Second Look Commission

2024 Annual Report

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Tennessee Commission on Children and Youth authorization number 316627. December 2024. 150 copies. This public document was promulgated at a cost of $1.36 each.

Purpose

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

Tennessee's continued prosperity requires that we support healthy child development. The link between adverse childhood experiences (ACEs), and a broad range of negative outcomes is well documented. Data accumulated over the past two decades provides strong evidence that toxic stress and early childhood adversities can derail optimal health and development (CDC, 2019; Merrick et al., 2019). Moreover, the resulting financial toll is estimated to cost hundreds of billions of dollars every year (CDC, 2019). These adversities often build upon one another producing a cascade of issues which ultimately place the next generation at risk (CDC, 2019). With thoughtful reflection and strategic planning, it is possible to break this devastating cycle of trauma and provide the necessary supports to families across the state. Each child in Tennessee deserves to live in a safe, stable, supportive, and nurturing environment.

Research shows healing from ACEs and toxic stress occurs in the presence of safe, stable, and nurturing relationships (SSNRs) (Garner & Yogman, 2021). SSNRs buffer adversity and help build resilience. Through thoughtful interventions aimed at fostering SSNRs, Tennessee children can live healthier and more productive lives. Utilizing a public health approach, as recommended by a multitude of reputable organizations such as the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP), resources should be employed for prevention, mitigation, and intervention. For maximal impact, universal prevention remains a key objective, but more intensive efforts are necessary for individuals known to be at a higher risk of ACEs (Garner & Yogman, 2021). Furthermore, effective

implementation will require coordination across public service sectors, including health care, behavioral health, education, social services, justice, and faith communities (Garner & Yogman, 2021).

Research has identified factors that protect or buffer children from experiencing abuse and neglect, commonly referred to as protective factors. Consistently, supportive social networks, community environments, and family support emerge as protective factors (Fortson et al., 2106). Although no one factor can fully explain why abuse or neglect may occur in a child's life, these protective factors have proven to reduce the likelihood of these traumatic experiences. The CDC's Preventing Child Abuse and Neglect: A technical package for policy, norm, and pragmatic activities identifies five evidence-based protective strategies including strengthening economic support to families, changing social norms to support parents and positive parenting, providing quality care and education early in life, enhance parenting skills to promote healthy child development, and intervene to lessen harms and prevent future risk (Fortson et al., 2016).

Supporting children, particularly those serving as the basis of this report who have already endured substantial hardships, while preventing additional children from enduring abuse and neglect, should be uncontroversial. They deserve to live fulfilling and productive lives. It is the responsibility of all Tennesseans to create communities where our families and children can thrive.

Unfortunately, this is not always the case and can result in children enduring abuse and neglect. The life-long impact of these experiences on children has long been studied, resulting in an increased risk of negative health, education, social and economic outcomes.

Stakeholder Feedback

The best outcomes will occur when the various child-impacting systems and stakeholders work collaboratively and inform the work of each other with the best interest of the child always being paramount. In continued efforts to facilitate collaboration and information sharing, the SLC sent its 2024 preliminary findings and recommendations to the following entities and departments to give them an opportunity to review the issues and have input into the solutions:

- Family and Children's Service
- Joint Task Force on Children's Justice
- Our Kids Center
- TennCare
- Tennessee Association of Chiefs of Police
- Tennessee Department of Children Services
- Tennessee Department of Education
- Tennessee Department of Health
- Tennessee Department of Human Services
- Tennessee Department of Mental Health and Substance Abuse Services
- Tennessee District Attorneys General Conference
- Tennessee Public Defenders Conference
- Tennessee Sheriff's Association
- Vanderbilt Center of Excellence for Children in State Custody

Reporting Requirements

In part, TCA§ 37-3-803(b) states, "The commission's findings and recommendations shall address all stages of investigating and attempting to remedy severe child abuse." The findings and recommendations included in SLC annual reports address all stages of investigating and attempting to remedy severe child abuse in Tennessee, including DCS and law enforcement investigations, provision of services and the prevention and mitigation of harm. TCA§ 37-3-803(d)(2) states, "The commission shall provide a report detailing the commission's findings and recommendations from a review of the appropriate sampling no later than January 1, 2012, and annually thereafter, to the general assembly. Such report shall be submitted to the governor, the judiciary and health and welfare committees of the senate and the civil justice committee of the house of representatives." The SLC has submitted the statutorily mandated report to the entire General Assembly, the Governor's Office and SLC members in a timely manner every year the SLC has been in existence. Additionally, the report is posted on the website of the Tennessee Commission on Children and Youth.

The following observation, findings and recommendations of this report are based primarily on the severe child abuse cases reviewed by the SLC during the 2024 calendar year. It is our hope 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. The observations, findings, and recommendations are discussed below.

2024 Second Look Commission Findings, Recommendations, and Observations

Observed Strengths

Findings:

Key Finding: When members focused on instances of substance-exposed children, they were encouraged by the response and support provided to parents who were having challenges with substance use.

Findings related to this include:

- Members were encouraged by the patience and grace caseworkers displayed when interacting with caregivers with substance use challenges.
- Members noted caseworkers continuing to believe parents until given proof otherwise.
- Members were encouraged that their experience regarding caseworkers providing support to parents struggling with substance use also appeared to be occurring statewide.
- Members noted the strength of not treating the caregiver's substance use as a moral failing but dealing with the addiction.
- Members were encouraged in one case, the system appeared to work as it should. When the caregivers were struggling with substance use and incarceration, the grandparents were able to provide care for the children. Eventually, after serving their time, completing their permanency plan, and a successful trial home visit, the caregivers gained custody back and there have been no further incidents.

Key Finding: Members frequently referenced the success seen in Safe Baby Courts and the need to implement the practices and philosophy of Safe Baby Courts in cases with older youth.

Findings related to this include:

- Members emphasized the success seen by Safe Baby Courts, particularly non-custodial cases with a focus on prevention and targeted work. It was noted that these cases are worked the same way as custodial cases. Members hoped that the approach taken by Safe Baby Courts could permeate into cases involving older children.

Key Finding: In several cases, members noted the engagement and positive impact that the caseworker had on a child.

Findings related to this include:

- Members noted that although the child's time in custody was challenging, their caseworker was excellent. She formed a strong bond with the child and continually provided support.
- Members noted the importance of continued efforts to reduce turnover, which allows children to have more consistency and a stronger relationship with their caseworkers.

Key Finding: Members noted the specialized teams created by DCS appear to be working well for complex or special populations.

