Second Look Commission
2013 Annual Report

Tennessee Commission on Children and Youth

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

The SLC reviews some of the worst incidents of child abuse and neglect in Tennessee. Only the Second Look Commission reviews cases of children from all across Tennessee who have experienced a second or subsequent incidence of severe abuse to identify ways to improve the system and help other children avoid a similar fate. Special, concentrated efforts must also be devoted to analyzing and responding to the tragedy of child abuse. The SLC was created as a catalyst to facilitate improved response to child abuse. The composition of the SLC includes representatives of all key stakeholders and disciplines and members of the General Assembly, and it has facilitated much needed communication and collaboration.

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

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

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

Impact of Child Abuse

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

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

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

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

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

In what is reportedly the first major study of child abuse and neglect in 20 years (http://www.iom.edu/Reports/2013/New-Directions-in-Child-Abuse-and-Neglect-Research.aspx?utm_source=feedburner&utm_medium=feed&utm_campaign=Feed%3A+NewIomReports+(New+IOM+Reports)), researchers with the National Academy of Sciences reported on September 12, 2013, the damaging consequences of abuse can not only reshape a child's brain but also last a lifetime. "What the committee sees as hopeful is the evidence of changing environments can change brain development, health, and behavioral outcomes. There is a window of opportunity, with developmental tasks becoming increasingly more challenging to negotiate with continued abuse and neglect over time." (pg 4-37)

> As reported by the Centers for Disease Control and Prevention in "The Effects of Childhood Stress Across the Lifespan," researchers have identified a link between Adverse Childhood Experiences (ACE) and adult health. Research identified particularly strong links between exposure to violence, especially child abuse, neglect and domestic violence, with risky behaviors and health problems in adulthood (Middlebrooks, 2008).
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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.
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> 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.
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> Additionally, the authors of the study found that adverse childhood experiences affected health throughout the lifespan, first in health risks during childhood and adolescence,

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

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

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

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

In fiscal year 2012- 2013, DCS reportedly received approximately 157,000 referrals through the child abuse hotline. Of those referrals, 60,693 referrals were assigned to CPS. Of the referral assigned to CPS, 24,181 referrals were assigned as investigations and 36,512 were assigned as assessments. Based upon data from January-June 2013, the trajectory for fiscal year 2013 - 2014 indicates there will be a 34 percent increase in investigations and a 4 percent increase in assessment cases. The need to prevent child abuse and effectively intervene is crucial for Tennessee children and families.

Findings and Recommendation

This year the SLC focused its review on cases involving sexual abuse. The list of cases provided by DCS for fiscal year 2011-2012 reported 295 children experienced a second or subsequent incident of severe child abuse. Sexual abuse accounted for approximately 71 percent of the

abuse in the fiscal year 2011-2012 list of cases. Accordingly, approximately 209 of the 295 children were victims of sexual abuse. The SLC also considered when the incidents of abuse occurred. In the past, SLC members have reviewed cases in which DCS indicated the first incident of abuse as many as seven years before the second incident of abuse. Many of the laws, policies, procedures and practices in place and prevalent during the first incident of abuse were no longer applicable during the time of the SLC review. Accordingly, SLC decided to limit its review to cases in which the first and second incident of abuse occurred within three years of the previous fiscal year.

During the 2013 calendar year, the SLC thoroughly reviewed a sample of cases of children who experienced second or subsequent incidents of severe child abuse. The sample of cases reviewed by the SLC was taken from the list of cases provided by DCS for fiscal year 2011-2012. For each case reviewed, the SLC gathers information from various individuals, departments and agencies. The documentation gathered by the SLC typically includes records from the following, when applicable: DCS, medical service providers, juvenile courts, law enforcement, criminal courts, educational systems, child advocacy centers and various service provider records. In addition to gathering documentation, the SLC obtains additional information through email requests, telephone calls and site visits. The director of the SLC reviews all of the gathered information and provides a written case summary of the cases the SLC will review one week prior to the investigatory meeting of the SLC. The average number of pages of the summaries for the cases reviewed by the SLC during 2013 is approximately 45. Members of the SLC read the summaries prior to the investigatory meetings and arrive at the meetings prepared to thoroughly analyze each case.

