



Second Look Commission 2011 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 that brings 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 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 the worst incidents of child abuse in Tennessee, excluding child fatalities. State and Local Child Fatality Review Teams review all child fatalities in Tennessee, not just those resulting from abuse or neglect. 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 Department of Children's Services (DCS) is mandated to investigate allegations of child abuse and neglect. The DCS staff works tirelessly to help ensure safety, permanency and well-being for the children of Tennessee. Several agencies, entities and community members play major roles in the protection of Tennessee's children. For example, the Tennessee Commission on Children and Youth (TCCY) is involved in a wide range of efforts to improve the quality of life for children and families in Tennessee. The Tennessee Citizen Review Panels, law enforcement and the courts also play a vital role in protecting Tennessee's children. The list goes on and on. 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 abuse cases.

As a result of these reforms, countless 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.

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. 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.

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 build; 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.

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.

Findings and Recommendations

The SLC's first year represents a substantial investment of time on the part of legislators, law enforcement, and child protection experts and advocates. Much of the SLC's efforts in year one were dedicated to determining the best methodology for finding and examining cases, and a great deal has been learned about how that might be improved.

During 2011, the SLC thoroughly reviewed a sample of cases of children who experienced second or subsequent incidents of severe child abuse. 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.

The review process made certain things clear to the SLC. It is difficult, but not impossible to fully comprehend the depth and enormity of the issues regarding repeated severe child abuse in Tennessee. The SLC determined there are significant problems with the manner in which severe

child abuse cases are being handled in Tennessee. While it is clear action must be taken to better protect Tennessee's children, determining the best courses of action will take time. 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. Although it does not yet have all the answers, the SLC believes many of the problems can and should be addressed through improved collaboration, communication, cooperation and training.

The following findings and recommendations are based on the cases reviewed.

1. **Finding:** The Second Look Commission is an efficient mechanism to identify weaknesses in how severe child abuse cases are handled in Tennessee and to identify strategies to improve responses to severe child abuse.

Recommendation: The General Assembly should continue the existence of the Second Look Commission through the Sunset/Sunrise Review Process.

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

The SLC is the primary mechanism in Tennessee to provide and ensure open communication between the various stakeholders in child protection. It is a critical entity because involvement of all groups represented on the SLC is essential for assuring Tennessee responds effectively to child abuse and neglect.

Through its knowledgeable and diverse membership and consultative input from various key stakeholders in preventing child abuse, the SLC identified several weaknesses and opportunities for improvement of how to handle severe child abuse cases as set forth in this report. Even prior to preparing its first report, the SLC has laid the groundwork for providing additional training to various stakeholders. However, identifying weaknesses and making recommendations are just the beginning of improving how severe child abuse cases are handled. The data and various processes must be tracked and evaluated over time to determine whether recommendations are implemented.

2. **Finding:** 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.

Recommendation: Develop improved joint and collaborative training for all child abuse investigation stakeholders.

Explanation: Once a child abuse investigation is commenced in Tennessee, the alleged child victim is likely to come in contact with an intimidating array of individuals and bureaucracies, including social workers, police, doctors and nurses, prosecutors, mental health professionals and judges. In hearing anecdotal testimony from veteran investigators, the SLC found that good investigations—and humane, child-friendly investigations—are best ensured when all of these entities make the effort to work together in coordinated fashion.

The importance of a multidisciplinary approach to outcomes in child abuse cases is made clear in TCA §37-1-607(a)(3), which states:

It is the intent of the general assembly that the child protective investigations be conducted by the **team members** in a manner that not only protects the child but that also preserves any evidence for future criminal prosecutions. **It is essential**, therefore, that all phases of the child protective investigation be appropriately conducted and that further investigations, as appropriate, be properly conducted and **coordinated**. [emphasis added]

The review of case outcomes and anecdotal testimony raises concerns that there may be disparity from county to county in the level of involvement of all the key actors from the child protection and justice systems. Failure to perform with excellence in this process has two predictable and dangerous outcomes: children may be harmed by repeated, sometimes traumatic, interviews; and evidence is less likely to be preserved for future criminal prosecutions.

