

THE SECOND LOOK COMMISSION

ANNUAL REPORT HIGHLIGHTS

2024



The Second Look Commission (SLC) reviews cases of children across Tennessee who have experienced a second or subsequent incidence of severe abuse to identify ways to improve the system and help other children avoid a similar fate. The SLC publishes an annual report of their findings. This document outlines key information primarily contained in the 2024 annual report. The full report can be found at tn.gov/tccy.

Included Highlights

- Purpose of The Second Look Commission
- FY2023 Case Data
- Key Findings & Recommendations
- Abuse Death Data

Purpose of The Second Look Commission

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

Protective Factors

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

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

Protective Factors



Strengthening economic support for families



Changing social norms to support parents and positive parenting



Providing child care and education early in life



Enhancing parenting skills to promote healthy child development



Intervene to lessen harms and prevent future risk

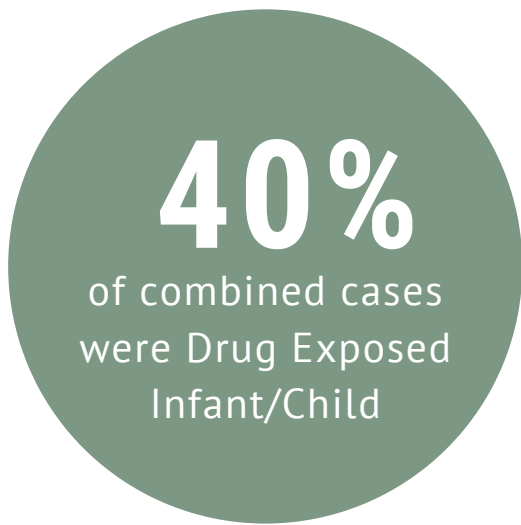
(Fortson et al.,2016)

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

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

2022-2023 CASE DATA

The Department of Children's Services reported 623 children experienced a second or subsequent incident of severe child abuse in FY 2022.



70.0

60.0

50.0

40.0

30.0

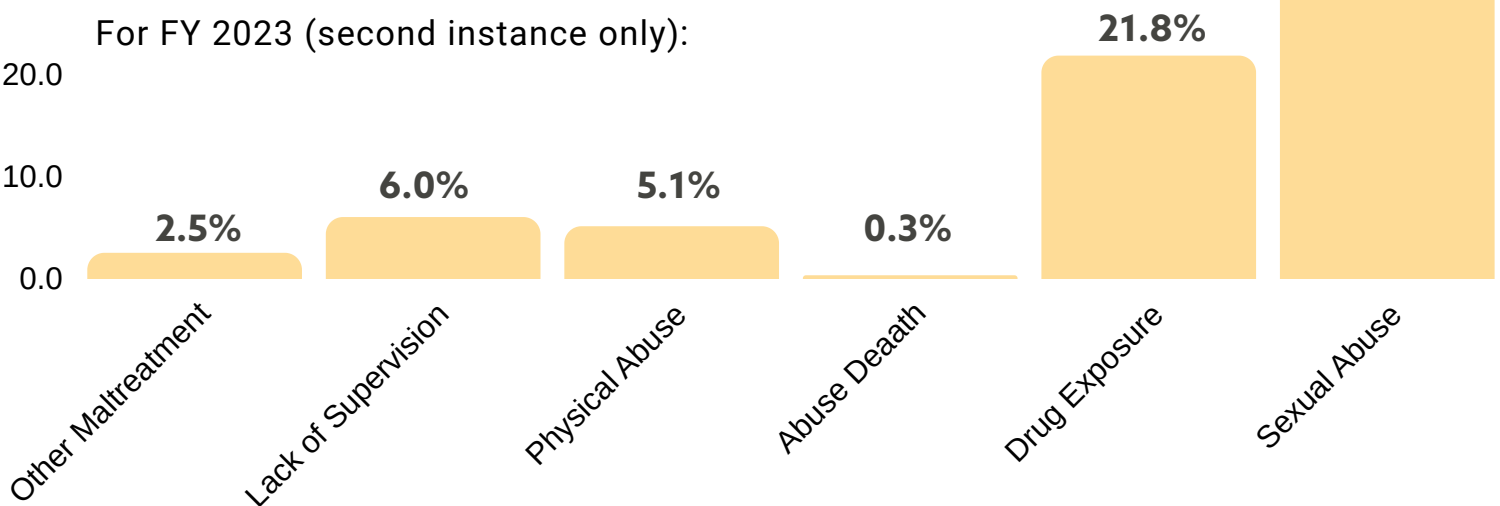
20.0

10.0

0.0

TYPES OF MALTREATMENT

For FY 2023 (second instance only):



Key Findings

Observed Strengths

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.

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.

