12-1-2017

Second Look Commission 2017 Annual Report

Tennessee. Commission on Children and Youth.

Second Look Commission
2017 Annual Report

Craig Hargrow, Director

Tennessee Commission on Children and Youth
502 Deaderick Street
Nashville, TN 37243-0800

Tennessee Commission on Children and Youth authorization number 316627. December 2017. 162 copies. This public document was promulgated at a cost of $3.40 each.

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 providesadequate protection for the children of Tennessee. The SLC is designed by statute to bring together representatives of all key stakeholders in the child protection system in Tennessee with representatives from all three branches of state government: members of the General Assembly, Department of Children's Services (DCS), the Administrative Office of the Courts (AOC), law enforcement (including the Tennessee Bureau of Investigation and officers from urban and rural areas), district attorneys general, public defenders, child advocacy centers, a physician who specializes in child abuse detection, and other children's advocates. The SLC is the only entity with statutory authority to hold closed meetings to critically analyze confidential information in individual cases, and also to compel participants in the investigation and disposition of the cases reviewed to appear before it to discuss issues and answer questions. The SLC is the vehicle for representatives of these key groups to meet together to review cases and identify strategies for improving child protection in Tennessee. The SLC has facilitated much needed communication and collaboration.

The SLC reviews some of the worst incidents of recurring child abuse and neglect in Tennessee. The SLC reviews cases of children from 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.

Despite the best efforts of an array of child abuse prevention stakeholders, Tennessee's children continue to be subjected to and traumatized by horrifying experiences of repeated incidents of severe child abuse. These issues 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. In 2015 by invitation of Governor Bill and First Lady Crissy Haslam and Deputy Governor Jim Henry and Pat Henry, Tennessee held the Adverse Childhood Experiences (ACEs) Summit. The ACEs Summit was attended by leaders within state and local government, communities, philanthropy, academia, faith organizations and providers. The ACEs Summit helped to serve as a part of the foundation of a myriad of ACEs-related initiatives.

Despite these and other reforms, more remains to be done. It is our hope that the proposed recommendations of the SLC will be embraced and implemented and will spur child protection professionals to engage in meaningful dialogue that will produce additional ideas for reducing repeat abuse of our children.

Impact of Child Abuse

The future prosperity of any society depends on its ability to foster the health and well-being of the next generation. Child development is important for community and economic development. When a society invests wisely in children and families, the next generation will pay that back through a lifetime of productivity and responsible citizenship. The wise investment in children and families becomes the basis of a prosperous and sustainable society.

The basic architecture of the human brain is constructed through an ongoing process that begins before birth and continues into adulthood. Like the construction of a home, the building process begins with laying the foundation, framing the rooms and wiring the electrical system in a predictable sequence. Early experiences literally shape how the brain gets built; a sturdy foundation in the early years increases the probability of positive outcomes. A fragile foundation increases the odds of later difficulties.

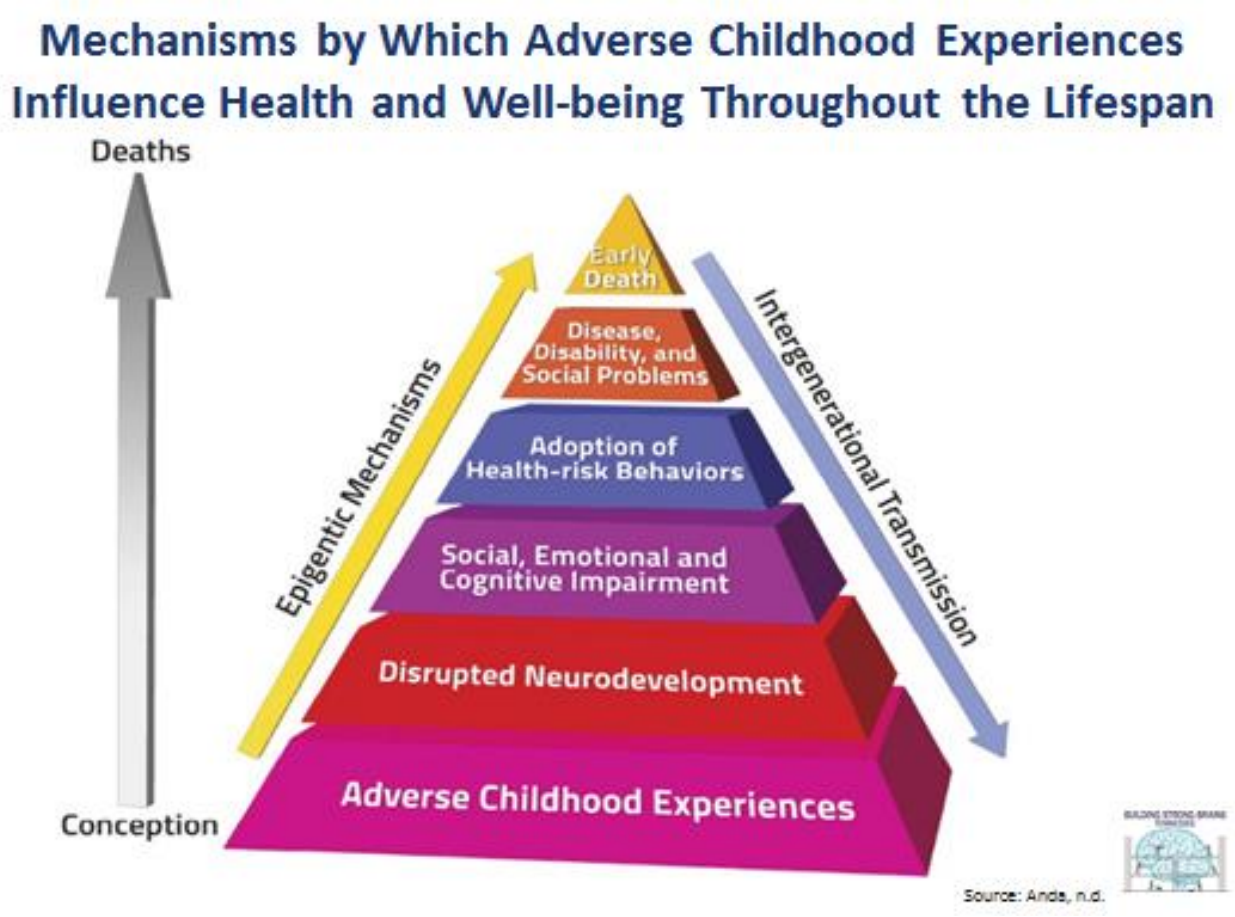
The interactive influences of genes and experience shape the developing brain. The active ingredient is the "serve and return" relationships of children with their parents and other caregivers in their family or community. Like the process of serve and return in games such as tennis and volleyball, young children naturally reach out for interaction through babbling and facial expressions. If adults do not respond by getting in sync and doing the same kind of vocalizing and gesturing back at them, the child's learning process is incomplete. This has negative implications for later learning.

When a young child experiences excessive stress, such as Adverse Childhood Experiences, extreme poverty, abuse or severe maternal depression – what scientists now call "toxic stress" – it can disrupt the architecture of the developing brain. This can lead to lifelong difficulties in learning, memory and self-regulation. Severe or chronic stress releases harmful chemicals in the brain that impair cell growth and make it harder for neurons to form healthy connections,

damage the brain's developing architecture and increasing the probability of poor outcomes. Intervention in the lives of children who are experiencing toxic stress should not be delayed.

Children who experience the trauma of child abuse are more likely to have difficulty developing trusting relationships. They are less likely to be successful in school and more likely to exhibit behavior problems. They are more likely to have mental health and substance abuse treatment needs. Even in adulthood, they are more likely to experience challenges in maintaining stable relationships and employment. Too frequently, child abuse is intergenerational, and effective responses to first instances of abuse are more likely to reduce future abuse not only to that individual child, but to future generations.