Sexual abuse comprised 77 percent of the incidents of abuse in the profiled cases of children who experienced second or subsequent incidents of severe abuse. TCA 37-1-406(b) provides cases involving child sexual abuse shall be investigated by a CPIT. A substantial majority of the cases involving a second or subsequent incident of abuse have been through the CPIT process. Several of the issues identified by the SLC potentially can be addressed by strengthening CPIT. A more consistent best practices model for CPITs should be developed and implemented across the state to reduce inconsistent CPIT practices and poor outcomes for children in Tennessee.

The current statutes regarding the composition and functioning of CPIT provide a solid foundation upon which we can build and improve. Mandatory joint training for CPIT members as a team, collaboratively designed or approved by the Child Advocacy Centers, law enforcement, district attorneys and other stakeholders, will likely improve the efficiency of CPIT. Physicians should be included as permissible CPIT members. Physicians should also be afforded the opportunity to help in the development of the training and receive the training as well.

In addition to CPIT-specific training, joint and collaborative training is also needed in effective child maltreatment investigative techniques. Perhaps more important is training regarding the impact of child maltreatment on children and the critical importance of close collaboration with all key stakeholders to ensure a thorough and detailed investigation and the sharing of information and perspectives across disciplines with all who need to know.

We found several cases of alleged severe child abuse were initially handled by CPS without more highly trained law enforcement officers. Some law enforcement professionals interviewed by the SLC expressed frustration at the quality and appropriateness of CPS investigations, while some CPS professionals expressed frustration at the difficulty of developing closer working partnerships with law enforcement on investigations. Joint training involving law enforcement, district attorneys, child advocacy center staff and child protective services workers and supervisors enhances development of the collaborative relationships needed for effective responses to child maltreatment. Such joint training is essential to improve evidence collection, increase successful prosecution and ensure fewer children are re-abused. Regional training is needed in non-urban areas due to multi-county districts and the small number of staff who are involved in child abuse investigations.

Extending joint and collaborative training beyond CPIT members will improve the quality of investigations in various areas. Some of the DCS investigations were incident driven investigations as opposed to issue driven investigations. DCS and all stakeholders involved must address the underlying issues as well as the incident. For example, it is not appropriate to close an investigation solely because the perpetrator has been physically removed from the child victim's life if the child victim is still in need of counseling. Additionally, the parent or guardian may need services to address proper supervision of the child or proper parenting in general. In one case reviewed by the SLC, failure to properly educate a parent resulted in a child being abused by the same perpetrator after the first case was closed. Incident driven investigations missed key issues that must be addressed to properly protect Tennessee's children.

Mental health treatment needs of parents and children are a key underlying issue easily overlooked if not properly stressed. Adequately identifying and addressing the mental health needs of the child victim and the parents or caregivers of the child victim are essential to help protect the child victims from further abuse. Approximately 45 percent of the cases investigated involved mental health issues as a contributing factor or an indicator of abuse. All stakeholders should be trained to consider whether the mental health needs of the child victim and the parents or caregivers are adequately addressed. If the mental health needs are not being met, the stakeholder should be trained to make a referral to an appropriate service provider. The training should also stress the importance of ensuring the necessary assessments are completed by the appropriate professionals.

Joint and collaborative training should also address the issue of uncooperative alleged perpetrators. In some of the cases reviewed, alleged perpetrators refused to submit to drug screens or otherwise cooperate with the investigation and DCS and/or law enforcement took no further action. Accordingly, some investigations were closed because the alleged perpetrator refused to cooperate with the investigation.

Another major training issue relates to the inexperience of many DCS child protective service (CPS) workers. CPS investigators have one of the most important jobs in public service. At their best, they are a lifeline for the safety of children and a guardian of competent and fair treatment for parents and families. However, we found CPS workers sometimes made decisions that did not appear to be in the child's best interest. Many of the decisions seemed to indicate a lack of experience, training or supervision. Too frequently, the state is asking DCS investigators with the least amount of experience to make what could be life and death decisions for Tennessee children. In one case, a DCS child protective services (CPS) worker closed a case as "Unable to Complete" because the address of the alleged perpetrator could not be located. A more experienced or better trained CPS worker may have indicated the alleged perpetrator using witnesses and collateral information. In some instances, investigators relied too heavily on information provided by one individual. Severe child abuse cases should be investigated by the best trained, more experienced CPS workers.