As in previous years, the review process was often painful as members considered the horrific experiences endured by the children whose cases were reviewed, and through the review process could see missed opportunities that could have prevented repeat abuse. Although there continues to be problems with the manner in which severe child abuse cases are being handled in Tennessee, changes are occurring which will likely have a positive impact on reducing the rate and consequences of severe child abuse. Before providing the 2013 findings and recommendations, a review of the status of the 2012 findings and recommendations is appropriate.

2012 Finding and Recommendations 1:

Joint and Collaborative Training Needed

The SLC found there is a need to strengthen relationships, interaction and investigation, and to improve communication and collaboration to reduce the incidents and impact of severe child abuse in Tennessee. To address the finding, 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.

DCS recognizes the importance of having highly trained individuals who conduct child abuse investigations. DCS believes partnerships play a vital role in protecting children, developing youth, strengthening families, and building safe communities. Partners who train together build stronger partnerships and allow DCS to reach and maintain this mission. Building upon these principals, a training division within the Office of Child Safety (OCS) was created to focus solely on developing training opportunities for child protective services (CPS) investigators. DCS has developed and implemented a new non-consecutive three week CPS Investigator Training Academy (Academy). The Academy was developed in collaboration between the Tennessee Bureau of Investigation (TBI) and DCS. TBI is providing some of the training. The inaugural class of the Academy began in November 2013.

Through this academy, DCS intends to provide the knowledge and tools CPS Investigators need to perform their jobs with the highest quality possible while keeping the children of Tennessee safe. The Academy includes an array of courses which will hopefully address many of the SLC recommendations. The courses include:

- Introduction to CPIT
- Medical evaluation of child sexual abuse, physical abuse, and neglect
- Conflict management
- Mock Court
- Case file organization, documentation and presentation
- Working with Law Enforcement
- John E. Reid Interviewing Techniques, Child Sex Abuse, and Child abuse Reconstruction Techniques

The 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 Academy, but TBI agents, CPIT partners and community partners are also invited and encouraged to participate in the Academy at no cost to their agency, with the exception of travel expenses. Following graduation from the Academy, the CPS investigators are expected to attend the Post Academy, which will be regionally located and will offer courses that further enhance the skills of CPS investigators and CPIT partners. DCS continuously encourages their staff to participate in joint training with CPIT partners.

A collaborative training effort is needed among all CPIT partners. The SLC is excited about the benefits of the CPS Training Academy, but it believes an additional tier of collaborative training

has the potential to further strengthen relationships, interaction and investigation, to improve communication and collaboration to reduce the incidents and impact of severe child abuse in Tennessee. CPIT teams need to be trained together to maximize their effectiveness. The SLC recommends regional CPIT training due to the diversity of practices and resources within Tennessee. Such training must have the necessary resources allocated to it to make it successful.

Furthermore, DCS has built in an ongoing Academy evaluation process to ensure various stakeholders have the opportunity to contribute to the strengthening of the Academy. Bonnie Beneke, Executive Director of the Tennessee Children's Advocacy Centers and SLC member, provides training during the Academy and valuable feedback regarding the inaugural cycle of the Academy. Craig Hargrow, the Director of the SLC, will also participate in the Academy and provide feedback to DCS and other child abuse prevention stakeholders.

The SLC will continue to monitor this Reoccurring Finding.

2012 Finding and Recommendation 2:

Issue-Driven vs. Incident-Driven Investigations

The SLC found there is a need to stress the importance of issue-driven investigations as opposed to incident-driven investigations through training. To address this finding, the SLC recommended multidisciplinary training should be developed to address the need to engage in issue-driven investigations. All stakeholders who want to be involved should have an opportunity to help in the development of the training. However, a representative from following agencies or organizations should take the lead in the development of the training: the Department of Children's Services, Child Advocacy Centers, and the Child Protective Investigative Teams.