Findings related to this include:

- Members felt that the new Human Trafficking team at DCS helped coordinate services and work with TBI. Members felt the involved agencies did the best they could with the information available to them at the time.
- Members discussed the importance of the new specialized drug teams. Particularly planning for and understanding relapse as a part of recovery.
- Members discussed the nuances and challenges that can come with these special populations and cases. These cases benefit from specialized training and experience. The specialized teams are not statewide, but DCS is working on providing training to support areas that do not yet have these teams.

Key Finding: Due to the many stakeholders involved in child abuse cases, members were encouraged by instances when all parties involved in the case collaborated effectively.

Findings related to this include:

- Members were encouraged to see all the partners involved in the case (Child Protective Investigative Teams, Department of Children's Services, Sheriffs,

and District Attorneys) collaborate effectively and efficiently, leading to positive outcomes for the children involved.
- Members were encouraged to see that an individual who knew of the abuse and did not report was charged with failure to report.
- Members felt that the Department handled the case in the best manner possible and could not identify a different course of action that would have changed the outcome. Members felt the Department took every piece of information available to them.

Transition Homes

Findings:

Key Finding: Members noted challenges with documentation of children's placement and time at transition homes.

Findings related to this include:

- Members noted that the Transition House Protocol on documenting where a child is placed was not being followed. The lack of documentation made it nearly impossible to tell where children were each day, when they had run away, and when they returned.
- There were several children documented as being placed at a foster home in Clarksville. However, case documentation and police reporting indicate they were living at a transition home in Davidson.
- The SLC continues to pursue the documentation from the Department of Children's Services regarding a runaway incident in which a child was trafficked.
- One child was in a transition home for more than 20 days, during this time the child's location was never documented in TFACTS or in accordance with the Transition Home Policy.

Key Finding: Members were concerned regarding the safety and supervision of children in transition homes.

Findings related to this include:

- Members had concerns with the safety of children placed at transition houses.
- Members noted that youth did not appear to be supervised appropriately and were victimized in the transition houses.

- Members additionally noted that due to the lack of supervision, youth frequently ran away from transition houses and found themselves in extremely dangerous situations.
- Members noted that children were not properly protected from other children in the transition house. One child with a history of running and risky sexual behaviors was placed in a transition house, convinced another child to run away with them, and trafficked that child. Following that incident, they were returned to the same transition house and victimized another child.

Recommendations:

- **Recommendation:** Members noted that many of the children placed in transition homes have extensive trauma history, resulting in reactive and challenging behaviors. Many of them have a higher level of need and staff are not adequately prepared to manage the needs or number of children in the facilities. The Department should ensure that current policy stating, "At least two (2) DCS staff will be present; with both staff providing continuous supervision in the Transitional House when children/youth are present and under no circumstances shall the ratio of children/youth to DCS staff exceed 3:1. Additional DCS Case Managers may also need to be present based upon the needs of the child/youth" is consistently followed. Additionally, the policy should be updated to provide guidance on procedure in the event a child arriving at a transition home creates a situation that exceeds the ratio.

- **Responsible party:** Tennessee Department of Children's Services

DCS Response: Security guards and sitter services are also utilized to supplement the adult/youth ratio and to assist in providing support and supervision. Security staff have been beneficial when youth exhibit challenging behaviors however, they are only allowed in certain transitional spaces.

DCS is in the process of hiring 9 behavior specialists to assist in addressing the complex behavioral needs of the youth in transitional houses. They will be located in the 6 regions which have the highest number of youth in transitional houses. Over the past year, two (2) additional cottages have been renovated and opened on the Cloverbottom campus in Nashville bringing the total cottages to three (3). This has alleviated the overcrowding at transitional houses by providing 72 beds for youth awaiting placement. A fourth cottage is currently being updated and expected to open in January 2025, which will add 24 more beds with an overall

capacity on the campus to temporarily house and provide services to 96 youth seeking placement. The Bartlett Assessment Center is on schedule to open in February 2025 to serve Juvenile Justice youth awaiting a staff secure placement and Dependent/Neglected youth with delinquent charges. DCS has a real estate plan that when completed, will open intake and assessment centers across the state and eliminate youth staying overnight in temporary settings.

Recommendation: The Department should ensure that the placement of children in transition homes is appropriately tracked, and those records are retained. DCS should ensure the protocols in place for reporting placement changes are being consistently followed and the location of the child is easily accessible to those working with the child in TFACTS.

- Responsible party: Tennessee Department of Children's Services

Recommendation: Due to the complex backgrounds, situations, and behaviors many children in transition home are facing, it is critical that those working with children in these settings have all of the appropriate information. The Department should ensure the Child Daily Log for Transition Homes is being completed for every child, every day and that those records are being retained appropriately.

- **Responsible party:** Tennessee Department of Children's Services

Recommendation: Many transition homes rely on a variety of individuals including volunteers and third-party providers. Due to the trauma and vulnerability already experienced by many youths in transition homes, the Department should ensure that all adults in transition homes with children have background checks as outlined in Protocol for Delegated Authority (DA) Sitter Services Vetting.

- **Responsible party:** Tennessee Department of Children's Services

DCS Response: All volunteers, sitters, security guards, and others who interact with children/youth in DCS custody undergo background checks. This is a contractual requirement for guards and sitters and volunteers at transitional houses are not approved until the background check is successfully completed.

Foster Homes/ Placements

Findings:

Key Finding: Members found opportunities for additional support for families caring for children, particularly relative or kin caregivers.

Findings related to this include:

- Members noted familial placements are not given the same support as a foster placement. In particular, Relative Caregivers do not receive the full foster care daily board rate. Members were encouraged by newly passed legislation that would remove the income cap on Relative Caregivers.
- Members discussed opportunities for additional support for Relative Caregivers beyond the daily board rate such as insurance, social support, and interventions.
- Members noted that familial placements and Relative Caregiver Placements do not have the same level of accountability as foster homes. It was discussed that sometimes safeguards can be established through the courts. Members noted that judges have latitude and sometimes request the Department of Children's Services case remain open.
- Members questioned if there was a translation hotline for foster parents to communicate with foster youth who do not speak English. Members discussed the different needs of a translator for formal instances such as interviews and court appearances compared to day-to-day in-home interactions and relationship building.
- While a youth was in a residential facility, the Department of Children's Services had to be court-ordered to begin the Interstate Compact on Placement of Children (ICPC) process due to concerns from the child's Guardian Ad Litem regarding how long the process would take and that the Department had not begun the process. The delay in starting the ICPC process resulted in the child being kept in the residential facility for four additional months after being medically discharged.

DCS Response: Effective October 2024, relative caregivers receive payments, which are 50% of the foster home board rate, and in a more expeditious timeframe. Services can be accessed and provided to the relative caregivers to stabilize a placement and the agencies managing the relative caregiver programs often provide those services or assist in connecting the family to local resources.

Key Finding: Members expressed concerns regarding the safety, supervision, and care provided to children in placements.

