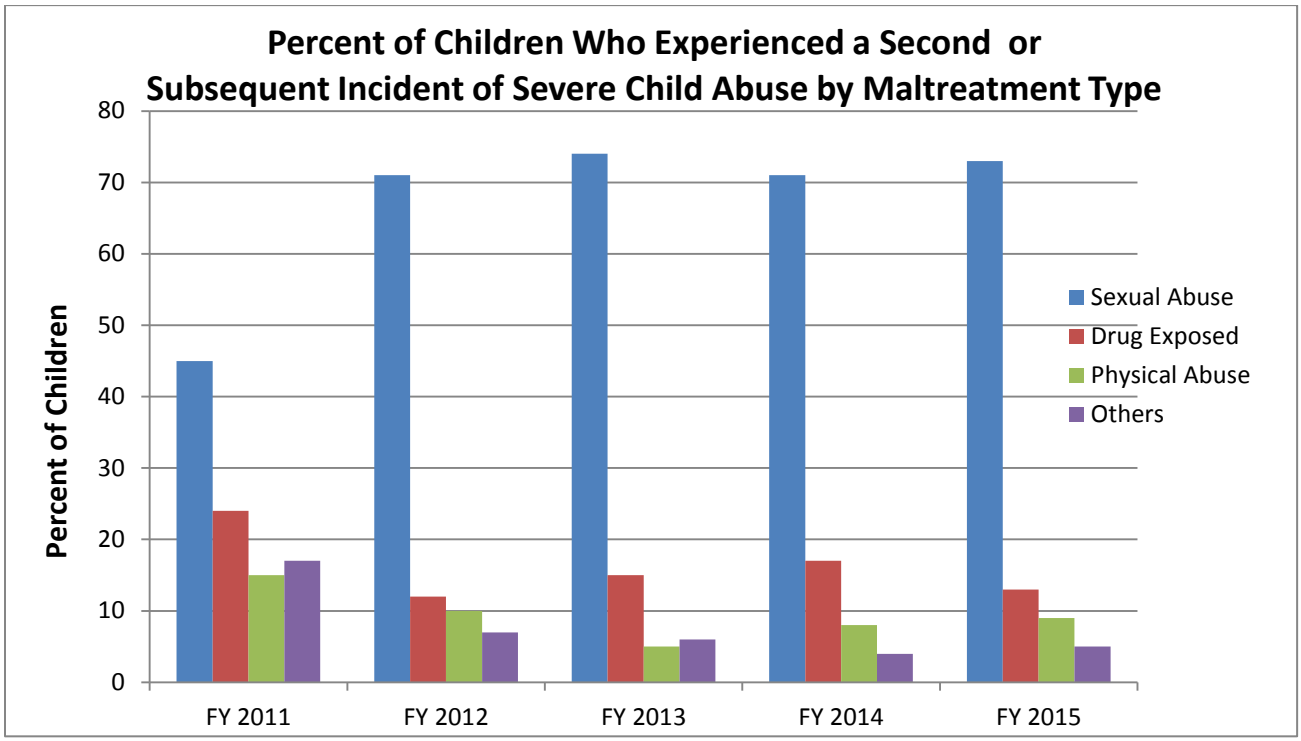


Chart 5



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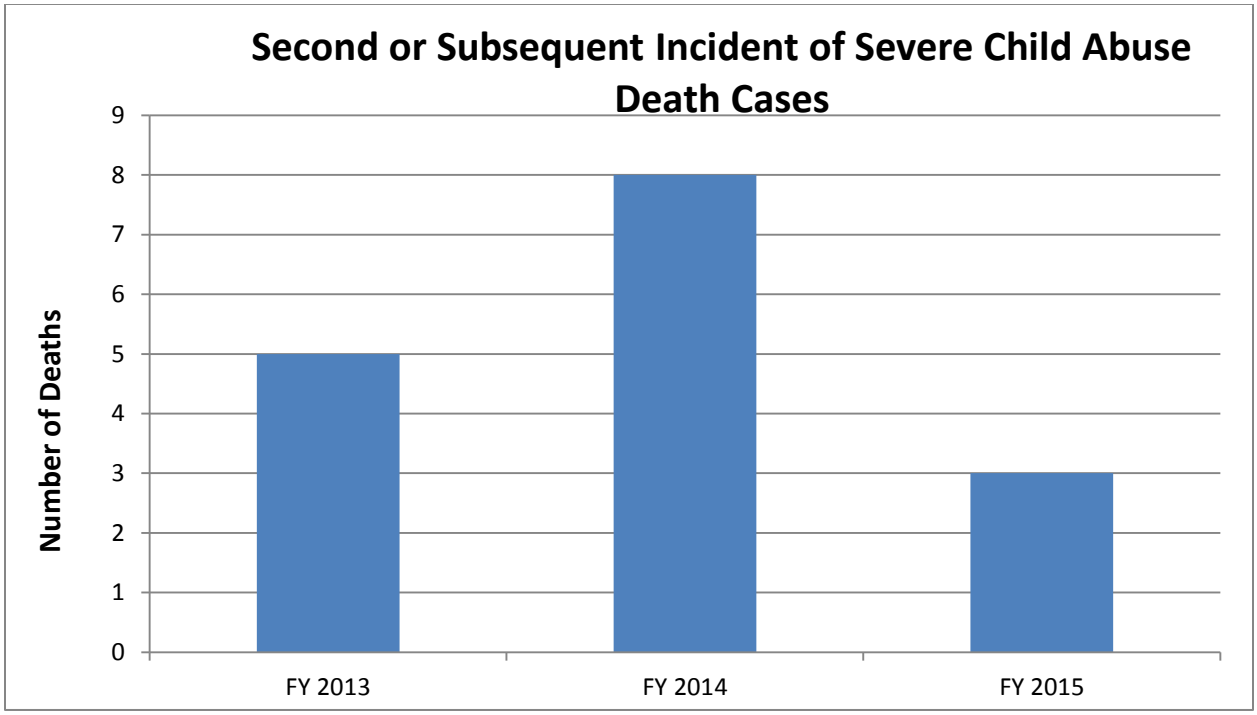