The Academy has the potential and was partly designed to address the practices and strengths of issue-driven investigations over incident-driven investigations. Additionally, an Internal Quality Control division was created within the OCS to provide an internal audit process for the Investigations and Child Abuse Hotline divisions. Data collected during this process will be utilized to improve staff performance, increase consistency in policy and protocols, and improve the overall practice of Tennessee's child welfare system. Continued monitoring is necessary.

This finding continues to be a prominent issue in cases reviewed in 2013. The SLC is hopeful the Academy, any multidisciplinary training developed later and the creation of the Internal Quality Control division will adequately address this finding.

<u>2012 Finding and Recommendations 3</u>:

Inconsistent Child Protective Investigative Team Practices

The SLC found a more consistent best practices model for Child Protective Investigative Teams (CPIT) should be developed and implemented across the state to reduce inconsistent CPIT practices and poor outcomes for children in Tennessee. To address this finding, the SLC recommended the creation of a Statewide CPIT Coordinator whose only responsibilities would be assessing and improving the CPIT process throughout Tennessee and monitoring compliance of the various CPITs in Tennessee. The SLC also recommended the development of a CPIT advisory board. At a minimum, the CPIT Advisory Board should include some local CPIT coordinators from across the state.

In 2013, a Director of Community Partnerships was appointed within the Office of Child Safety. This Director will serve as a statewide CPIT Coordinator to build partnerships and improve consistency among the CPITs statewide. This position provides frequent and consistent communication between the Department, Child Advocacy Centers and other CPIT partners. Additionally, the Department is currently developing a statewide CPIT Advisory Board. The Director of Community Partnerships has consulted with several stakeholders, including the SLC, in the development of the statewide CPIT Advisory Board. A Charter for the CPIT Advisory Board has been developed and the Department is in the process of identifying board representation with a goal of holding the initial meeting in the first quarter of 2014.

The Department is also exploring co-location opportunities statewide and determining the appropriateness of housing investigators within child advocacy centers. Continued monitoring is necessary.

<u>2012 Finding and Recommendations 4</u>:

Children Exposed to Abuse and Neglect through Domestic Violence

The SLC found domestic violence in general and particularly in matters involving children must be properly addressed. The failure to identify and properly address domestic violence issues by severe child abuse prevention stakeholders exposes children to abuse and neglect. To address this finding, the SLC recommended the establishment of additional family justice centers in Tennessee. The SLC also recommended the establishment of enhanced penalties if the victim of domestic violence is pregnant or if a child is present during the domestic violence. TCA 39-13-111 should be amended to include the following language, “If a minor who is not the alleged perpetrator of the domestic abuse witnesses the domestic assault or the domestic abuse victim is

pregnant, the minimum and maximum fines as set forth in TCA 39-13-111(c)(1)-(3) shall be increased by $1,000.00 and the minimum time of confinement shall be increased by 30 days."

A major part of Governor Haslam's Public Safety Action Plan is to establish a statewide family justice center initiative. On October 1, 2013, Bill Gibbons, Commissioner of the Tennessee Department of Safety and Homeland Security, announced Tennessee had made significant progress in an effort to reduce incidents of domestic violence in Tennessee. Tennessee plans to use federal grant funding through the Office of Criminal Justice Programs (OCJP) to expand the number of family justice centers in Tennessee. Knoxville established the first family justice center in Tennessee in 2006. Memphis opened the Family Safety Center in 2012. "The OCJP has awarded grant funding to organizers in Chattanooga, Cookeville, and Nashville to help establish family justice centers in those communities." https://news.tn.gov/node/11449

The SLC is in no way attempting to take credit for any of the hard work of the Administration regarding the creation and expansion of family justice centers in Tennessee. The SLC is showing its support of the existing and future family justice centers as programs to support victims of abuse and their children.