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



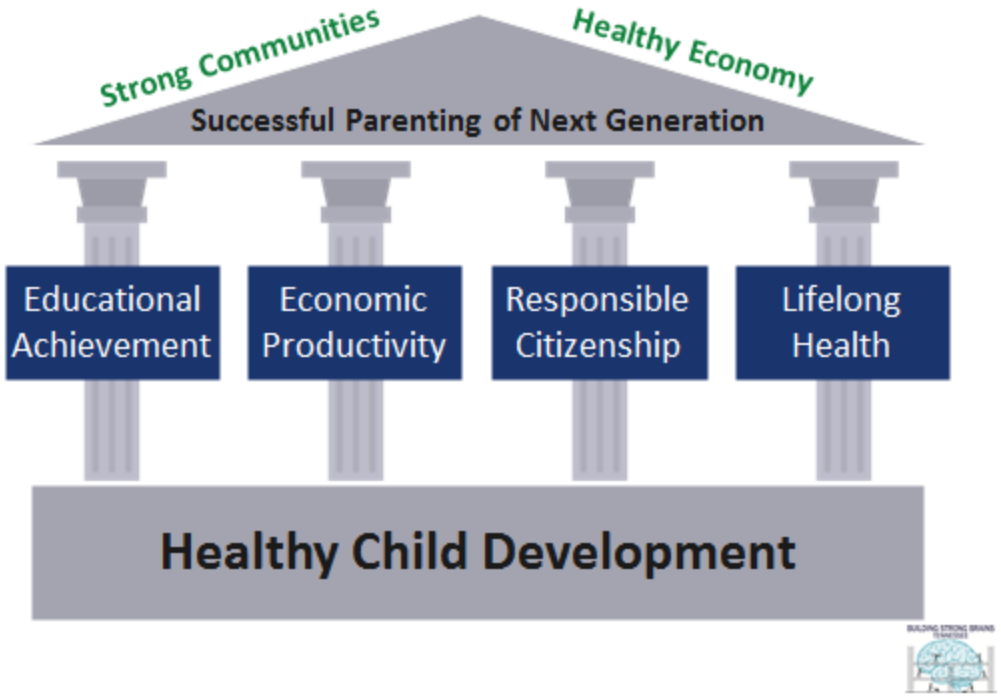
This pyramid was developed to explain the relationship between ACEs and the rates of disease and disability associated with a higher score. When children and families do not have policies and community supports to prevent high ACE scores, higher ACEs leads to disrupted brain development through a lack of serve and return interactions. Science has shown higher ACE scores compromise social, emotional and cognitive development. When communities do not provide safe, stable and nurturing relationships to support strong brain architecture and buffer constant stress, children and adolescents with high ACE scores are at a greater risk to adopt health risk behaviors to cope such as substance and alcohol abuse. Disease, disability and social problems logically follow the adoption of these unhealthy coping skills. One of the most astounding findings from the study from which the pyramid is based is the study showed when a person has four or more ACEs, they tend to die 5-10 years earlier than people who have low or no ACEs. A subsequent study conducted by the National Institute of Health found that when a person has six or more ACEs, their life is cut short by 20 years on average.

The left side of the pyramid depicts the epigenetic mechanisms changing across the lifespan. The right side of the pyramid going down depicts intergenerational transmission of ACEs. Parents with high ACE scores who have children have a much higher likelihood of passing ACEs onto their children. Communities and supports that provide safe, stable and nurturing relationships and environments can disrupt this this cycle and positively impact epigenetics.

Preventing child abuse and intervening effectively when it first occurs are keys to avoiding lifelong negative consequences from child abuse. Cases reviewed by the SLC continue to make it abundantly clear that there are opportunities to strengthen the systems responding to child maltreatment in Tennessee. As a state, we can and we must identify and implement strategies to ensure children who experience severe abuse, who are among the most vulnerable

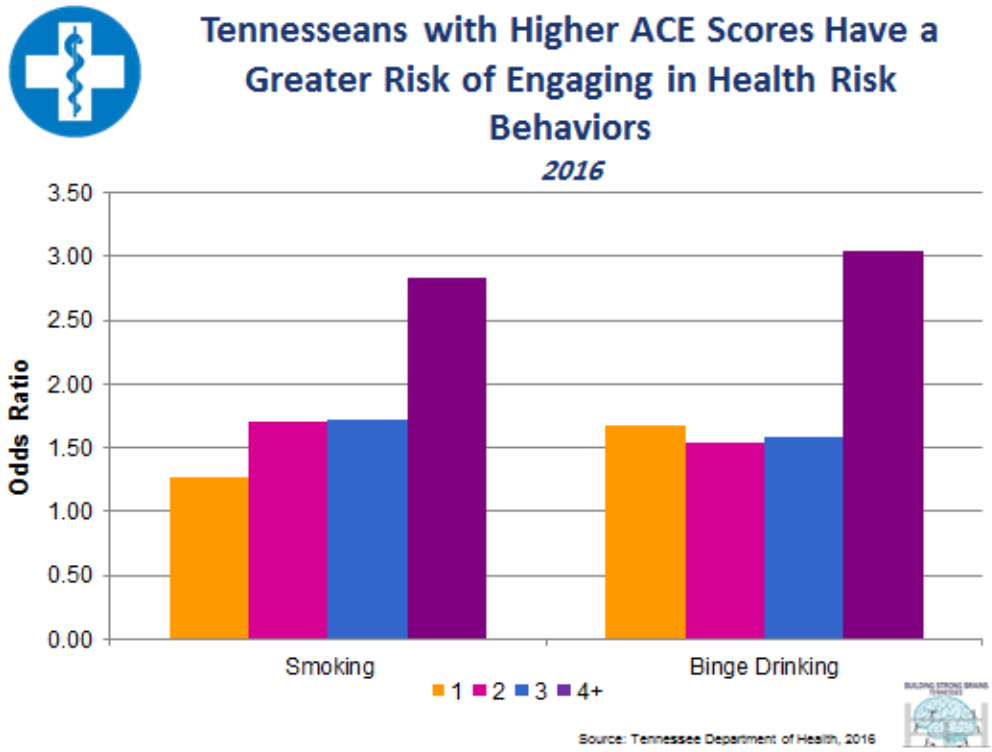
Tennesseans, receive the protection and remediation assistance they deserve. It will take a concerted and sustained effort to peel away the many layers of this complex issue to get to the core.

As Tennesseans understand the impact of ACEs, they will realize the future economic development and prosperity of the state depends on what we do to prevent these experiences whenever possible and to wrap services around children and families when they cannot be prevented. The picture below illustrates how healthy child development ultimately leads to strong communities and a healthy economy.

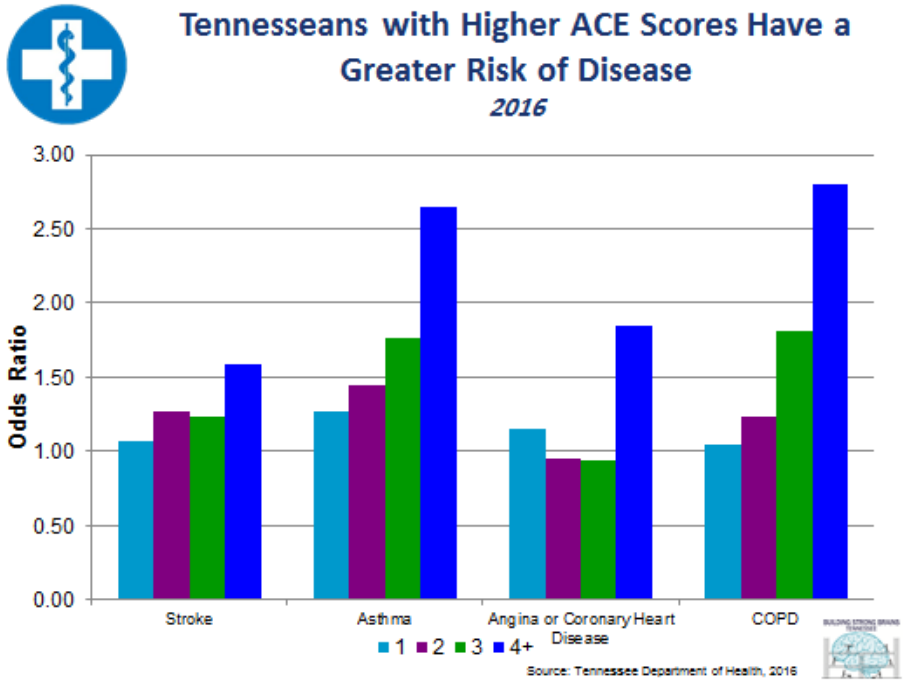


There will be better collaboration across disciplines, departments, agencies and communities, and focus on the infrastructure of services and supports that make a difference. When child abuse and domestic violence prevention, home visiting, mental health and substance abuse services for parents, and a variety of other services and supports are available for early intervention, they put in place a preventive system that catches children before they fall. This kind of sound investment in our society's future is confirmed by brain science. It improves outcomes for children now and is a significant foundation for solutions to many of the long-standing and nagging challenges we face as a state in our health, mental health, social services, child protection, and juvenile and criminal justice systems.

Based on data provided by the Tennessee Department of Health, Tennesseans with higher ACE scores have a greater risk of engaging in health risk behaviors. Four or more ACEs dramatically increase the risks of smoking and binge drinking.



Based on data provided by the Tennessee Department of Health, Tennesseans with higher ACE scores have a greater risk of disease. Four or more ACEs dramatically increase the risks of having asthma, Chronic Obstructive Pulmonary Disease, a stroke and coronary heart disease.



2017 FINDINGS AND RECOMMENDATIONS

This is the fourth year the list of cases provided by DCS contains cases involving abuse and neglect deaths. The SLC decided to review all the abuse and neglect death cases on the FY 2016 list, as well as a sampling of cases representative of the higher maltreatment type percentages, sexual abuse and drug exposure. The SLC also considered the time between the first and second incident of abuse. To maximize its efforts and make the case reviews more relevant, the SLC decided to review only cases in which the first and second incident of abuse occurred within three years of FY 2016.