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

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

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

Key Findings

Foster Homes/Placements

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

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

Key Findings

Services

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

Recommendations

Foster Homes/Placements

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.

Recommendations

Services

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.

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.

Key Findings

Transition Homes

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

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

Recommendations

Transition Homes

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.

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.

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.

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.

Key Findings

Missed Opportunities for Earlier Intervention

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

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

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

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

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

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

Observations

Missed Opportunities for Earlier Intervention

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

Missed Opportunities for Earlier Intervention

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.

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 through 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.

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

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.

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

Key Findings

Courts/Legal

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

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

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

Members found opportunities for increased documentation.

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

Observations

Courts/Legal

Members discussed concerns with Pro Se filings and Court Access.

Recommendations

Courts/Legal

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.

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.

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.

Key Findings

Department of Children's Services

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

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

Key Findings

Medical

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

Department of Children's Services

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.

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.

Recommendations

Medical

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.

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.

ABOUT SLC ABUSE DEATH REVIEW

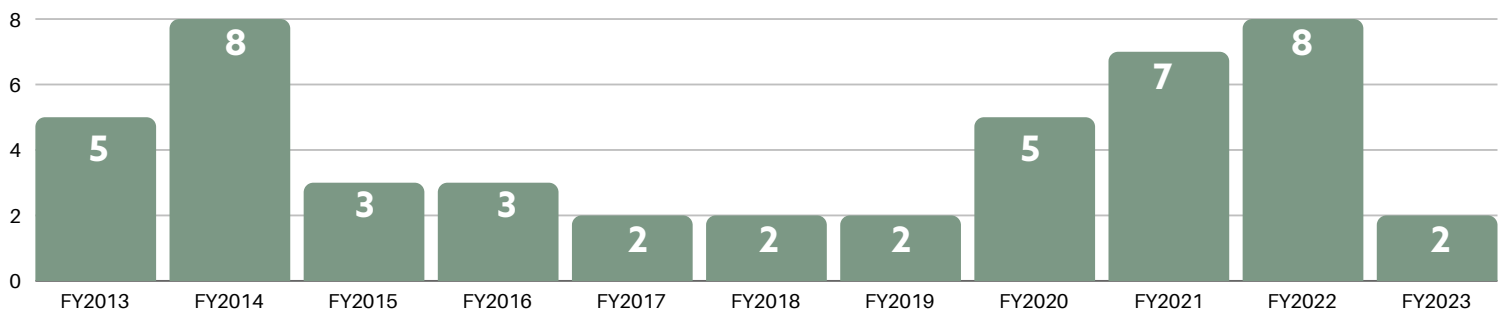
The fiscal years listed throughout the report reflect the disposition date. In many cases, these fall into the same year as the occurrence of abuse, however sometimes with more complicated cases, such as an abuse death, there is a longer timeframe between the occurrence and the disposition.

There were two instances of a second or subsequent incident of severe child abuse resulting in a death in the SLC's FY 2023 case review. This represents a decrease from previous years, matching FY2017-FY2019 for the lowest number reviewed by the SLC.

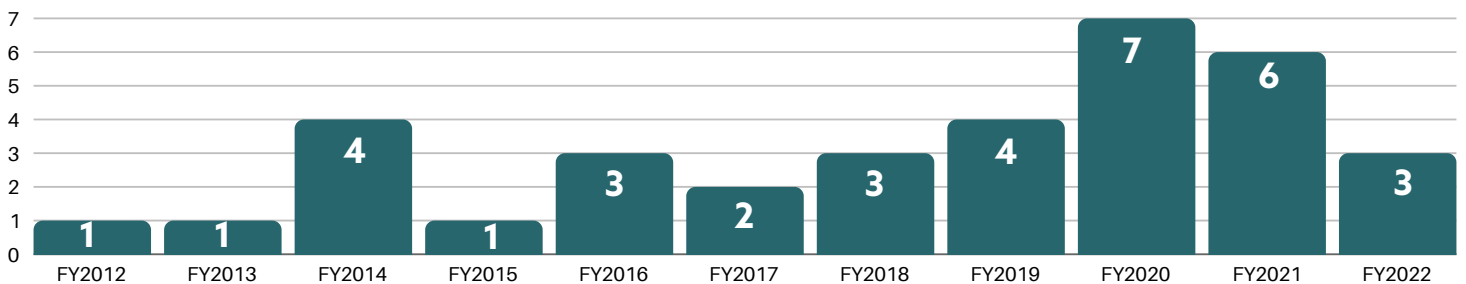
There is often a longer timeframe to reach a disposition in child death cases meaning in many of the cases reviewed by the SLC, the death did not occur in the same fiscal year as the disposition. First chart outlines the number of cases reviewed by SLC (based on the date of disposition) whereas the second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

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

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



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



The SLC reviews every abuse death that meets the commission's statutory authority. In 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.



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