Findings related to this include:

- In one case, there were six kids in a foster home. Members had concerns that this made it difficult for the parents to appropriately monitor all the children.
- Members were concerned about children being exposed to sexual material at a facility that was supposed to be safe. There was particular concern for the youth victims who had a history of sexual victimization.
- Members were concerned that several people in the case mentioned the child in the home was reported to be treated differently because they were not a biological child.

DCS Response: When allegations of abuse or neglect are reported in a facility where custodial children are placed, the Special Investigations Unit investigates. This is a joint effort involving the DCS licensing and provider quality team to assess safety and address issues. For allegations involving sexual abuse, the CPIT partners are also involved.

Recommendations:

Recommendation: There should be more consistent implementation of the Department's Administrative Policies and Procedures: 14.13 Non-Custodial Immediate Protection Agreements, specifically section C (6) stating: The Case Manager and supervisor/designee consult with the RGC within three (3) business days, but no later than ten (10) business days from implementation of the IPA to determine whether the IPA will be dissolved or a petition will be filed. In the event that the Case Manager and RGC/designee have determined that a petition will be filed, the petition should be filed no later than ten (10) business days from implementation.

An Immediate Protection Agreement is designed to be a short-lived document and agreement between the Department of Children's Services and parents, not a permanency tool. A petition should be filed with the juvenile court within 10 days of the implementation of the IPA, when DCS determines, they are going to file.

The Department of Children's Services Form CS_0701, Immediate Protection Agreement should include information regarding the IPA timelines established in Administrative Policies and Procedures: 14.13.

- **Responsible party:** Tennessee Department of Children's Services

Missed Opportunities for Earlier Intervention

Findings:

Key Finding: Members continued to notice a pattern of multiple prior allegations of sexual abuse resulting in later sexual behaviors exhibited by the child.

Findings related to this include:

- There were concerns about the number of sexual abuse allegations and sexually reactive behavior that was being displayed by children in the case.
- Members again noted that it is not surprising that a child with an extensive history of sexual abuse later displayed sexual behavior.

Key Finding: In several cases, members felt earlier, and appropriate intervention could have changed outcomes.

Findings related to this include:

- Members discussed a need to critically examine the abilities and limitations of caregivers.
- Members found opportunities for the Department to more effectively use the history of the child and family captured in the standardized assessment practice (CANS/FAST) when making decisions.
- Members noted that the mother did not inform medical professionals treating the child of falls that had occurred.
- Members were concerned that the significant neglect occurring by the father did not appear to be addressed until it was brought up in a meeting with the child's public defender.
- Members discussed that if it had been found the mother had failed to protect the youth in the first case, there might have been a shift in the child's trajectory. Members felt that responsibility should have been placed on the mother earlier.
- Members discussed a child with both Dependent/Neglect and Juvenile Justice history. Members felt that potential changes to earlier investigations could have prevented the escalating behaviors that led to the child being involved with the juvenile justice system.
- Members discussed when a youth is involved in the Juvenile Justice system, but there are underlying Dependent/Neglect issues at home that are not being addressed, it can make it difficult to have a lasting and meaningful change in that child's life. The child can make progress in their program or on their plan, but if the situation in the home they are returning to is not being

addressed or changed, it is not surprising when the behaviors begin to escalate again.

- When discussing the case of a youth with Dependent/Neglect and Juvenile Justice involvement, it was noted that the child is blamed for their escalating behaviors., However, members wondered if the escalating behaviors could have been prevented, if appropriate interventions were implemented in the beginning.

DCS Response: The department's budget request for 2025-2026 includes the expansion of available services to 300 families in Youth Villages Intercept Program. This program is an intensive in-home evidence-based model to address the needs of the youth and the family and aligns with preventing a custodial episode or supporting a successful reunification.

Key Finding: In particularly complex cases, members felt there was a missed opportunity for the Department to use additional available resources.

Findings related to this include:

- Members discussed how a case had a significant number of referrals and overlapping investigations. Members felt DCS should have paused and brought all incoming information together in a multi-disciplinary team meeting. The department could have coordinated more effectively to address the various factors in the case, ensuring that nothing was overlooked or left unaddressed.
- Members discussed the value that a third-party review and recommendation such as the Centers of Excellence can bring to a case, particularly those with a significant number of referrals and investigations.
- Members felt that Centers of Excellence should have been brought in to assist in the case. Members also felt there were additional internal resources at the Department that could have been used due to the complexity of the case.
- Members felt that after the second instance of abuse, there was an additional opportunity for more intensive services in the home and safeguards to protect the children while in the home. It was noted that there was some level of home care being provided but the details, services, and intensity were not documented. Members felt that the mother's behaviors were never adequately addressed.

Key Finding: In certain cases, members felt efforts to continue to involve biological parents were preventing permanency.

Findings related to this include:

- Members felt efforts to include the mom delayed getting the child a more consistent safety net.
- Members discussed the many chances the mother had to regain custody over a long period made finding permanency harder. Members noted that the children are three years in and still do not have permanency.
- While members were encouraged by the support given to the parents, they did note in certain cases a concern for the child and the goal of achieving permanency particularly when placed through an Immediate Protection Agreement. Members noted in one case with two siblings, one child went from family member to family member on IPAs while another was able to find stable placement through an IPA with the right family member.
- Members had concerns with the level of agency given to a child in terms of the direction and outcome of the case. Members felt that not terminating parental rights was putting significant energy into a goal that was not feasible.

Key Findings: Members continue to find instances in which engaging the fathers can provide permanency for a child.

Findings related to this include:

- Members noted that although the father had been actively involved in the child's life, he did not file a petition for custody for several years. Once he was granted custody, the child finally had stability for the first time. Members discussed the adversity and dangerous situations the child could have avoided had this been done sooner.
- Members discussed continued opportunities to further support fathers in gaining custody, cost of attorney, etc.
- Members expressed concern about fathers receiving less support than mothers. It was mentioned that sometimes fathers have to do an Immediate Protection Agreement or Safety Placement. It was noted that this is treating them like another family member, not the parent they are.

DCS Response: Both parents or guardians must sign the Immediate Protection Agreement.

Key Finding: Members noted that engaging multi-disciplinary collaboration can help lead to better responses and services for children.

Findings related to this include:

- Members discussed the importance of working with families to keep kids from entering custody and reducing further custody episodes. Members emphasized the importance of working with the addiction community in this process.
- Members discussed if there is an opportunity for caseworkers and mental health workers to collaborate more frequently. Members felt this would allow the caseworker to support and ensure the child was getting and implementing help from counseling. Members discussed opportunities for follow-ups to evaluate how well the practices from counseling are being implemented in daily life.
- Members discussed opportunities to engage mental health providers with DCS. They noted the value it brings when providers treating the child can share with the case manager how they think the services are going.
- Members noted while mental health providers are permitted to participate in CPIT, they are not always there. Members discussed the valuable perspective they bring and felt their participation in CPIT is critical.