For each case reviewed, the SLC gathers information from various individuals, departments and agencies. The documentation gathered by the SLC typically includes records from the following, when applicable: DCS, medical service providers, juvenile courts, law enforcement, criminal courts, educational systems, child advocacy centers and various service provider records. In addition to gathering documentation, the SLC obtains additional information through email requests, telephone calls and site visits. The director of the SLC reviews all the gathered information and provides a written case summary of the cases the SLC will review one week prior to the investigatory meeting of the SLC. Members of the SLC read the summaries prior to the investigatory meetings and arrive at the meetings prepared to analyze each case thoroughly.

The list of cases provided by DCS for fiscal year 2015-2016 (FY 2016) reported 689 children experienced a second or subsequent incident of severe child abuse. Similar to previous years, sexual abuse was the most prevalent type of listed severe child abuse. Sexual abuse accounted for approximately 73 percent of the severe abuse that occurred in FY 2015. However, sexual abuse only accounted for approximately 28 percent of the prior maltreatment type set forth in the FY 2016 list of cases. The second most prevalent type of severe abuse was drug exposed child/infant. Drug exposure accounted for approximately 13 percent of the severe abuse that occurred in FY 2016. However, drug exposure accounted for approximately 33 percent of the prior maltreatment type set forth in the FY 2016 list of cases. Approximately one-third of all the children represented in the FY 2016 list were first exposed to drugs and were then subjected to a second or subsequent incidents of child abuse.

As in previous years, the review process was often painful as members considered the horrific experiences endured by the children whose cases were reviewed and, through the review process, could see missed opportunities that might have prevented repeat abuse. Although there continues to be opportunities to improve the manner in which severe child abuse cases are handled in

Tennessee, changes continue to occur that will likely have a positive impact on reducing the rate and consequences of severe child abuse.

The following findings and recommendations are based primarily on the child death and severe abuse cases reviewed by the SLC during the 2017 calendar year. The recommendations recommend specific action steps to help resolve a finding in some instances and further research

and investigation in other instances. The findings and recommendations are discussed below and grouped by the following broad categories: Mental Health Issues, Drug Addiction, Court and Legal Issues, Collaboration and Communication, and Training.

The names and genders of families and people identified in this report have been changed to protect the identities of the families and people.

Mental Health Issues

Recognizing signs of mental health issues can be extremely difficult. In the United States, approximately 1 in 5 adults have a mental health condition. As reported by the Substance Abuse and Mental Health Services Administration, an annual average of approximately 443,000 adults in Tennessee with Any Mental Illness (AMI) from 2011 – 2015 received mental health services. Accordingly, 43.2 percent of the adults who reported having a mental health illness in Tennessee received mental health services. Conversely, well over half of the adults who reported having a mental health illness in Tennessee did not receive much needed services. "Any Mental Illness (AMI) is defined as having a diagnosable mental, behavioral, or emotional disorder, other than a developmental or substance use disorder. Any mental illness includes persons who have mild mental illness, moderate mental illness, and serious mental illness." Untreated mental illness can cause severe emotional, behavioral and physical problems. Problems related to mental illness sometimes include self-harm and harm to others. Additionally, living with a parent who has a mental health illness is an adverse childhood experience.

Finding – Properly identifying and addressing mental health issues continues to be a challenge and an opportunity for improvement.

In the Andrews child abuse death case, the parent exhibited indicators of mental illness that went unaddressed. The child was placed with relatives on at least two occasions. On both occasions, the child was returned to the parent without properly assessing her ability to care for the child. During a DCS investigation involving the Andrews family unrelated to the child abuse death, a child abuse stakeholder even noted the parent of the child appeared to be "low functioning." Investigation notes also state the parent was not cooperative with an investigation and did not complete a mental health assessment. Additionally, the parent was being belligerent and hostile toward the child. The Andrews child abuse/neglect death case is obviously a worst case scenario, but the issues highlighted in the Andrews case are reoccurring in cases reviewed by the SLC in 2017 and previous years.

In the Evans case, a parent refused mental health services because she felt she did not need them despite being diagnosed with several mental health issues. She was taking medication and the child appeared safe. However, DCS was involved, in part, because the parent had a "nervous breakdown." The parent was on medication. Accordingly, the child remained with the parent and the child was subsequently abused.

In the Fox matter, the perpetrator parent failed to follow through with her mental health appointments for approximately three months prior to the child being returned to the parent pursuant to a court order. All of the parties at the hearing that resulted in the child being returned to the mother represented the mother completed all her services. Within four months of the final order in this matter, the subject child was the victim of severe child abuse. Medical staff stated the child was near death. During the course of investigating the near death incident of severe child abuse, DCS received mental health records indicating the parent had missed several mental health appointments during the previous investigation and had only made slight improvement when she received custody of the subject child.

Recommendation – Policies and procedures should be put in place or reinforced to help ensure caregivers of children submit to and follow recommendations of appropriate assessments when the mental health of the caregiver is a safety concern. This recommendation applies to all child abuse prevention stakeholders and agencies working with vulnerable children and families including courts, attorneys and law enforcement. Moreover, all child abuse prevention stakeholders and agencies working with vulnerable children and families should receive ACEs training and should utilize trauma informed decision making.

Recommendation – Child abuse prevention stakeholders working with a caregiver who has been identified with mental health issues requiring services should verify the caregiver is receiving the necessary mental health services. When a caregiver who has been identified with mental health issues requiring services does not participate in those services, the matter should be brought to the attention of the juvenile court.

DCS Response – The CPS Academy has a 3.5 hour session on mental health. The regional staff also arrange and attend trainings utilizing local partners regarding ways to better address mental health issues. These trainings increase the understanding of mental health issues for DCS staff which are critical in analyzing when they represent a safety issue to the children.

Drug Addiction

Drug addiction continues to be a substantial factor in severe child abuse cases reviewed by the SLC. Over half the cases reviewed in 2017 contained substantiated allegations of drug exposed children or infants. The increase in the abuse of prescription medications makes it difficult for DCS and other child abuse prevention stakeholders to protect children.

The opioid epidemic is a national issue. However, Tennessee has been impacted especially hard by the opioid epidemic. According to a report prepared by the Sycamore Institute in 2012, Tennessee had an average of 1.4 opioid prescriptions for every Tennessean — the 2nd highest rate in the U.S. Among other negative consequences, the epidemic in Tennessee has resulted in more children in state custody and a ten-fold rise in infants born with neonatal abstinence syndrome.

Finding – Continued training on identifying and addressing drug addiction of caregivers continues to be an opportunity.

During several investigations of the Gordon family, the parents tested positive for prescription medication. The parents stated they had prescriptions. Ultimately, the Gordons did not provide proof of the prescriptions except for one time. The DCS employee located bottles indicating the father had a prescription. However, the pill count indicated potential drug abuse. The child in the Gordon matter remained with the parents. The child came into state custody when the parents were arrested on drug-related charges. Two cases reviewed by the SLC contained alleged perpetrators who tested positive for prescription medication, but the alleged perpetrators could not produce the prescription. The children in those cases initially remained with the parents**.**

Recommendation – Continued training is needed to aid DCS in appropriately verifying prescriptions and addressing drug addiction.

Recommendation - Many mental health and drug and alcohol addiction professionals recognize drug addiction as a mental illness. For example, the National Institute on Drug Addiction and the National Institute of Mental Health both recognize drug addiction as a mental illness. In general, professionals who agree drug addiction is a mental illness hold this position because "addiction changes the brain in fundamental ways, disturbing a person's normal hierarchy of needs and desires and substituting new priorities connected with procuring and using the drug. The resulting compulsive behaviors that override the ability to control impulses despite the consequences are similar to hallmarks of other mental illnesses." *National Institute on Drug Abuse*. In the 2016 SLC report, the SLC recommended training, practice improvements and resources to address drug abuse using a public health approach. The SLC renews this recommendation. A public health response to drug abuse would involve a coordinated collaborative strategy involving various agencies, departments and communities to provide treatment as opposed to punishment. Community health and safety are priorities in a public health approach to addressing drug abuse.

DCS Response - The Office of Child Safety created a specialized drug team to work with the University of Tennessee Hospital targeting alleged drug exposed infants born in this facility who reside in the Knox, Smoky and East regions. The drug team is designed to create a more consistent and urgent response to infants with a drug exposed child allegation. Team members are expected to attend hospital meetings and rounds as appropriate to enhance the communication efforts and ensure information related to the drug-exposed infants is shared timely and accurately. This team also supports the Family Support Services (FSS) case work which provides additional case monitoring following a CPS investigation. In response to the increased number of infants born affected by drugs in other counties in East Tennessee, additional specialized teams are being implemented in the Northeast region. These teams will work closely with other hospitals in the eastern portion of the state and be focused on drug

exposed infants. Additionally, the department continues to work with the Governor's Children's Cabinet Multi-Agency Collaborative in streamlining Tennessee's response to drug abuse and addiction issues. This coordinated response is in 17 counties and will continue to expand throughout 2018.