Chart 7*

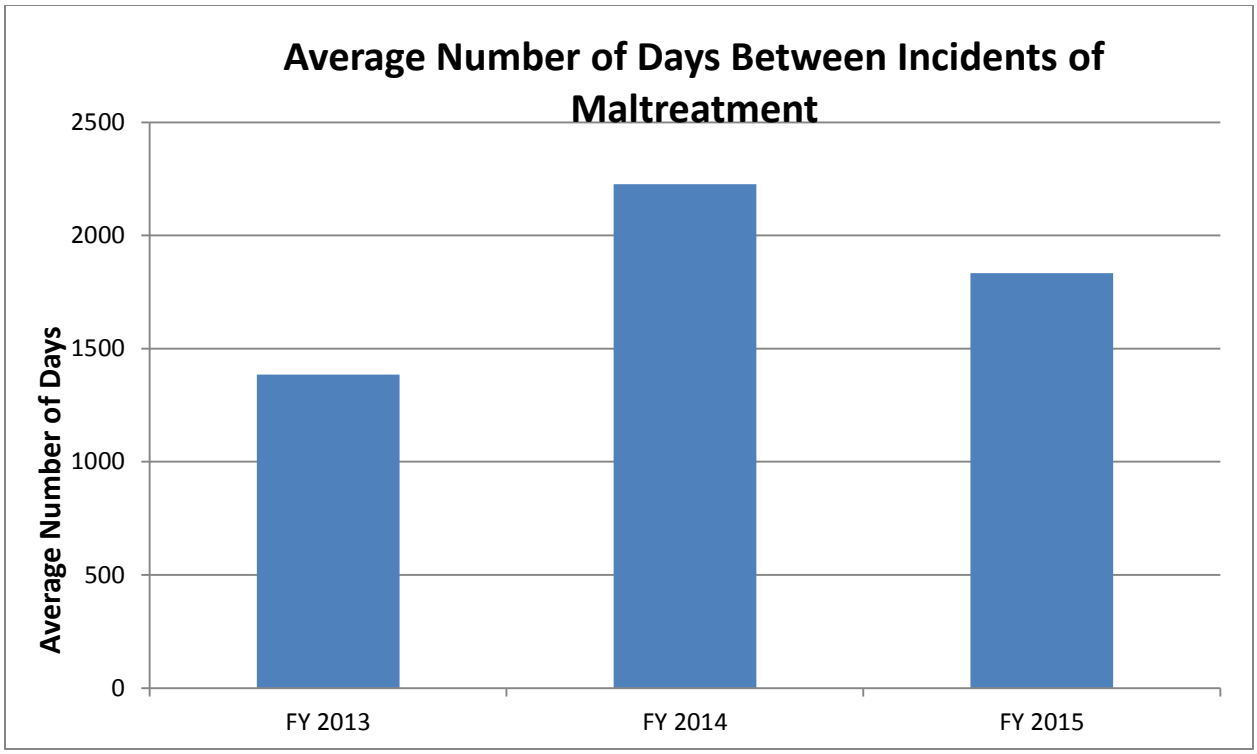

Chart 8*

*Charts 7 and 8 contain data only from FY 2013 – 2015 because the data was not collected in previous years.

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December 22, 2016

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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
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