DCS Response: Child Protective Services diverted the following number of children from entering custody.

2022: 3,232
2023: 3,908
YTD 2024: 3,138

Observations:

Members noted that there can be significant difficulties in assessing the needs of older youth and finding them permanency.

Members discussed that had the early circumstances with the child been addressed appropriately, they may have had a different trajectory.

Recommendations:

Recommendation: There is a need for additional services as well as clearer understanding of who is currently providing services for youth with sexual behaviors across the state. The Department of Children's Services & Department of

Mental Health and Substance Abuse Services should work together to establish a database contains information of providers who offer services for youth with sexual behaviors.

- **Responsible party:** Tennessee Department of Children's Services & Tennessee Department of Mental Health and Substance Abuse Services.

Recommendation: Currently, when a child is receiving services that are not being billed through DCS, such as those provided by the Child Advocacy Centers, that information is not easily or quickly accessible in TFACTS. It often requires looking though case documentation or permanency plans. As the Department implements a new case management software, they should consider implementing a feature that would allow for quick access to all services a child is receiving, both those billed to the department and not.

- **Responsible party:** Tennessee Department of Children's Services.

Recommendation: The Second Look Commission should review data from the Department of Children's Services regarding permanency and family member IPAs in 2025.

- **Responsible party:** The Second Look Commission and Tennessee Department of Children's Services.

Recommendation: The Department should establish a policy that once a case has a certain number of referrals or overlapping investigations, a multi-disciplinary team meeting shall occur. During that meeting, it should be determined if a third-party review such as the Centers of Excellence should be brought in for assistance.

- **Responsible Party:** Tennessee Department of Children's Services

Recommendation: The Second Look Commission should review DCS guidelines regarding custody decisions and continue to encourage familial placements, including paternal contacts.

- **Responsible Party:** The Second Look Commission

Services

Findings:

Key Finding: Members continue to see significant challenges in obtaining services that are timely & appropriate.

Findings related to this include:

- Members noted the importance and need for the right type of services to match the needs of children, particularly those with more complex needs or a higher level of care. Members discussed the need for providers with the appropriate level of training and expertise to adequately assess and treat this population.
- Members expressed concern about what follow-up mechanisms and services are available to the family once both DCS and the court close the case.
- Members noted that access to services, particularly mental health services, continues to be a challenge.
- Members noted often a child would be discharged from a residential mental health facility doing well. However, once they were out, they were not able to access outpatient mental health services for a month or two. During that time, the child's mental health would deteriorate again resulting in re-admission into a residential facility.
- Members again noted challenges with getting youth and families the services that they need.
- Members noted that there are many challenges with mental health service provision across the state including not enough mental health providers, months-long lapses in care before a new provider is available, and frequently changing providers.
- Members discussed establishing a new client-provider relationship takes consistency and sometimes months to build rapport and then that provider leaves.

Recommendations:

DCS Response: There are 15 counties which account for 50% of the entries into custody. Of these counties, DCS will focus efforts to increase services in the rural areas by expanding the Youth Villages Intercept Program. In the 2025-2026 budget request, DCS asked for an increase in funding for an additional 300 slots.

Recommendation: Access to a variety of mental health services including outpatient, residential and varying needs of acuity continue to be a need for children across the state. The state should continue to prioritize funding mental health services and initiatives to expand the mental health workforce in Tennessee.

The state should take into consideration local resources, needs and funding streams. Members discussed building off existing services such as Tennessee Child and Adolescent Psychiatry Education and Support which supports the integration of mental health care into pediatric primary care.

- **Responsible party:** Tennessee General Assembly

Recommendation: The state should evaluate existing mental health providers who provide services to children and accept TennCare. They should assess the acuity of care provided, modality in which it is provided and their ability to provide appropriate services to children who have experienced severe abuse. This evaluation can assist in determining any coverage gaps or need for additional providers and investment.

- **Responsible party:** TennCare, Tennessee Department of Mental Health and Substance Abuse Services and Tennessee Department of Children's Services.

Court/Legal

Findings:

Key Finding: Members discussed additional opportunities for communication and follow-up regarding criminal charges.

Findings related to this include:

- Members noted there appears to be a breakdown in the system between the Department of Children's Services and Child Protective Investigative Teams substantiating a case and referring it for prosecution, to the case being prosecuted or handled in criminal court. It was discussed that this is likely because it can take a significant amount of time to prepare cases and at that point, DCS and CPIT have moved on to the next case. Members recommended that when cases referred for prosecution by CPIT are not prosecuted or pursued further, the district attorney's office should provide information to the CPIT on why prosecution was not pursued.
- Members were concerned that aside from a substantiation, there did not appear to be any further consequences for someone providing condoms to be used to have sex with a child who was 12.

Key Finding: Members expressed concerns regarding processes and procedures related to custody and Child Protective Investigative Teams.

- Members noted that the biological father gained custody of the child even though he had a history of criminal behavior, including domestic assaults. Members discussed how far back criminal history should be considered and the weight it should be given when determining custody.
- Members expressed concerns about the changing of a CPIT disposition without bringing the case and all CPIT members back together. Additional evidence was heard from the public defenders, guardian ad litem, and district attorney in separate meetings. Members felt that all this evidence should have been presented together in one hearing.

DCS Response: CPIT recommends the DCS classification however, an alleged perpetrator is afforded due process, and the classification can be overturned by an administrative judge or during a juvenile court proceeding.

Key Finding: Members found need for additional support and increased access to legal processes.

Observation -
Members discussed concerns with Pro Se filings and Court Access. These include:

- Parents have to work so hard to gain access to the court system. Mentioned the significant cost for attorneys that can be prohibitive.
- Parents are running into challenges when filing Pro Se. In certain courts, clerks are resistant; telling people they have to have an attorney and are not able to file on their own or rejecting Pro Se petitions because they are not typed. Members described this as an access to justice issue.
- The Children's Justice Taskforce has developed forms for Pro Se filings. These are provided to the courts but not required.

Key Finding: Members found opportunities for increased documentation.

- Members questioned why law enforcement reported not having any files when they participated in CPIT on the case.
- Members were concerned that a school reported not having the restraining orders for a parent who was an alleged perpetrator.
- Members noted that the alleged child victims appeared to be seen as unreliable narrators.

Key Finding: Members noted several scenarios in which the child appeared to be at risk of further victimization.