Recommendation – The SLC supports the continued expansion of zero to three court programs in Tennessee. Two of the goals of the zero to three court programs as set forth in TCA 37-1-902 are to reduce incidences of repeat maltreatment among children thirty-six (36) months of age or younger, and promote effective interaction and the use of resources among both public and private state and local child and family service agencies, state and local mental health agencies, and community agencies.

The results of similar programs in other states has been positive in emphasizing the need for comprehensive and timely service provision to support parents and result in speedy reunification of parents and young children, or determination such will not be possible and move to termination of parental rights. Brain research is clear regarding the impact of ACEs on the developing brain, especially of very young children. Appropriate two generation strategies, like zero to three courts, can be instrumental in both preventing ACEs and mitigating their impact. Expanding the availability of evidence-based zero to three court programs has the potential to improve the outcomes for the children and families served by these courts.

In jurisdictions that have zero to three court programs, children fitting the criteria to participate in such court program should be referred to the juvenile court. The SLC acknowledges the statutes that created and govern the zero to three court programs do not confer a right or an expectation of a right of participation in a zero to three court program to a person within the juvenile court system.

DCS Response – DCS supports the expansion of zero to three court programs also known as Safe Baby Courts and works closely two courts that have already established zero to three court programs. The implementation of the Safe Baby Courts across the state will focus efforts on substance abuse, addiction and recovery, as well as and infant mental health needs for the children in the zero to three age population. By early 2018, there will be seven Safe Baby Court programs in Tennessee with an additional five established by early 2019.

Court and Legal Issues

When protecting Tennessee's future, its children, all reasonable and sometimes extraordinary steps must be taken. "The best interest of the child" repeatedly is the deciding factor found throughout statutes, case law, policies and procedures in Tennessee when determining how this state and its resources should best serve children. The courts, DCS and other child abuse prevention stakeholders have various options available to them to ensure the safety of children in Tennessee. When protecting children, meeting minimally acceptable standards may not be in the best interest of the child.

DCS Response – DCS is partnering with Casey Foundation to establish a resident "jurist" program that utilizes a retired judge to work directly with DCS, the Tennessee Supreme Court and the Administrative Office of the Courts to strengthen relationships and communication between agencies working with vulnerable children and the judiciary.

Immediate Protection Agreements and Court Orders

Finding – Substantiating a matter may not provide the abused child appropriate protection.

When investigating alleged incidents of abuse, DCS goes through a process to determine whether the allegation and the perpetrator will be classified as "Substantiated." An allegation may be substantiated based on a preponderance of evidence and on proof of several factors linking the abusive or neglectful act(s) to the alleged perpetrator. When a perpetrator is substantiated, subject to applicable laws and policies, DCS may release the identity and other related information of a perpetrator to organizations or individuals providing care, supervision, instruction or treatment of a child or children either as an employee, employer or volunteer.

Substantiation of the abuse and perpetrator does provide some protection to the abused child and other children who may have contact with the perpetrator. Not all substantiated child abuse cases are brought before the juvenile court, and not all of them should be. Even fewer substantiated child abuse cases are brought before criminal courts for the prosecution of the perpetrator. In some instances, the substantiated case needs to be brought to court or additional options should be exhausted to help ensure the safety of the child.

In the Cooper case, the mother tested positive for opiates when she gave birth. Additionally, the child's meconium drug test was positive for opiates. The mother denied using drugs while pregnant and did not cooperate with services to address her addiction. The infant appeared to be doing well and remained with the mother. All infants who test positive for drugs do not exhibit signs of harm or withdrawal. The investigation was substantiated. During a subsequent investigation of the same mother, the infant's hair follicle tested positive for amphetamines and methamphetamine. The matter was substantiated and DCS filed a petition in the matter. The court ordered the mother to cooperate with the necessary services. The infant remained with the mother and the mother agreed to cooperate with services. The mother failed to cooperate with services and the infant was placed in the custody of DCS.

In the Brown case, DCS substantiated a father for sexual abuse against his child. The mother was told to prohibit contact between the father and child. The mother appeared to be protective. The documentation in the Brown case did not include an Immediate Protection Agreement (IPA). Additionally, the matter was not taken to court. Less than six months later, the mother allowed contact between the child and the father and the father sexually abused the child again.

In the Johnson case, DCS used an IPA, but did not take the case to court. After DCS closed its investigation, the mother subsequently moved back in with the substantiated perpetrator in violation of the IPA. In cases reviewed by the SLC where this has occurred, a common response from the non-perpetrating party is they did not know the IPA still applied. Obtaining a court order to prohibit or limit contact provides additional protection for the child and additional clarification for the parties involved.

Recommendation – Despite how protective a non-offending parent may seem, when contact between a child and an offending parent should be prohibited or supervised, child abuse prevention stakeholders should pursue a court order to clearly define what type of contact, if any, is allowed.

DCS Response – DCS is reviewing policies to incorporate directive language for requesting no contact orders, and ensuring legal consults and petitions are explored specifically related to parents retaining their parental rights after the parent has been substantiated for abuse or neglect. This will ensure the protection of the victim is not solely the responsibility of the non-offending parent. DCS already has policies outlining timeframes for filing petitions in juvenile court when an IPA is created. However, DCS will review its policies further to determine whether additional actions are needed for compliance. Additionally, DCS is working with its legal staff to help provide consistency in seeking IPAs and other court orders.

Additional Concern – During the course of discussing cases involving drug exposed children, members of the SLC expressed concerns about the ability of child abuse prevention stakeholders to protect infants when they test positive for drugs, but the mother tests negative for all drugs. All child abuse prevention stakeholders, including DCS, hospitals, law enforcement and the courts, should review their controlling policies and statutes to determine how to best protect children when the child is born with drugs in the child's system and the parent's drug screen is negative for all substances.

DCS Response – DCS policy has been updated to provide additional clarity in response to the Comprehensive Addiction and Recovery Act (CARA) to specify when an infant tests positive from substance abuse, which includes misuse or abuse of legal prescription medication, an investigative response is to take place regardless of whether the mother also tests positive at the time of delivery.

<u>Lack of Consequences for Failure to Protect</u>

Finding – Children remained in the home with non-offending family members after they failed to protect the children.

In the Ingram case, when the child disclosed sexual abuse to the DCS employee, a family member in the house told the child it did not happen and the child should not say that it did. The parents were told to strictly supervise any contact between the child and the alleged perpetrator.

During the forensic interview, the child disclosed sexual abuse by a non-relative. The child also stated he told several family members about the abuse. The child was sent home with the same family members. The non-relative was arrested the same day. In the Johnson case, a child was allowed to remain with the non-offending parent even though the non-offending parent allowed the offending parent to move back in the home with the child. In the King case, the caregiver allowed children to have unsupervised contact with a registered sex offender and a substantiated sexual perpetrator. The children were removed and returned and the caregiver did it again. Other than the removals, there were little to no consequences to the caregiver regarding his actions.

Recommendation – Non-offending family members must receive the appropriate education, guidance and support to help prevent future abuse. When appropriate, non-offending parents should participate in non-offending parenting classes and other services. Moreover, DCS and service providers need to closely monitor the child's safety when the child remains with a non-offending family member. However, when a caregiver knowingly fails to protect a child from abuse, DCS should consider whether the caregiver should be substantiated for Lack of Supervision.

Finding – Kinship placements continue to ignore No Contact and Supervised Contact orders.

The SLC recognizes the legal obligation to place children with family members when a child must be removed from his home due to severe abuse allegations or findings against the child's parent/caregiver. When a child is placed with family members under these circumstances, contact between the child and the parent/caregiver is often prohibited or directed to be supervised pursuant to a court order or directions from DCS.

When this happens, DCS and the courts must take the necessary steps to ensure the kinship placement understands its obligations to the child, and the court and DCS when applicable. In the event the kinship placement violates the order or agreement appropriate actions should be taken.

In the Fox case, a kinship placement allowed the child to be alone with the parent despite a court order prohibiting such contact due to the parent's history of abusing drugs. While the parent was having prohibited contact with the child, the parent and child were involved in a serious car accident. The parent was driving under the influence of alcohol at the time of the accident. The car accident was not the first time the parent was allowed to transport the child without supervision in violation of the court order. The parent also stated the kinship placement left her alone in the home with the child several times. Despite the actions of the kinship placement, the court ultimately awarded temporary custody of the child to the kinship placement.

In an effort to improve the enforcement of Juvenile Court No Contact orders, the SLC will renew its efforts to include No Contact orders from juvenile courts in the State of Tennessee Integrated

Criminal Justice Portal (Portal). SLC members believe including these orders in the Portal will improve the enforcement of Juvenile Court No Contact orders. Additionally, the SLC will explore DCS having limited access to the Portal.

Recommendation – The Tennessee Administrative Office of the Courts (AOC) provides training to juvenile court judicial officers throughout Tennessee on a regular basis. The AOC and SLC will explore opportunities to work with the juvenile courts to enhance the orders and instructions given to kinship placements when no or supervised contact between the parent and child is ordered.