3. **Finding:** Multiple referrals of child abuse often occur prior to investigation and determination of the first incident of indicated abuse. The average number of referrals received prior to the first incident of indicated abuse is 6.4.

Recommendation: A higher level of scrutiny should be assigned to cases that have received multiple referrals, especially when they are from multiple referents and/or professionals.

Explanation: Many of the cases investigated by the SLC had multiple referrals alleging abuse prior to the first and second indicated incidents of abuse. Currently, DCS policy does not adequately consider cases with multiple referrals. Multiple referrals are addressed in the structured decision making tools used by DCS. However, based on the findings of the SLC, more weight must be given to multiple referrals to adequately protect the children of Tennessee.

Any referral meeting the criteria of a multiple referral should be reviewed by a consultative group (as contemplated in Finding 4) to provide direction regarding the investigation and disposition of the case. After the initial consultation and directive, the CPS investigator/assessor or the FSW must review the case with the consultative group at least once every 30 days. A matter meets the criteria of a multiple referral case if the child, his/her sibling or the alleged perpetrator is identified as a victim or perpetrator in more than one referral within the previous twelve months.

4. **Finding:** DCS frontline staff does not consistently have adequate supervision and guidance.

Recommendation: Strengthen supervision of the CPS assessor/investigator and the family services worker for children in foster care. Create a designated team of experienced DCS employees (Child Safety Consultation Team) to help frontline staff when needed in the decision making process.

Explanation: 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. Each designated group should consist of the following: at least one DCS employee with at least three years experience in child protective services investigation, at least one DCS employee with at least three years experience in working directly with families and at least one DCS employee with at least three years experience in child welfare system administration.

5. **Finding:** There is insufficient recognition of violations of the mandatory reporting statute.

Recommendation: Increase the public's knowledge regarding the statutory obligation to report child abuse.

Explanation: The Penn State scandal has drawn national attention to the issue of mandated reporting of child abuse. Tennessee can be proud of its mandatory reporting

law (TCA § 37-1-403), which makes our state one of a handful in the nation that requires “any person” to report suspected child abuse or neglect to authorities. A modest investment in making the public more aware of this law could yield great returns in public reporting of abuse.

In several cases investigated by the SLC, family members and other individuals were aware a child was being abuse and failed to report it. Strategies for implementing a public information campaign designed to increase the public’s awareness and understanding of Tennessee’s mandatory reporting statute is one method of educating the public about the importance and obligation to report child abuse. Another method of educating the public about the mandatory reporting statute is the consistent prosecution of violations of the statute.

The SLC acknowledges the difficulty of determining whether a person has violated the mandatory reporting statute. Often, a child may make a general statement about the perpetrator or the abuse believing he/she has disclosed the abuse. When asked during the course of an investigation, the child will state they disclosed the abuse to an adult. However, upon hearing the statement made by the child to the adult, a reasonable person would not suspect child abuse based on the statement. Despite the difficulty of determining when a person has violated the mandatory reporting statute, action must be taken to enforce the statute if it is going to adequately protect the children of Tennessee.

Issues Identified Requiring Additional Research for Recommendations

In addition to recognizing the need to optimize the multi-disciplinary approach and other recommendations identified above, the SLC identified a number of issues for which additional research is required. The SLC acknowledges the importance of these issues. The fact specific recommendations are not provided in this report does not reflect a lack of importance. Issues for future exploration and recommendations are presented here in an effort to keep the General Assembly and all interested parties informed and to solicit recommendations for protecting the children of Tennessee. The following is a list of issues the SLC will continue to research and evaluate for the development of more detailed recommendations:

- a. **Finding:** Stakeholders are not effectively communicating and sharing essential child abuse-related data. Strategies to improve communication could include, but are not limited to, co-location center(s) for child abuse stakeholders to facilitate collaboration, coordination and communication or a “Fusion Center” for child abuse cases similar in concept to the Tennessee Bureau of Investigation’s (TBI) Fusion Center for terrorism and other crimes.