2012 Finding and Recommendation 5:

Best Practices Protocol Needed to Properly Assess and Treat Children Possibly Exposed to Methamphetamine

The SLC found there is a need to develop and implement a statewide multidisciplinary best practices policy or protocol for all severe child abuse prevention stakeholders to assess and treat children possibly exposed to methamphetamine or refer such children to an appropriate provider. To address this finding, the SLC recommended the state should provide the necessary support to aid in the development and implementation of a statewide multidisciplinary best practices policy or protocol to be used when dealing with children who may have been exposed to methamphetamine or any stage of producing methamphetamine.

Prior to the 2012 SLC findings and recommendations, the Tennessee Alliance for Drug Endangered Children (TADEC) had already prepared suggested protocols and training materials regarding responding to methamphetamine production, abuse and cleanup. The TADEC provided training and guidance to communities throughout Tennessee. The Tennessee Methamphetamine and Pharmaceutical Task Force (TMPTF) was one of the member organizations of TADEC that played a substantial role in the training and guidance received by the various communities. Several communities used the protocols as templates and revised them to meet the needs of their particular community.

2012 Finding and Recommendation 6:

Multiple Referrals Prior to First Incident of Indicated Abuse

The SLC found multiple referrals of child abuse often occur prior to investigation and determination of the first incident of indicated abuse. In response to the finding in the 2011 SLC report, DCS initiated pilot programs in three DCS regions to address multiple referral issues. DCS continues its efforts to address the issues of multiple referrals through the pilot programs and the Office of Child Safety. The SLC will monitor ongoing efforts of DCS to address the finding.

2012 Finding and Recommendation 7:

A Statewide Child Abuse Resource Directory is Needed

The SLC found a statewide child abuse resource directory is needed for child abuse prevention stakeholders to help them find expertise in various areas of child abuse prevention, education and services. To address this finding, the SLC recommended the production of a statewide child abuse resource directory.

The SLC communicated with several groups or organizations regarding potentially creating and maintaining a statewide child abuse resource directory. To date, the SLC has not found a group or organization willing and capable to be primarily responsible for the creation and maintenance of a statewide child abuse resource directory. Based on its discussions with various groups or organizations, the SLC concluded one of the main obstacles to providing such a directory is the allocation of resources to maintain the directory. The SLC will continue to search for ways to create and maintain a statewide child abuse resource directory.

Kidcentraltn.com, created by the Tennessee Children's Cabinet, is an excellent example of the type of resource the SLC recommends for child abuse prevention stakeholders.
"Kidcentraltn.com is a one-stop shop for Tennessee families to connect with important information and resources provided by state departments. This new website organizes content from across departments, making it easier for families to find what they need. In addition to articles about valuable topics relating to health, education and development, kidcentraltn.com features a comprehensive directory of state services for children and families."
http://news.tn.gov/node/11032. The child abuse resource directory would be a place child abuse prevention stakeholders could go to find important information and valuable resources to help them provide effective services and advocacy.

2012 Finding and Recommendation 8:

Child Left in Home with an Indicated Perpetrator

The SLC found a female child remained in a home with a person indicated for sex abuse against her older sister. The older sister (victim) was removed from the home. The remaining female child was not the daughter of the perpetrator. To address this finding, the SLC recommended DCS, the SLC and other appropriate stakeholders work together to conduct a policy review to determine whether DCS has sufficient policies in place to reduce the likelihood of a child being placed or remaining in the home of a non-relative indicated perpetrator.