Recommendation – The 2016 SLC report also contains a finding based on kinship placements failing to comply with no or supervised contact orders. The 2016 SLC report stated, "[c]ourts must clearly explain to those designated as supervisors their responsibilities and encourage non-supervisors to report violations of No Contact and Supervised Visitation Orders; DCS must bring violations to the attention of the Court; and Courts should take such violations very seriously and enforce the provisions of these Orders with the full weight of the law." The SLC renews this recommendation.

Collaboration and Communication

Helping to provide a safe, stable nurturing environment for children in Tennessee is a responsibility of all Tennesseans. No one person, department, agency, organization or group is able to accomplish this. As stated earlier, child abuse cases are often complex and require diverse resources to investigation and address. Providing the best protection available requires frequent communication and collaboration amongst and between all child abuse prevention stakeholders. The collaboration of agencies and services must be a priority of all child abuse prevention stakeholders. Appropriate communication and collaboration enhances the delivery of services to the child and family and helps child abuse prevention stakeholders make better informed decisions about the safety of children. Collaboration and communication is at the heart of the multidisciplinary team approach to investigating incidents of severe child abuse. The multidisciplinary team approach has proven to help keep children safe when investigating and addressing child abuse. Moreover, this approach also helps provide cost-efficient and effective prosecution. Collaboration and communication should not be limited to Tennessee's Child Advocacy Centers (CAC) and Child Protective Investigation Teams (CPIT). Collaboration and communication must be a part of every stage of investigating and addressing child abuse.

Finding – Collaboration and communication within DCS and among external child abuse prevention stakeholders continue to be opportunities for improvement.

Although DCS generally does a good job with internal communication, in several cases reviewed by the SLC, DCS investigations overlapped and the documentation did not indicate DCS employees communicated with each other. In some of those instances however, the documentation did indicate the DCS employees reviewed portions of the investigative records of

the overlapping investigations. In several cases reviewed by the SLC, SLC members thought DCS waited too long to collaborate with juvenile courts and law enforcement. Early and coordinated involvement of appropriate child abuse prevention stakeholders helps with timely permanency for a child in a safe, stable and nurturing environment.

DCS Response – DCS is now using intake readers in the review and assignment process for investigations and assessments. There is minimally one reader, a back-up reader and a specified supervisor in each DCS region. The appropriate staffing of this process ensures continuity, timeliness in assignment and minimizes duplicative casework while creating the opportunity to communicate and collaborate internally within the region and enhancing collaboration across regional lines. Monthly conference calls and additional trainings will occur with the readers to further develop skills and enhance networking.

It is the responsibility of the intake reader to research the Tennessee Family and Children Tracking System (TFACTS) and facilitate discussions between Child Protective Services Assessments (CPSA), Child Protective Services Investigations (CPSI) and Family Social Services (FSS) Team Leaders (TL) to ensure there are not multiple case managers in one home/case unless mandated by policy.

Specific job tasks of an intake reader include the following:

- Review intakes for investigations and assessments,
- Assign intakes from the regional pool to the investigator or assessment worker,
- Review and assign courtesy requests for in-state and out of state requests,
- Review and assign Orders of Reference (if applicable to the region),
- Conduct history search to ensure intake is not open and to assist in case assignment,
- Assign new referrals on closed cases to the same CPSI/CPSA who handled the case previously if possible,
- Review intakes on open FSS cases to determine if a new intake is necessary or if it can be handled by the FSS worker,
- Submit reconsiderations to the Child Abuse Hotline,
- Facilitate discussion with CPSA, CPSI and FSS supervisors when considering a track assignment/change, and
- Maintain assignment data for equity.

Recommendations – Appropriate avenues for working collaboration and communication in investigating and addressing severe child abuse cases in Tennessee currently exist. Tennessee's CACs and CPITs generally embrace the multidisciplinary team approach to investigating and addressing severe child abuse cases. The Statewide CPIT Advisory Board continues to enhance the effectiveness of the multidisciplinary team approach and the director of the SLC is a member of that board. DCS policies currently require Child Protective Services Investigation and Assessment workers to make efforts to collaborate and communicate with appropriate child

abuse prevention stakeholders. All child abuse prevention stakeholders should continually reinforce the importance of collaboration. This may occur through trainings and reviewing and improving policies that enhance or hinder the ability to collaborate and communicate effectively.

In previous years, the SLC has supported efforts to maintain and improve existing family justice centers and the establishment of additional family justice centers in Tennessee. Family justice centers provide an excellent infrastructure for effective collaboration between child abuse prevention and investigation stakeholders. The SLC continues to provide this support.

DCS Response – DCS continues to support the co-location of child abuse prevention stakeholders. Additionally, DCS continues to explore opportunities for its employees to facilitate collaboration and communication through alternative work stations being located in or in close proximity of other child abuse prevention stakeholders' offices.

Collateral Interviewees

Interviewing collateral witnesses provides an opportunity to obtain potentially valuable information to help protect the children from alleged abuse. Collateral witnesses may know information that would help the investigator make an informed decision about the safety of the child. Identifying and interviewing collateral witnesses may also be helpful determining whether an alleged perpetrator should be criminally prosecuted and help with the prosecution in the event the alleged perpetrator is prosecuted.

Finding – Appropriate collateral interviews continues to be an opportunity for improvement.

In one case, the investigation lacked interviews with appropriate collaterals, particularly the fathers. In the Long case, DCS attempted to conduct interviews of collaterals after the family could not be located four months into the investigation. In a subsequent investigation involving the same family, collateral interviews were sought approximately three months after receiving the referral.

Recommendation – Although DCS has shown improvement in this area, DCS should continue to stress the need to interview collateral witness identified in the referral or otherwise identified during the course of the investigation. Additionally, improved collaboration and communication will help ensure all appropriate collateral witnesses are interviewed and interviewed by the appropriate child abuse prevention stakeholder.

Training

Documentation

Proper documentation of all case activity is essential to making informed decisions regarding the safety of a child. It provides an accurate picture of every phase of the investigation. Misspelling

names and using different names to identify the same person make it difficult for people reviewing a case to develop an accurate understanding of the parties and issues involved in a matter. Inaccurate documentation may also lead to the misunderstanding that there are separate incidents of abuse when there is only one incident of abuse. Additionally, valuable time may be spent trying to obtain accurate information when is should be readily available.

Finding – Documentation issues continue to be an opportunity to improve.

The documentation issues including misspelling the name of the perpetrator and child/victim several times, using different names to identify the same person, documentation in the wrong place in the records, and confusing documentation made it difficult obtain all relevant information. Timely entering information into TFACTS continues to be an issue, but it has substantially improved over time.

Likewise, general documentation issues have decreased. During the 2016 review of cases, the SLC noted improper documentation in 75 percent of the cases. During the 2017 review of cases, the SLC noted improper documentation in approximately 50 percent of the cases. The SLC believes DCS employees are receiving the necessary training to address documentation issues.

Recommendation – Continued training, emphasis and monitoring regarding proper documentation are recommended.

Recommendation – When a child is left in the care of a person who has been substantiated for abuse or neglect, added emphasis should be given to ensure all child abuse prevention stakeholders, including DCS, law enforcement and the courts, clearly document which services were provided and how they relate to the safety of the child. In the event of subsequent investigations, this information is necessary to make an informed decision about the safety and best interest of the child.

DCS Response – Documentation training continues to be a focus for case managers and enhanced training and a pilot have been developed to determine if a case summary model enhances the quality of documentation as well as efficiency. The case summary model requires the CPS worker to enter a summary of various investigative tasks in TFACTS at least once every month.

<u>Incident-driven v. Issue-driven Investigations</u>

Generally, incident-driven investigations provide immediate safety for a child but often fail to address all the factors that impact a child's safety and well-being. When investigating and addressing severe child abuse cases, ensuring the safety of the child is the best place to start. Continued safety and well-being is accomplished through issue-driven investigations. Focusing on a particular incident may result in the failure to address underlying issues that could have a negative impact on the safety of the child if appropriate services are not provided.

Finding – Incident-driven v. Issue-driven investigations is an opportunity for continued training and emphasis.

Two of the child abuse death cases presented as incident-driven investigations. In the Andrews case, the child was placed with relatives and was temporarily safe. When the relative placements did not work, the child was returned to the parent. Based on the provided documentation, it appears proper attention was not given to the reasons why the child was placed with the relatives. The child was returned to the parent without addressing the underlying reason for placement with the relatives. It is not clear if the court had the benefit of DCS input when returning the child to the mother because the relatives filed private petitions.

In the Dawson child abuse death case, DCS received several drug exposed infant and child allegations against the mother. The mother was substantiated for exposing her child to drugs. DCS also received a referral alleging the mother physically abused the child. During the investigation of the physical abuse allegations, the juvenile court placed the child with the father. The father had previously been substantiated for physical abuse against the child. Additionally, the mother alleged the father was physically abusive toward the child. However, the father never received services to address physically abusing the child, partially due to him refusing to cooperate with the investigation. While DCS was investigating the mother for physical abuse, the father killed the child. It should also be noted that the juvenile court stated it did not have the benefit of information from DCS in the Dawson case. This is mentioned because it is another example of how the lack of collaboration and communication can impact the safety of a child.