- b. **Finding:** DCS frontline employees are not adequately compensated or prepared for the level of expertise required in complicated severe child abuse cases resulting in challenges attracting and retaining qualified staff needed to protect Tennessee children. Innovative and creative ways are needed to recruit, support, inspire and retain the highest quality DCS professionals possible. Options to be considered should include student loan forgiveness and performance-based pay increases.
- c. **Finding:** Many of the problems identified by the Commission are not easily remedied legislatively. In some cases formal policy changes may be required. In many others, solutions are ultimately dependent upon the commitment of individuals and agencies to honestly compare and assess their performance and to change and improve if necessary. The SLC will explore strategies to improve child protection through stronger public transparency and accountability.
- d. **Finding:** Cases where children have been abused and then re-abused may go on for years. Many of the children in cases the SLC examined came in contact with a shifting array of social workers or other professionals over a long period of time. Turnover and lack of continuity can lead to poor communication, missed opportunities and mistakes. Similarly, lack of continuity in the CPS field makes proper supervision and guidance much more difficult. The SLC will explore future recommendations to address this situation.
- e. **Finding:** All cases of indicated severe child abuse are not brought before the juvenile court, reducing the opportunity for better protection of children through the involvement of the juvenile court judge and a guardian ad litem.
- f. **Finding:** Sometimes children engaging in consensual sexual behavior while placed in residential facilities is classified as abuse. DCS should maximize the use of evidence-based treatment for juvenile sexual offenders and explore the best way to respond to these circumstances.
- g. **Finding:** 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.
- h. **Finding:** Sometimes DCS staff fails to timely enter data into Tennessee Family and Child Tracking System (TFACTS)/TnKids, which could impact the safety of children.

- i. **Finding:** District attorneys and assistant district attorneys (collectively referred to as DAs) often chose to enter into plea agreements with perpetrators for a crime less serious than the original charge or chose to not prosecute cases of child abuse.
- j. **Finding:** On average in cases reviewed by the SLC, from the beginning of the investigation, it takes 9.8 months for severe child abuse cases to be tried in criminal court. Strategies are needed to reduce the time it takes to prosecute child abuse cases.

Repeat Child Abuse Data

The total population of cases of children who experienced second or subsequent incidents of severe abuse presented by DCS for fiscal year 2009-2010 is 256.

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

- Female: 75 percent;
- Male: 25 percent.

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

- White: 69 percent;
- Black: 24 percent;
- Mixed Race: 2 percent;
- Unknown: 3 percent.

Incidents of repeat abuse by population of the county are as follows:

- Population 49,999 or less: 29 percent;
- Population 50,000 –299,999: 35 percent;
- Population 300,000 or more: 36 percent.

The ages of the victims at the time of the incidents of abuse in this total population of the cases are as follows:

- 0-4 years old: 14 percent;
- 5-9 years old: 28 percent;
- 10-13 years old: 34 percent;
- 14-18 years old: 24 percent.

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

- Sexual Abuse: 77 percent;
- Drug Exposure: 12 percent;

- Physical Abuse: 8 percent;
- Neglect: 3 percent.

First and second incidents of abuse were perpetrated by the same person 34 percent of the time.

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. States across the nation are responding to failed systems and the need for effective responses to child abuse. The responses of the various states are often to due the death or near death of a child and scrutinizing publicity.

Violence against children is increasingly recognized as a national crisis. U.S. Politics Today reported the following:

Leading policymakers, researchers, scholars, jurists, and child advocates from across the country have issued a public statement calling for the development of robust plans of action at federal, state and local levels to address all violence against children. The joint statement cites epidemic levels of violence against children in the U.S., which has the worst record of fatalities due to child abuse among industrialized nations. . .

The statement calls for the creation of a national commission on children—the first since 1987—to address the challenges facing our nation's children; the development of federal, state and local policies, legislation and regulations to prohibit all forms of violence against children in all settings; and the consolidation of national data systems and research on violence against children in order to inform advocacy, policy making and resource mobilization to safeguard children's right to freedom from violence.

By creating the Second Look Commission, the Tennessee General Assembly recognized the need to improve how severe child abuse cases in Tennessee are handled. The total population of cases presented by DCS for fiscal year 2010-2011 is 267, 11 more cases than last year. Through the creation and 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. 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.



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