The SLC reviewed DCS policies and discussed the matter with DCS representatives. Consistent with the Explanation provided in the 2012 Report, the SLC concluded the matter was likely an isolated incident and no policy changes are necessary to address the finding. In an effort to ensure DCS policies are consistent with best practices, the OCS is reviewing policies directly related to the child abuse hotline and investigative processes. Thorough reviews are being conducted by subject matter experts with suggested revisions vetted through a review team. Included in the review process will be external partners as their review is critical to improving investigative practice and strengthening relationships with other agencies. With this in mind, the policy review process will include an opportunity for partners to provide feedback to the department.

Other Findings and Recommendations

Confusing Terminology

The SLC has continuously discussed and even made note in the 2011 SLC annual report that the terms used by the Department of Children's Services 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"). The difference in terms often creates confusion and discord among the various stakeholders, especially within CPIT and also creates unnecessary confusion for the general public.

DCS has made significant terminology changes in efforts to align language with nationally recognized and accepted language used by other child welfare agencies, law enforcement, disability and adult protective services. The term "substantiated" will replace the term "indicated" and the term "unsubstantiated" will replace the term "unfounded." This change will be effective January 1, 2014.

Frontline Staff Supervision

Severe child abuse cases are often very complex and time consuming. The very nature of these cases often makes the cases mentally and physically taxing. The CPS assessor/investigator and the FSW are called upon to make decisions that carry substantial consequences. Tennessee children would benefit from a designated group of experienced DCS employees to help when needed in the decision making process.

The SLC has ongoing concerns regarding the proper supervision of the frontline staff. In the 2011 SLC Annual Report, the SLC recommended DCS strengthen supervision of the CPS assessor/investigator and the family services worker for children in foster care. The SLC recommended DCS create a designated team of experienced DCS employees (Child Safety Consultation Team) to help frontline staff when needed in the decision making process.

DCS reorganized the Office of Child Safety (OCS). The SLC is hopeful that the reorganization will bring improvements in the quality of investigations through proper supervision of frontline staff, increased consistency in decision making, revised workflows, and external collaboration which leads to an overall improvement in the practice of child protection. DCS anticipates the reorganization will also bring added stability and reduce turnover by enhancing the areas of support that are critical to retaining frontline staff in child protection. The turnover rate of CPS workers is also an ongoing concern of the SLC.

The reorganization involves moving regional investigations under the auspices of the OCS, which were historically under the supervision of the twelve Regional Administrators. The plan included transitioning 326 investigators, 63 supervisors and three program coordinators from regional positions to the OCS by March 31, 2014. Within these positions, 192 investigator positions were upgraded from Case Manager 2 to Case Manager 3, which allowed for promotional opportunities statewide. By December 31, 2013, seven of the twelve regions will be under the supervision of the OCS.

2013 Findings and Recommendations

The following findings and recommendations are primarily based on the cases reviewed during the 2013 calendar year.

Record Maintenance and Documentation

DCS records provided to the SLC often do not contain the necessary documentation to make informed decisions regarding the safety of the child. On several occasions during the course of investigating cases in 2013 and previous years, the SLC determined the records received from DCS did not contain sufficient documentation to adequately assess the safety of children and

families or determine actions to be taken to protect the victim and help the family. Additional areas of the suggested file documentation training include the reduction of duplication in TFACTS entries and providing full names, numbers and agency identification of people referenced in TFACTS entries.

The SLC recommends including aspects of record maintenance and building a file in the Academy training. A course in case file documentation will likely be included in the CPS Investigator Post Training Academy as well. The SLC will provide feedback to DCS regarding whether the SLC thinks the Academy courses address the issues discovered by the SLC.

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

In order to adequately represent the investigative work that has been done and effectively share information with CPIT partners, file documentation, organization and presentation are addressed in the Academy. The curriculum aligns the case file structures and terminology for DCS investigators with those already established for law enforcement. Consistency between the two disciplines will enhance communication and provide for a more coordinated investigation.

Non-offending Parent Services

The importance of services for the non-offending parent is often underestimated. Non-offending parents need the tools (or know how to access the tools) to help protect his/her child from further abuse. Additionally, they must understand the necessity of properly addressing the trauma, through counseling or otherwise, of the child victim. A supported and supportive parent can make significant contributions to the recovery of an abused child.