Recommendation – The SLC renews its recommendation for DCS to continue to provide training through the CPS Training Academy and other appropriate avenues for DCS employees to engage in issue-driven investigations as opposed to incident-driven investigations.

DCS Response – The specialization of the drug teams and the trainings offered to enhance skills focus on and encompass the practice of an issue-driven approach. As the issue-driven approach is further incorporated, the overall practice in child protection can benefit.

DCS has also implemented a quality review process that enhances its ability to engage in issue-driven investigations as well as address other findings and recommendations in this report. The quality review process has been instrumental in identifying challenges within case documentation, administrative reviews and timeliness of practice. The creation of Quality Improvement Plans ensures the Office of Child Safety's (OCS) commitment to addressing these concerns and will guide OCS into improved quality in an organized, systematic and memorialized method of investigation and otherwise working cases.

The Quality Review Process for Supervisors focuses on the quality of decision making at the supervisory level with regard to quality documentation, safety and risk outcomes, classification decisions and case closures. This process provides the opportunity to not only review the quality of the frontline case work but also improve upon the supervisors' skills and the ability to make

appropriate and consistent case decisions. The Quality Review Process for Supervisors was recently introduced as a pilot. Upon completion of the pilot, reviewers will provide feedback on the tool and process. Pending the results of the pilot and feedback received, full implementation of the process is scheduled for the first quarter of CY 2018.

In addition to the quality review for investigations process, OCS Investigations has worked to identify critical points within a CPS case that are key times for decisions and actions. To monitor, track and trend these data points, DCS contracted with an external vendor (National Council on Crime and Delinquency/SafeMeasures) in May 2014 which has allowed an automated dashboard reporting system to provide daily updates and information. For CPS, SafeMeasures provides daily compliance data for meeting response times, timely completion of safety and risk assessments, timely approval of initial assessments, case classification and case closures. The SafeMeasures dashboard is available to all CPS staff and allows the frontline workers to see their case activity status at a glance. The web-based tool also allows workers and supervisors to see a monthly calendar of tasks to be completed as well as an automated To-Do list. For example, since the FAST Assessment Submission Timeliness Report was added to the workers' automated To Do List, the Department has seen a steady rate of improvement in the completion of the assessment tool. This is because workers now automatically get a snapshot of work to be completed. SafeMeasures is available to all DCS programs to measure specifically identified compliance measures (as determined by the program) at all levels of the DCS structure. SafeMeasures currently provides reports for CPS, Ongoing Non-Custodial Family Services and the Juvenile Justice programs.

Appropriate Medical Examinations

Appropriate medical examinations for children who are potential sexual abuse victims or exposed to drugs may help mitigate any adverse impact of the abuse. Additionally, the examinations may produce valuable evidence to help keep the child safe and to be used in court.

Finding – Appropriate medical examinations of children are not occurring in all the cases reviewed by the SLC.

In the Hill case, the investigation revealed the child was present during the purchase of drugs, present while adults abused drugs and slept all night in a room with drugs. The child was not screened for exposure to drugs. The SLC acknowledges children often receive the necessary drug screens during child abuse prevention stakeholder investigations. However, the SLC also consistently reviews cases in which children are not screened for drugs when they should have been. Consistently screening children for drugs when they have been drug exposed is necessary to ensure the appropriate services and treatments are provided to the child victim.

In the Ingram case, the child disclosed various forms of sexual abuse and being exposed to bodily fluids. The record did not contain any documentation regarding a medical exam of the child. When a child has been sexually abused, especially when there is a potential exposure to

bodily fluids, the victim must undergo a medical exam. The exam should be used, not only to help determine whether the abuse occurred, but also to mitigate the impact from potential sexually transmitted infections (STI). In most instances, early treatment of an STI can mitigate the adverse impact of it. The SLC acknowledges the absence of physical evidence of abuse, particularly in sex abuse cases, does not mean the abuse did not occur.

Recommendation – Additional training is necessary to ensure medical examinations of victims are being conducted when appropriate.

DCS Response – In collaboration with the Statewide CPIT Advisory Board, medical professionals and other appropriate individuals and organizations, DCS developed a work aid to address this issue. The work aid defines and differentiates between an exam for medical treatment and a forensic medical exam. Among other tasks and activities, the work aid also prescribes when a CPSI must refer a child for a forensic medical exam and when it is recommended that the CPSI consult with their Lead Investigator to determine the need for a forensic medical evaluation. Additionally, the CPS Academy and the Family Support Services (FSS) Training includes sessions on motivational interviewing. This training develops engagement skills which can assist in obtaining parental consent for necessary medical evaluations.

Recommendation – All children who are subject to DCS case management, whether the child is DCS custody or not, need to receive routine medical examinations.

<u>Provision of Services</u>

Finding – The children and their caregivers do not always receive the necessary services and training to provide a safe, stable and nurturing environment for the abused/neglected child.

In the Gordon case, during an investigation in which the mother was substantiated for abuse, DCS received another referral alleging Drug Exposed Child against the mother and father. The parents admitted obtaining hydrocodone from a friend, allegedly for back issues. The subsequent investigation was unsubstantiated and services were not placed in the home to address the previous substantiation of the drug exposed child allegations against the mother. As stated earlier in this report, the Gordon child eventually came into custody. DCS used a hair follicle test to drug screen the child. The child tested positive for oxycodone and hydrocodone.

In the Brown case, the provided documentation did not include proof of services for the abused child other than medical services. The child should have participated in services to assess whether the child needed mental health services.

Recommendation – Additional training is needed to ensure all individuals, including parents, are receiving the necessary services and training to provide a safe, stable and nurturing environment for the abused/neglected child.

DCS Response – DCS has implemented the Nurturing Parenting Program, an evidence-based service delivery program, in pilot areas. This program is being delivered directly by DCS and private provider staff to create a safe and nurturing home environment through parental skill development and risk mitigation.

Classification of Investigations

There appear to be inconsistencies regarding classification of investigations. Different counties investigate related sets of facts or overlapping investigations and the investigations are classified differently. The occurrences of this are limited to this year's review of cases. The SLC will continue to monitor this issue to determine whether these are isolated incidents or systemic intervention is recommended. Additionally, the SLC continues to review cases with similar fact scenarios being classified differently.

Finding – Investigations with seemingly similar facts are being classified differently.

Despite a history of drug abuse and the perpetrators continually testing positive for THC, the Evans matter was Unsubstantiated because the parents stated they did not use drugs in front of the child.

In the Miller matter, an investigation was classified as Unsubstantiated, in part, because the alleged perpetrator refused to meet with DCS in person and denied abusing drugs. However, a young child was able to describe marijuana and how her father uses it.

Recommendation - Additional training is needed to ensure appropriate and consistent classifications.

See the DCS response regarding its quality review process under the Incident-driven v. Issue-driven Investigations section of this report. The quality review process has the potential and expected outcome of enhancing DCS's ability to make more consistent decisions to include classification decisions.

SLC members questioned whether too much discretion is a major factor in the inconsistent classification decisions. The DCS quality review process is not designed to limit discretion, but to add more consistency at points where discretion is necessary.

DCS Response – DCS developed and implemented a training entitled, Burden of Proof, which outlines to CPS staff the evidence necessary to determine whether child abuse and/or neglect has occurred.

Contact with Registered Sex Offenders

Finding – An alleged perpetrator's sex offender's probation officer was not contacted during the course of investigating a child sex abuse case.

In the King matter, a registered sex offender was residing in a home or on the same property with children who were not his biological children. As mentioned before in this report, the caregivers admitted to allowing unsupervised contact between the sex offender and the child. The child had unsupervised contact with the sex offender again. Contacting the sex offender's probation officer may have been a better strategy to provide a safe environment for the child.

Recommendation – DCS employees should contact sex offender probation officers of alleged perpetrators when applicable.

Consideration of Case Histories

Finding – Provided documentation indicates case histories are may not be thoroughly reviewed or may not be given the proper weight in determining child safety.

As mentioned earlier in the Evans case, the mother had a significant history of drug abuse and intermittently treated mental health issues. After several failed attempts to obtain compliance with services, DCS obtained compliance with services by filing a petition with the court. Shortly thereafter, the mother was arrested and charged with simple possession. The children were placed in state custody. Hair follicle drug screens were obtained for the children in this matter. One child tested positive for benzoylecgonine and THC. The other child tested positive for THC. Despite this history and ongoing issues, a parent retained custody of her children longer than SLC members thought was appropriate.

Recommendation – Case histories must be thoroughly reviewed and given the appropriate consideration.

See the DCS response regarding its quality review process under the Incident-driven v. Issue-driven Investigations section of this report. CPS staff also has access to a history screen through SafeMeasures, which provides a historical glance of the case participants and outlines their past interactions with the department. It also provides the ability to retrieve a case record for the cases referenced in the history screen.

Engaging Fathers

Despite statements made by a mother or other individuals regarding the level of interest and involvement of fathers, DCS, law enforcement, judges and other child abuse prevention stakeholders must facilitate and make efforts to locate and engage fathers in child abuse cases. Notwithstanding legal obligations to do so, efforts to engage the father should be made because

representations of the father's level of interest may be intentionally inaccurate. Moreover, placement with the father may provide a safe alternative to state custody.