- Members had concerns regarding why a child was allowed to stay in the home for so long. Members were concerned that while in the home, the child had gone years without education and there were concerns that the child was at risk for being sexually exploited. Members noted that the risk for sexual exploitation was not mentioned in the DCS petition to the court.
- The grandmother was consistently a guardian and backup for the child. However, members felt her voice and evaluation of her ability to appropriately provide that care was not thoroughly evaluated.
- Members again noted that frequently step-parents will perpetrate and the mother will go back to the perpetrator, placing the child in danger of being victimized again.
- Members expressed concerns that a safety plan was not created after a child was treated for suicidal ideation, or if the safety plan was created, it was not available in the documentation.
- Members had concerns about a child forming a relationship and planning meetups with someone online through TikTok. Members discussed the dangers of children having conversations online with unknown people.
- Members noted challenges with practice, policy, and coordination regarding education when children are frequently moved between schools, truant or reported as being homeschooled. There is additional opportunity for coordination and communication between the school system, courts, and Department of Children's services to ensure children are safe and receiving an education.

Recommendations:

Recommendation: The SLC recommends offering additional training to courts on the newly developed Pro Se D&N Petition filing forms to ensure that everyone is aware of their existence. Additionally, training around the requirement to accept Pro Se filings should be provided to all court staff.

- **Responsible Party:** Administrative Office of the Courts

Recommendation: Members noted that TCA 37-1-607(a)(5) requires "within fifteen (15) days of the completion of the district attorney general's investigation, the district attorney general shall advise the department and the team whether or not prosecution is justified and appropriate in the district attorney general's opinion in view of the circumstances of the specific case." However, there is opportunity for this to be more consistently and regularly followed. The District Attorney's General conference should work together with local District Attorneys to capture data on

decisions of whether to move forward with prosecution following a recommendation from CPIT.

- **Responsible party:** District Attorneys General Conference & Local District Attorneys General

Recommendation: Members recommend funding a study, either through existing grant funds or General Assembly appropriations, to examine the effect of the recently passed Protecting Children from Social Media Act (Public Chapter 899) on social media concerns specific to foster care children, runaway youth, and human trafficking.

- **Responsible party:** The Tennessee General Assembly

Department of Children's Services

Findings:

Key Finding: Members noted the following items as opportunities at the Department of Children's Services.

Findings related to this include:

- Members noted that DCS' absconder unit recorded repeated visits to the mall looking for a child. Members questioned how effective this is.
- Members noted that caseworker changes occurring at DCS resulted in the TFACTs entries and timeline of the case recordings being incorrect.
- Members noted a need for more support for DCS caseworkers.

Key Finding: Members noted opportunities for increased consistency and thoroughness of hotline responses.

Findings related to this include:

- Members were concerned with a lack of consistency in hotline responses. One call was screened out, yet when the same information was reported several months later it led to an investigation and substantiation of severe abuse.
- Members discussed challenges when a new referral is added to an open case without revealing to the new referent the assigned DCS worker. Knowing the assigned DCS worker provides the referent with a point of contact for new or developing concerns. It was discussed that this is a challenge with DCS'

current TFACTS system and that will hopefully be able to be addressed in the new system.
- Members noted that the Department does not contact the referent for additional information, even for new calls screened to an open case.
- Although it was noted in the hotline report that a child had developmental delays, it is not clear through the documentation that everyone involved was aware and taking that as a factor in considering how to address the case.

DCS Response: The Hotline uses a Structured Decision Making tool to determine the assignment and priority response time of a report of abuse or neglect. The tool provides consistent decision making and all screened out reports receive a supervisory secondary review. Policy 14.6 *Child Protective Services Case Tasks and Responsibilities* Section 14.A.3(h) directs the case manager to contact the referent and Section 14.B directs the case manager to conduct investigative activities in accordance with policy on new referrals on open cases.

Recommendations:

Recommendation: The Department should change existing policy to require the referent be contacted for additional information on hotline referrals that are screened out to be added to an open case.

- **Responsible Party:** Tennessee Department of Children's Services

Recommendation: The case management system that is replacing TFACTs should be developed with the ability to include the current case manager's name and other relevant information for the referent when a hotline referral is screened out to be added to an open case.

- **Responsible Party:** Tennessee Department of Children's Services.

Medical

Findings

Key Findings:

- **Members noted that the delay in getting an autopsy impacted the investigation and prosecution of the case.**
- **Members noted it was odd to include the term "reasonable degree of medical certainty" in a DCS report as that is typically a legal term.**

- **Members noted that although secondary brain bleeds can occur after a minor injury, they are not often fatal.**
- **Members stated that due to the lack of information available, it was difficult to determine if the injury was accidental or inflicted.**

Recommendations:

Recommendation: Members recognize the importance of multi-disciplinary conversations to reach the appropriate CPIT determination. Members recommend more consistent participation in CPIT meetings by law enforcement partners.

- **Responsible Party:** District Attorneys General, Tennessee Association of Chiefs of Police & Tennessee Sheriff's Association

Recommendation: TCA 37-1-607(a)(2) states "Each team may also include a representative from one (1) of the mental health disciplines and one (1) appropriately credentialed medical provider, as needed."

SLC members recommend encouraging CPIT members to obtain direct information from medical providers evaluating the child including medical examiners for accurate interpretation of the information in team decisions.

- **Responsible Party:** Tennessee Department of Children's Services, Tennessee Child Advocacy Centers, and District Attorneys General.

Improvement from Previous Years

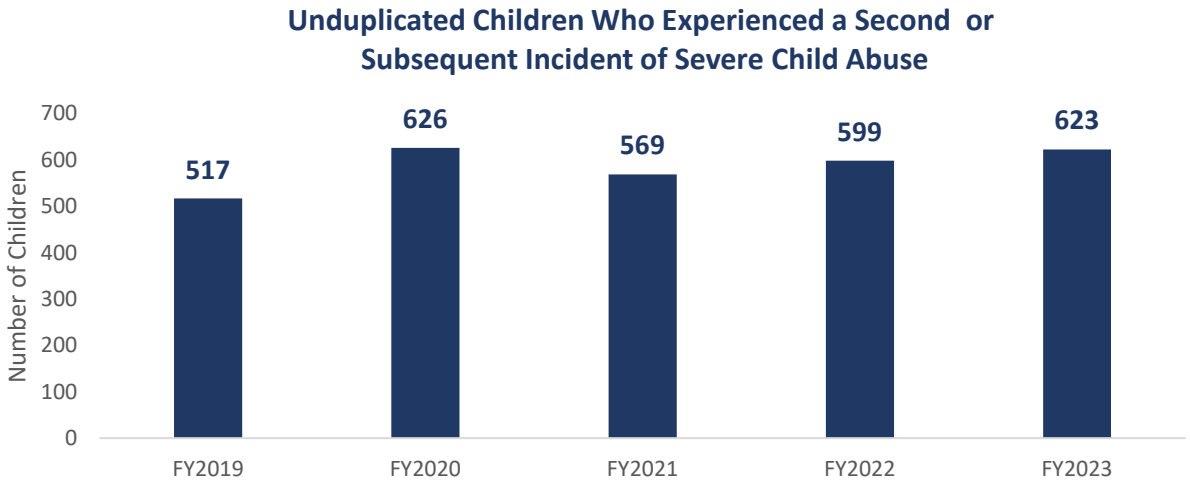
The Second Look Commission Membership is encouraged by improvements seen from previous years. These improvements represent a significant amount of effort invested by the many stakeholders who are working to ensure Tennessee's children are protected from victimization. One area where the Second Look Commission is particularly encouraged to see improvement is the timeframe for the Department of Children's Services to receive autopsy reports of potential abuse deaths. As a result of Second Look Commission recommendations, Public Chapter No. 881 (effective July 1, 2024) required the Department of Children's Services, county medical examiners, chief medical examiners, and facilities that perform autopsies, pursuant to § 38-7-105, must establish policies and procedures for the prioritization of the completion of final autopsy reports for fatalities for any child in the custody of the department; any child who is the subject of an ongoing investigation by child protective services or has been the subject of an investigation by child protective services within the forty-five (45) days immediately preceding the child's fatality or