Disclosure is a Process

Children often do not disclose abuse or often do not disclose abuse until well after the abuse occurred, sometimes several years after the abuse occurred. The child in one matter did not disclose abuse during an initial interview. However, DCS and law enforcement actually obtained video evidence of the abuse prior to the initial interview. In several other matters investigated by the SLC, children did not disclose sexual abuse despite having contact with DCS and law enforcement during and after the time the abuse occurred. In many cases, after the

children were removed from the situation or otherwise made to feel safe, they started disclosing the abuse.

SLC members believe most, if not all, people professionally trained to investigate child abuse allegations know children do not always disclose abuse and often disclose abuse well after the abuse occurs. However, SLC members also believe it is important to periodically emphasize that fact. Recognizing some of the more frequent patterns of disclosure of abuse by children helps inform the decisions of those investigating the abuse. All stakeholders need to be further educated or periodically reminded that the lack of disclosure does not mean abuse did not occur.

Tennessee Family and Child Tracking System Entries

Sometimes DCS staff fails to timely enter data into Tennessee Family and Child Tracking System (TFACTS), which could impact the safety of children**.** This finding was included in the SLC 2011 Annual Report as an, "Issue Identified Requiring Additional Research for Recommendations." Several of the TFACTS entries in the matters reviewed in 2013 were made in excess of sixty days after the activity took place. DCS policy provides the entries are supposed to be made within thirty days of the activity. In one matter, two DCS Child Protective Services workers were working with the same family at the same time. It was not clear how much information was shared between the employees because neither employee timely entered his/her activity in TFACTS. Both employees potentially did not know another DCS employee was working with the same family at the same time.

DCS staff in three regions are piloting tablet technology and related applications that may impact their daily job responsibilities by increasing case efficiency, and providing vital and timely information from the DCS's web based Statewide Automated Child Welfare Information System (SACWIS). DCS's FY 2014 budget request includes funding for tablets for all CPS staff. The SLC believes, if used properly, the tablets will facilitate the timely entry of vital data into TFACTS. The SLC supports the budget request.

Identify and Locate Alleged Perpetrators

Based on the documentation obtained, the SLC has concerns about efforts to identify and locate alleged perpetrators. In a study conducted by Gene Abel, M.D., and Nora Harlow, pedophile molesters who reported molesting boys and girls averaged 27.3 victims and 120.9 acts. http://www.childmolestationprevention.org/pdfs/study.pdf.

In one matter, DCS and law enforcement only had the nickname of an alleged perpetrator of child sexual abuse, so the alleged perpetrator was not identified. However, the provided records did not document reasonable efforts to identify the alleged perpetrator such as questioning known acquaintances of the alleged perpetrator about his name or his place of residence. In another matter, law enforcement and DCS arranged a meeting with an alleged perpetrator. The

alleged perpetrator did not answer the telephone the day of the meeting to confirm the meeting so law enforcement and DCS did not go to his residence and did not make other arrangements to interview the alleged perpetrator.

One of the many benefits of the diverse composition of the SLC membership is the ability to take corrective action immediately. In the matter in which DCS and law enforcement only had the nickname of the alleged perpetrator, law enforcement made additional efforts to identify the alleged perpetrator after the SLC meeting. Unfortunately, despite the additional efforts, the identity of the alleged perpetrator remains unknown.

In an effort to obtain additional information about the extent of the efforts made by DCS, law enforcement and other stakeholders to identify and locate alleged perpetrators, the SLC recommends DCS and the Tennessee Chapter of the Children's Advocacy Centers (TNCAC) collaborate to evaluate every CPIT in Tennessee to determine the extent of the efforts made to identify and locate alleged perpetrators. DCS and TNCAC will develop the evaluation process and tools, which may include surveys and face-to-face interviews. The results of the evaluation will be provided to the SLC no later than June 30, 2014.