Finding – Fathers are not consistently engaged during investigations.

In the Fox case, the mother stated the father lived in the same county as the child, but he was not involved in the child's life. Nothing in the provided documentation indicates efforts were made to locate and engage the father. In the Hill case, the provided documentation did not even mention an inquiry regarding the whereabouts of the father. In the Neal case, the mother told DCS the names of two of the children's fathers. Nothing in the documentation indicates they were contacted.

Recommendation – All child abuse prevention stakeholders, including DCS, law enforcement and juvenile court, must continually emphasize the necessity of locating and engaging fathers when reasonably possible. DCS should conduct diligent searches for fathers when they cannot be immediately located. Juvenile courts should consider when the father must be a party to an action and ensure they receive notice of hearings as required by law.

Duty to Report Child Abuse

Finding – Professionals are not reporting child abuse in a timely manner.

In the Evans case, a doctor ultimately provided a letter to DCS regarding concerns of abuse and/or neglect. However, the child was returned to the parent before the doctor provided the information to DCS. If a second or subsequent allegation of child abuse had not been called in, DCS may have never learned of the doctor's concerns.

In the Neal case, DCS received a referral for drug exposed infant approximately two weeks after the infant was discharged from the hospital to the mother. The child had signs of withdrawal and was treated with morphine. After approximately four months of trying to locate the mother and child, DCS made contact with the family. DCS should have received a referral long before the child was released from the hospital.

Recommendation – Professionals need to be reminded of the statutory duty to report suspected child abuse.

DCS Response – As DCS implements CARA, mandatory training for health care providers and community partners has been enhanced. The training is located on the DCS and Children's Justice Task Force websites. Here is the link to the training video: https://www.sworps.tennessee.edu/child_abuse_reporting/player.html.

A joint letter was issued by the Commissioner of DCS and the Tennessee Department of Health to all hospitals across the state with further follow up and outreach provided by the DCS hospital liaison.

Additional Concern - During the course of discussing mandatory child abuse reporting, members of the SLC expressed concerns about professionals failing to report abuse and conducting their own investigation. This fact scenario was not present in cases reviewed by the SLC during 2017. However, members of the SLC have seen cases in which this has happened. It is important for all people in Tennessee to report suspected child abuse to the appropriate person or agency as mandated by law and allow the person or agency with a statutory obligation to conduct an investigation investigate the matter. When parties who are not statutorily authorized to conduct a child abuse investigation do so, their actions may jeopardize the safety of the child and hinder potential prosecution.

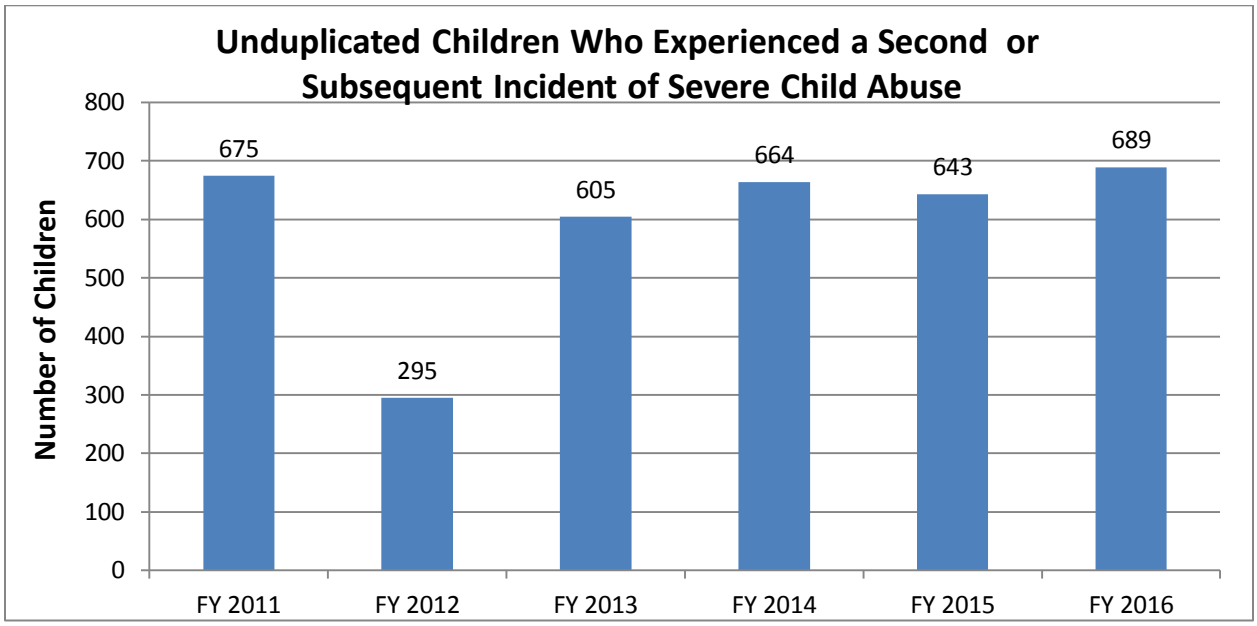
Family Planning Concern

In several of the cases reviewed by the SLC during 2017 and previous years, many of the parents continue to have repeated unintended pregnancies in the midst of their addiction and mental health battles. The SLC is concerned about whether these parents are presented with information regarding family planning and long acting reversible contraceptives at the same rate as other parents.

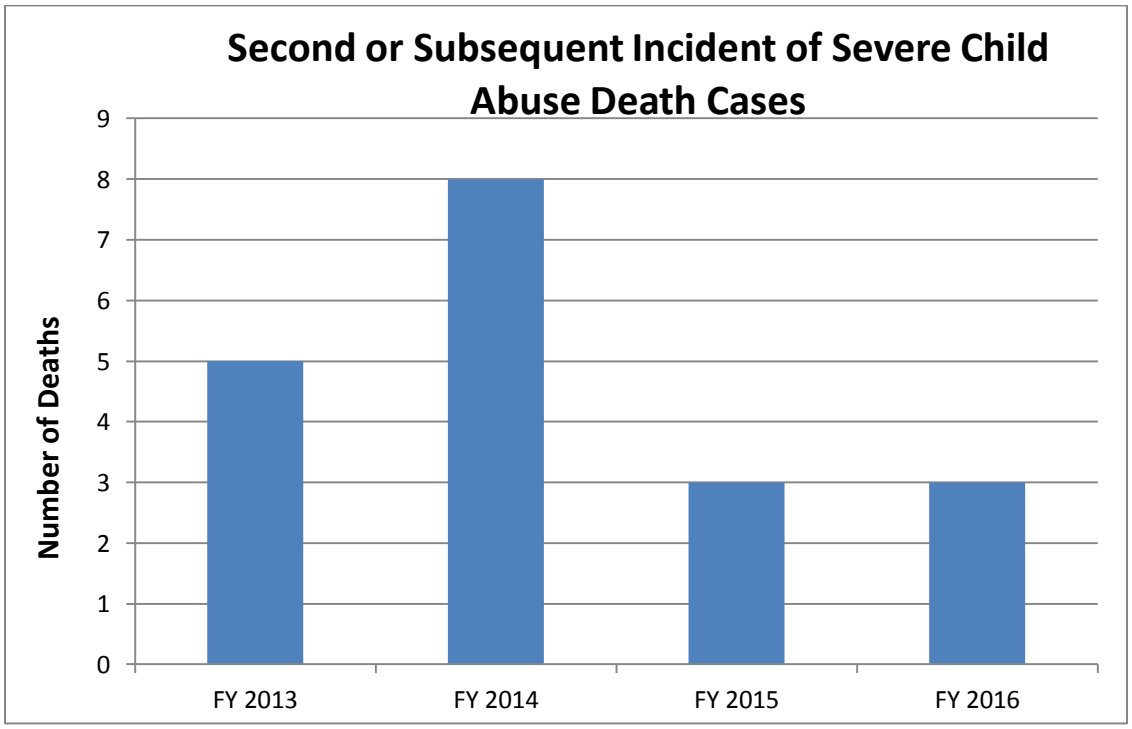
Recommendation – Hospital staff should ensure all parents, the mother and the non-birthing parent, are presented information regarding family planning and long acting reversible contraceptives.

Repeat Child Abuse Data

The reported number of children who experienced a second or subsequent incident of severe child abuse for FY 2016 is 689.