near fatality or any child whose fatality or near fatality resulted in an investigation of the safety and well-being of another child in the home. The Department has reported back to the Second Look Commission that the number of deaths with autopsies still pending has significantly decreased.

Repeat Child Abuse Data

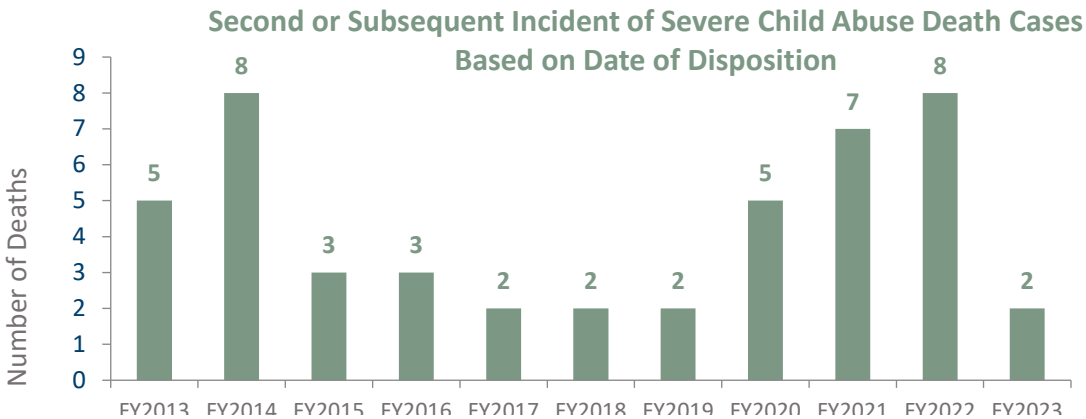
The reported number of children who experienced a second or subsequent incident of severe child abuse for FY 2023 is 623. The number of children who were subjected to a second or subsequent incident of severe child abuse represents an increase from FY 2022.

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



The types of maltreatment for FY 2023 (the second or subsequent incident) are as follows:

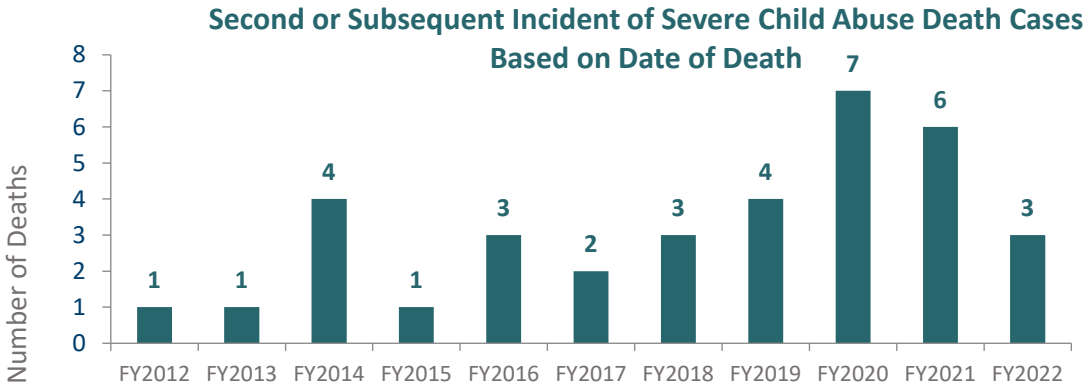
Abuse Death	Lack of Supervision	Physical Abuse
0.3%	6.0%	5.1%
Drug Exposed Child	Medical Maltreatment	Psychological Harm
21.8%	0.1%	1.0%
Domestic Violence	Nutritional Neglect	Sexual Abuse
0.9%	0.2%	64.3%
Environmental Neglect		
0.3%		



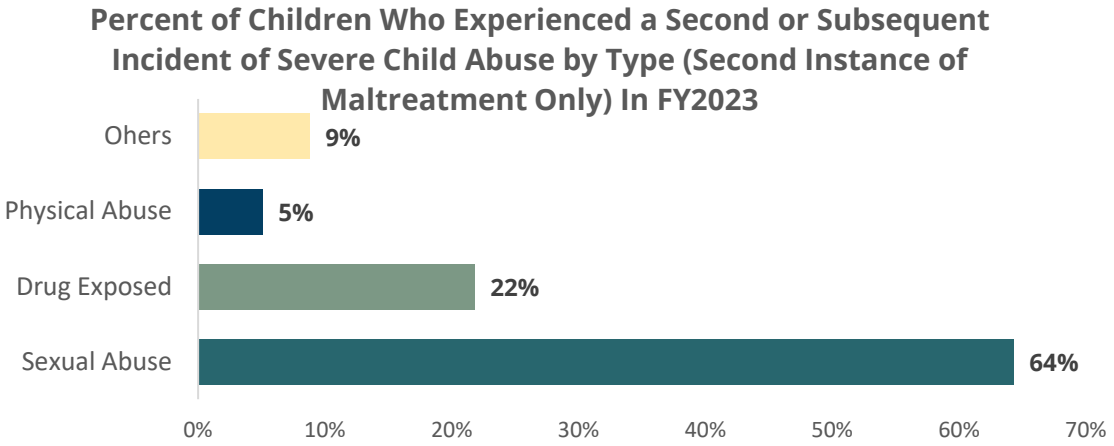
There were two instances of a second or subsequent incidents of severe child abuse resulting in a death in the SLC's FY 2023 case review. This represents another decrease from previous years after several years of increases.