Issue-Driven vs. Incident-Driven Investigations

There is a need to stress the importance of issue-driven investigations as opposed to incident-driven investigations through training. The SLC recognizes the necessity of ensuring the safety of the child first. However, ensuring the safety of the child is usually just the beginning of a long road to well-being, permanence and stability. In at least two cases reviewed by the SLC in 2013, these mothers had mental health issues which were not adequately addressed. The mothers will likely continue to experience difficulty properly caring for their children. The SLC also noted ongoing therapy is often needed after the matter has been closed. Additionally, alcohol and drug addiction recovery services may be needed for months after a matter is closed.

Multidisciplinary training should be developed to address the need to engage in issue-driven investigations. All stakeholders who want to be involved should have an opportunity to help in the development of the training. However, representative*s* from following agencies or organizations should take the lead in the development of the training: the Department of Children's Services, Child Advocacy Centers, and the Child Protective Investigative Teams.

As noted earlier, DCS implemented the Academy in response to its shared support of issue-driven investigations. The SLC should continue to participate in and monitor the training at various stages to help determine whether the training addresses this reoccurring finding.

Proper Use of Assessment Tools

All stakeholders must work together to ensure children and families receive the proper assessments at the proper time. Assessments in these matters are used to determine the level of safety of the children's environment and risk of future harm of the children. Additionally, assessments should be used to evaluate the strengths and needs of the caretakers and the children. Appropriate stakeholders should provide training emphasizing the utilization of the proper assessment tools at the beginning of all cases as is appropriate.

DCS is currently addressing this issue. DCS has contracted with the Children's Research Center (CRC) to provide technical assistance in the review and recalibration of the Structured Decision Making (SDM) Tool used at the Child Abuse Hotline to assign reports of abuse and neglect. It is anticipated that other SDM tools used in the regions will be included in a review process. Additionally, Vanderbilt has collaborated with DCS to review and revise the Family Advocacy and Support Tool (FAST), which is an assessment tool to determine the need for services for families. DCS will share the results of the reviews with the SLC.

Multiple Referrals Prior to First and/or Second or Subsequent Incident of Abuse

Multiple referrals of child abuse often occur prior to investigation of the first and/or second or subsequent incident of indicated child abuse. Often, the referrals are screened out or classified as unfounded.

Many of the cases reviewed by the SLC continue to contain multiple referrals prior to the first and/or second or subsequent incident of child abuse. DCS cannot prevent multiple referrals, but DCS does have some control of how it responds to such cases. Cases with multiple referrals often present an array of specific challenges. DCS employees must review the family's history, which usually spans several years. Due to turnover, the DCS employees who investigated the previous matters are often no longer employed by DCS, thus limiting access to any information not contained in the record. Sometimes DCS workers are concurrently investigating two or more referrals on a family. In one matter, two DCS employees were working related matters, visiting the same family residence one or two days apart and apparently not communicating with each other.

The SLC will continue to support and monitor ongoing efforts of DCS to address the issue of multiple referrals.

Optimal Case Assignment

All child abuse prevention stakeholders should develop and implement a system of assigning cases that takes the different strengths and skills of the individual investigators and service

providers into account. The SLC discovered some local DCS offices assign cases primarily based on a rotation. The primary reasons for assigning cases based on a rotation are to treat the employees equally and to evenly distribute cases. However, each employee has his/her own strengths and weakness. To maximize those strengths and minimize those weaknesses, a system that takes those strengths and weaknesses into account would be beneficial to children, families and the various stakeholders. The assigning supervisor could monitor caseloads to ensure optimal distribution of cases.

Repeat Child Abuse Data

The reported number of children who experienced a second or subsequent incident of child abuse for fiscal year 2011-2012 is 295.