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

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



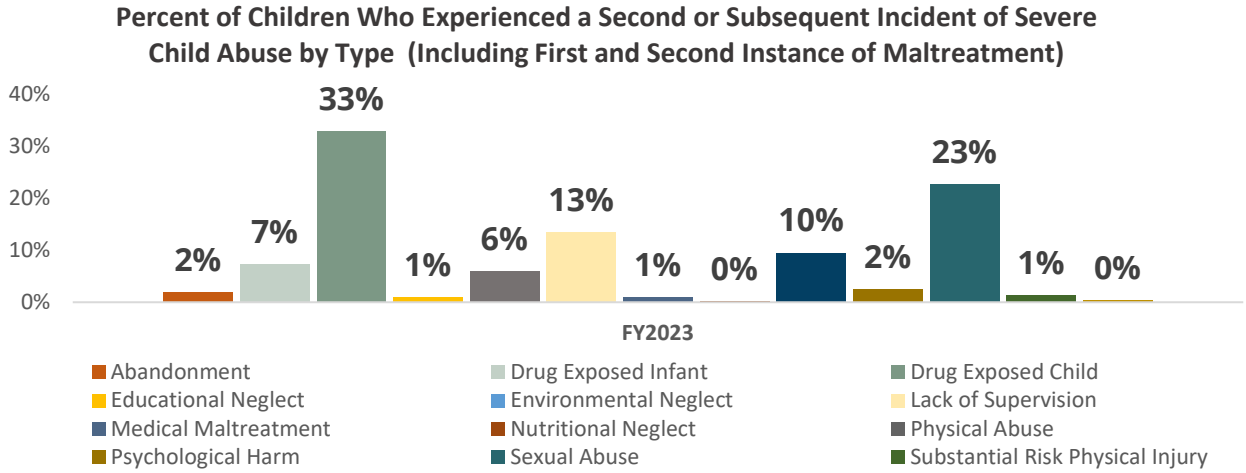
The SLC reviews every abuse death that meets the commissions statutory authority. This year's review of abuse death cases included two deaths that occurred in FY2021. Based upon the timeframe to reach dispositions in abuse death cases, it is not clear if the decline in 2021 and 2022 is a true decline or if those cases are still being investigated.

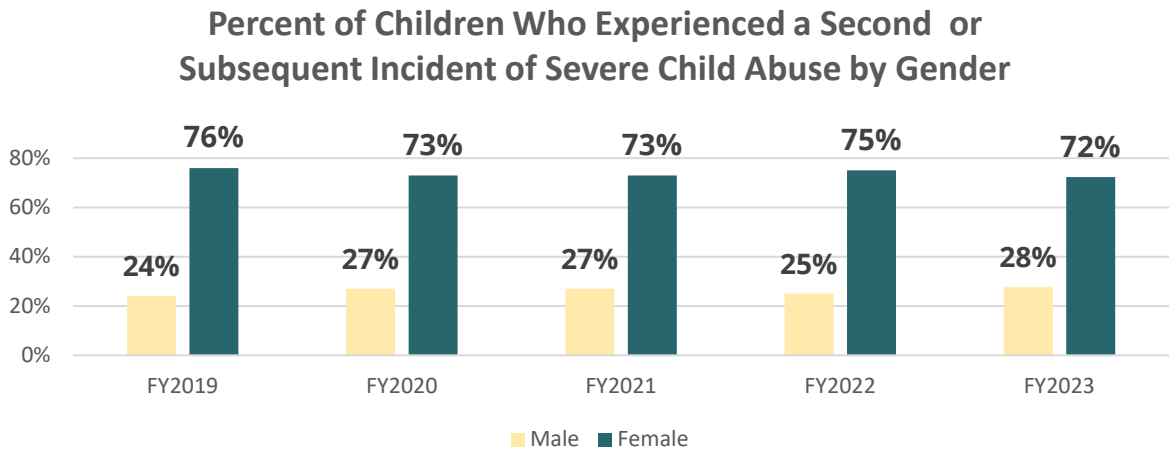


This chart is solely based on the second or subsequent incident of severe child abuse. It is important to note sexual abuse while sexual abuse accounted for 64 percent of second or subsequent incidents of maltreatment, it was approximately 22 percent of the combined maltreatment type set forth in the FY 2023 list of cases.

The most prevalent type of child abuse, including the first and second incidents, on the FY 2023 list of cases was Drug Exposed Child/Infant, shown in the chart below. Drug exposure accounted for approximately 42 percent of the combined maltreatment type set forth in the FY 2022 list of cases.

In FY2023, the Second Look Commission began including duplicates, meaning children who experienced multiple types or multiple instances of secondary or subsequent abuse into both of these calculations. Because of this, comparisons to previous years' data are not completely accurate.

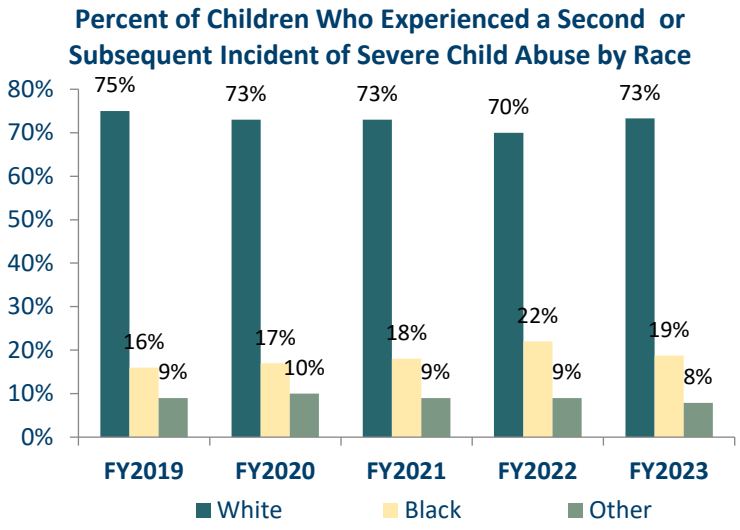




The gender composition of the victims of the total population of cases for FY 2023, is as follows: female: 72 percent; male: 28 percent. For the calendar year 2023, male children were approximately 51 percent and female children were approximately 49 percent of the total population of children in Tennessee. Based on the total population of children, female children are disproportionately represented among children who have a substantiated second or subsequent incident of severe child abuse.

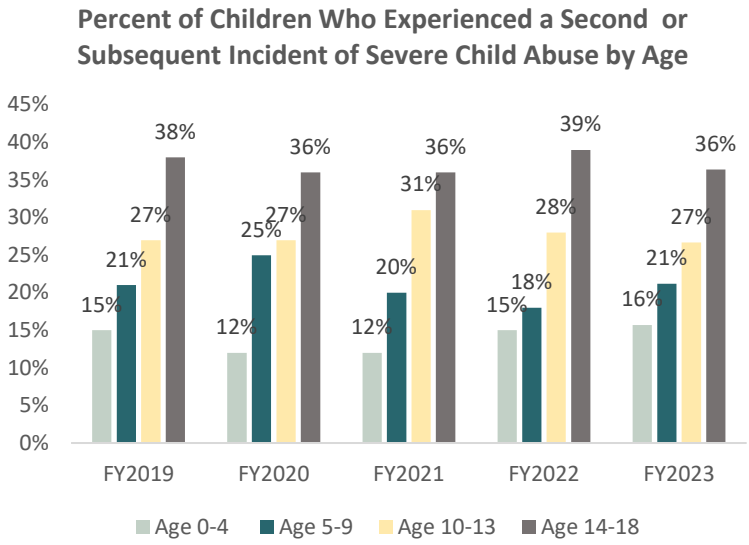
The racial composition of the victims of the total population of cases for FY 2023 is as follows:

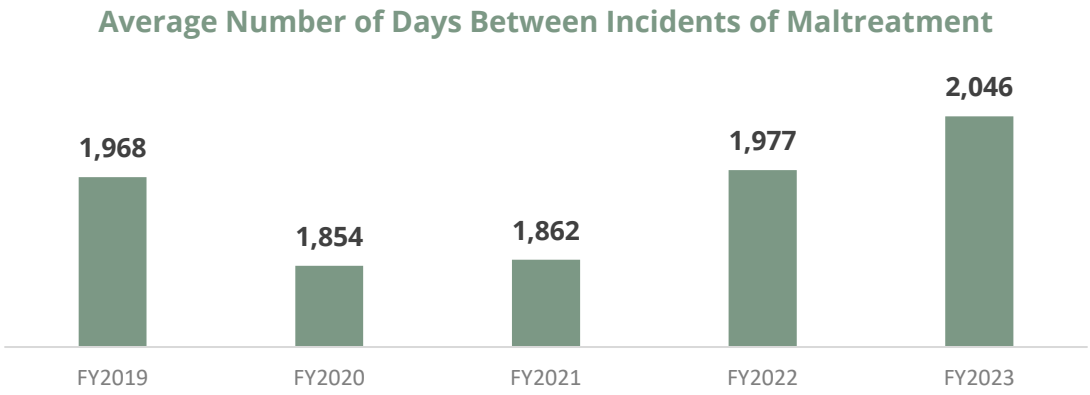
- White: 73 percent;
- Black: 19 percent;
- Multiple/Unable to determine: 8 percent



The age range composition of the children at the time of the incidents of abuse for FY 2023 is as follows:

- 0-4 years old: 16 percent;
- 5-9 years old: 21 percent;
- 10-13 years old: 27 percent;
- 14-17 years old: 36 percent.





The average number of days between incidents of maltreatment for FY 2023 is 2,046. The median number of days was 1,567.

Number of individual children who experienced a second or subsequent incident of severe child abuse for fiscal year 2023 reported in each county by judicial districts based on the list of cases provided by DCS:

1st Judicial District
Carter 8
Johnson 1
Unicoi 5
Washington 3

2nd Judicial District
Sullivan 17

3rd Judicial District
Greene 9
Hamblen 6
Hancock 6
Hawkins 8

4th Judicial District
Cocke 8
Grainger 2
Jefferson 4
Sevier 18

5th Judicial District
Blount 9

6th Judicial District
Knox 20

7th Judicial District
Anderson 8

8th Judicial District
Campbell 6
Claiborne 8
Fentress 1
Scott 7
Union 3

9th Judicial District
Loudon 3
Meigs 3
Morgan 1
Roane 4

10th Judicial District
Bradley 5
McMinn 2
Monroe 12
Polk 1

11th Judicial District
Hamilton 13

12th Judicial District
Bledsoe 3
Franklin 3
Grundy 0
Marion 1
Rhea 6
Sequatchie 2

13th Judicial District
Clay 1
Cumberland 10
DeKalb 10
Overton 6
Pickett 0
Putnam 7
White 8

14th Judicial District
Coffee 16

15th Judicial District
Jackson 0
Macon 9
Smith 2
Trousdale 1
Wilson 9

16th Judicial District
Cannon 4
Rutherford 14

17th Judicial District
Bedford 2
Lincoln 7
Marshall 2
Moore 2

18th Judicial District
Sumner 10

19th Judicial District
Montgomery 11
Robertson 7

20th Judicial District
Davidson 34

21st Judicial District
Hickman 5
Lewis 4
Perry 2
Williamson 4

22nd Judicial District
Giles 15
Lawrence 13
Maury 14
Wayne 0

23rd Judicial District
Cheatham 4
Dickson 9
Houston 3
Humphreys 2
Stewart 2

24th Judicial District
Benton 2
Carroll 3
Decatur 2
Hardin 8
Henry 8

25th Judicial District
Fayette 2
Hardeman 5
Lauderdale 8
McNairy 4
Tipton 3

26th Judicial District
Chester 10
Henderson 7
Madison 9

27th Judicial District
Obion 3
Weakley 5

28th Judicial District
Crockett 1
Gibson 8
Haywood 3

29th Judicial District
Dyer 11
Lake 0

30th Judicial District
Shelby 55

31st Judicial District
Van Buren 2
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

The number of unique children who experienced a second or subsequent incident of severe abuse in FY2023 represents from the two previous years and is just below FY2020 numbers. Substance use disorder continues to be a primary contributor to the abuse of children in Tennessee. Continuing to improve how Tennessee responds to and reduces drug exposure of children is imperative. Drug Exposed Infant/Child comprised 22 percent of the second incidents of maltreatment in FY2023.

Sexual abuse continues to be the most common time of subsequent abuse experienced by children, comprising 64 percent of second or subsequent cases. Among combined maltreatment types (first and second incident) in FY2023, sexual abuse comprised 23 percent of cases.

Physical abuse comprised 5 percent of all second incidents of maltreatment. Across combined maltreatment, physical abuse was 6 percent.

Tennessee must continue to address all forms of child maltreatment and use data to focus its efforts. The FY2023 data represents an increase from the previous year and replaces FY2022 as the second highest number of children experiencing a second or subsequent incident of maltreatment in the last five years. The SLC will continue to analyze the data over time to help Tennessee focus its resources in areas of greatest needs. The SLC is committed to helping improve the many systems that impact how Tennessee handles severe child abuse.

The SLC would like to thank all child abuse prevention stakeholders for their support and the opportunity to work with them to improve the lives of children and families in Tennessee. Additionally, the SLC would like to thank the Tennessee General Assembly for the opportunity to continue this vital work.

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