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

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

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

- White: 65 percent;
- Black: 20 percent;
- Unable to determine: 15 percent;
- Asian: less than 1 percent.

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

- 0-4 years old: 13 percent;
- 5-9 years old: 32 percent;
- 10-13 years old: 32 percent;
- 14-18 years old: 23 percent.

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

- Drug Exposure: 14 percent;
- Medical Neglect: 1 percent;
- Neglect: 5 percent;
- Physical Abuse: 9 percent;
- Sexual Abuse: 71 percent.

Percentage of times the same perpetrator committed both incidents of abuse: 17 percent.

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

1st Judicial Distrct

Carter	2
Johnson	0
Unicoi	2
Washington	0

2nd Judicial District

Sullivan	5

3rd Judicial District

Greene	1
Hamblen	6
Hancock	0
Hawkins	0

4th Judicial District

Cocke	3
Grainger	3
Jefferson	1
Sevier	2

5th Judicial District

Blount	3

6th Judicial District

Knox	25

7th Judicial District

Anderson	3

8th Judicial District

Campbell	9
Clairborne	2
Fentress	1
Scott	0
Union	1

9th Judicial District

Loudon	4
Meigs	1
Morgan	2
Roane	4

10th Judicial District

Bradley	8
McMinn	6
Monroe	6
Polk	0

11th Judicial District

Hamilton	8

12th Judicial District

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

13th Judicial District

Clay	0
Cumberland	4
DeKalb	3
Overton	1
Pickett	1
Putnam	5
White	0

14th Judicial District

Coffee	2

15th Judicial District

Jackson	1
Macon	2
Smith	2
Trousdale	0
Wilson	3

16th Judicial District

Cannon	0
Rutherford	5

17th Judicial District

Bedford	4
Lincoln	1
Marshall	3
Moore	0

18th Judicial District

Sumner	3

19th Judicial District

Montgomery	7
Robertson	1

20th Judicial District

Davidson	25

21st Judicial District

Hickman	4
Lewis	1
Perry	0
Williamson	3

22nd Judicial District

Giles	1
Lawrence	5
Maury	5
Wayne	3

23rd Judicial District

Cheatham	1
Dickson	2
Houston	0
Humphreys	2
Stewart	0

24th Judicial District

Benton	1
Carroll	1
Decatur	0
Hardin	3
Henry	1

25th Judicial District

Fayette	2
Hardeman	0
Lauderdale	1
McNairy	1
Tipton	6

26th Judicial District

Chester	3
Henderson	0
Madison	7

27th Judicial District

Obion	1
Weakley	1

28th Judicial District

Crockett	1
Gibson	1
Haywood	0

29th Judicial District

Dyer	1
Lake	0

30th Judicial District

Shelby	45

31st Judicial District

Van Buren	0
Warren	1

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. By extending the Second Look Commission to June 30, 2017, the Tennessee General Assembly confirmed the need to improve how severe child abuse cases in Tennessee are handled. Through the continuation of the SLC, Tennessee is proactively addressing issues related to severe child abuse.

The SLC has identified several areas of needed improvement in the investigation and disposition of severe child abuse cases in Tennessee. The SLC has worked with DCS, the Tennessee Children's Advocacy Centers and other stakeholders to provide and help implement findings and recommendations with the goal of Tennessee improving how it handles severe child abuse cases. As recommendations are implemented, the SLC will monitor the impact of the changes over time to determine whether such changes are actually improving how severe child abuse cases are handled in Tennessee.

STATE OF TENNESSEE

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December 20, 2013

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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

Bonnie Beneke, Executive Director
TN Chapter of Children's Advocacy Centers

Representative John J. DeBerry
TN General Assembly

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

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District Public Defender, 18th Judicial District
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Senator Dolores R. Gresham
TN General Assembly

Donna Hetherington, Lieutenant
Lexington Police Department

David Imhof, East Precinct Commander
Metropolitian Nashville Police Department

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Davidson County Juvenile Court

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