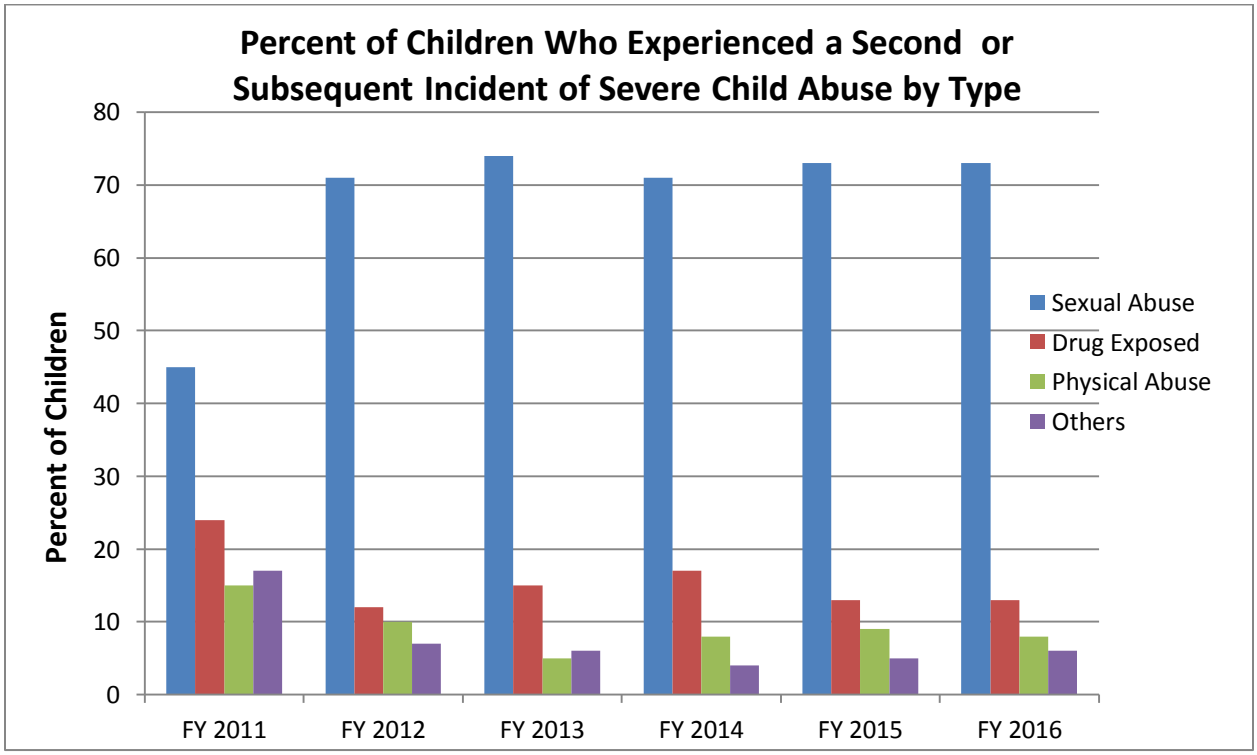


The number of second or subsequent incident of severe child abuse death cases for FY 2016 is 3.



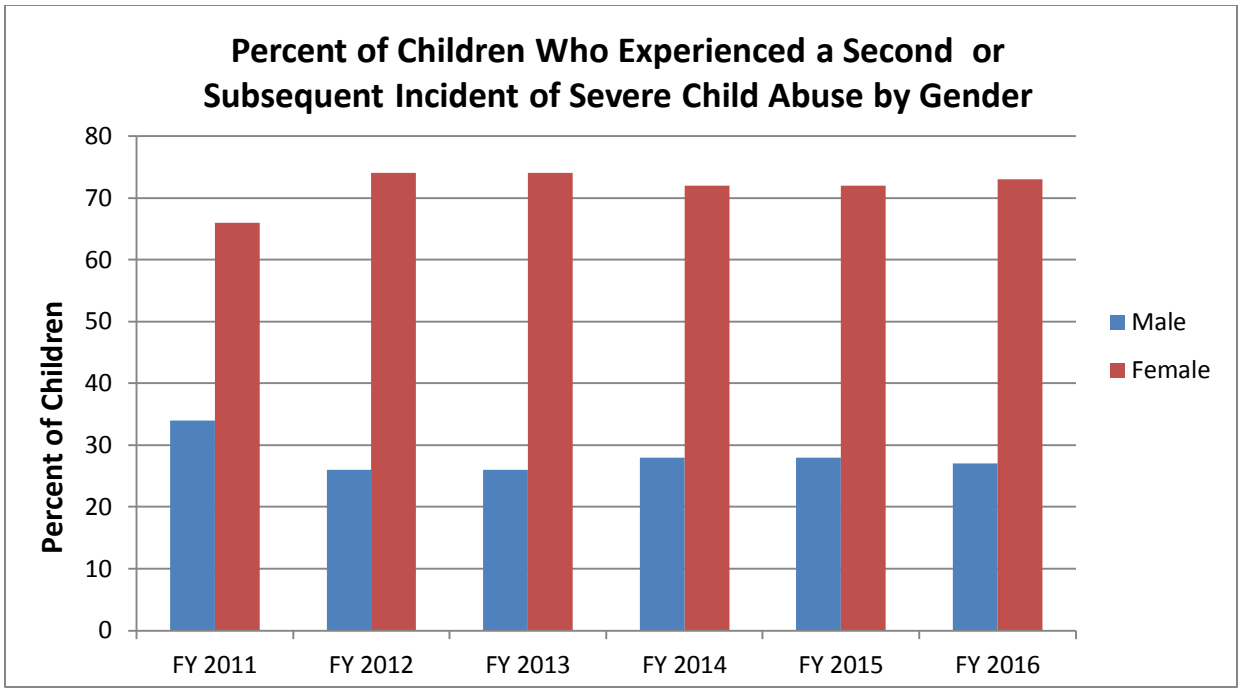
The types of maltreatment for FY 2016 are as follows:

- Abandonment: less than 1 percent;
- Abuse Death: less than 1 percent;
- Drug Exposed Infant: less than 1 percent;
- Drug Exposed Child: 12 percent;
- Lack of Supervision: 4 percent;
- Medical Maltreatment: less than 1 percent;
- Neglect Death: less than 1 percent;
- Physical Abuse: 8 percent;
- Psychological Harm: less than 1 percent;
- Sexual Abuse: 73 percent.



The gender composition of the victims of the total population of cases for FY 2016 is as follows:

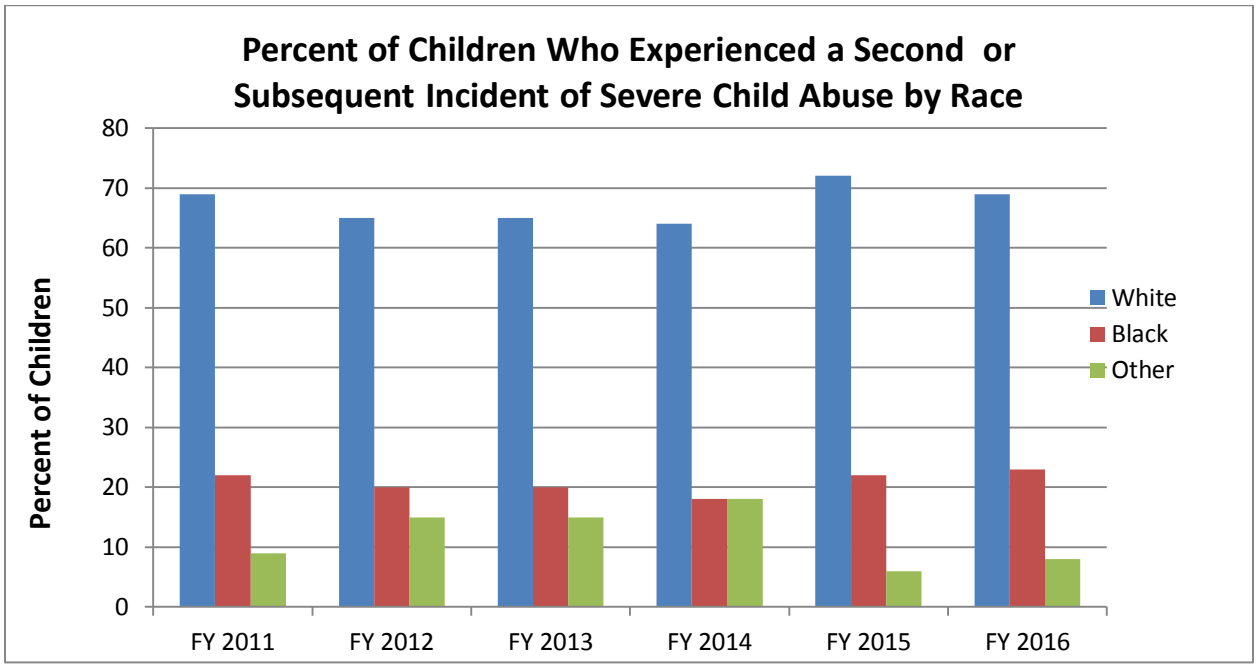
- Female: 73 percent;
- Male: 27 percent.



For fiscal years 2011 through 2016, male children were approximately 28 percent and female children were approximately 72 percent of the total population of the children who experienced a second or subsequent incident of severe child abuse in Tennessee based on data provided by DCS. However, for the calendar years 2011 through 2016, male children were approximately 51 percent and female children were approximately 49 percent of the total population of children in Tennessee. Based on the total population of children, female children are disproportionately represented among children who have experienced a second or subsequent incident of severe child abuse.

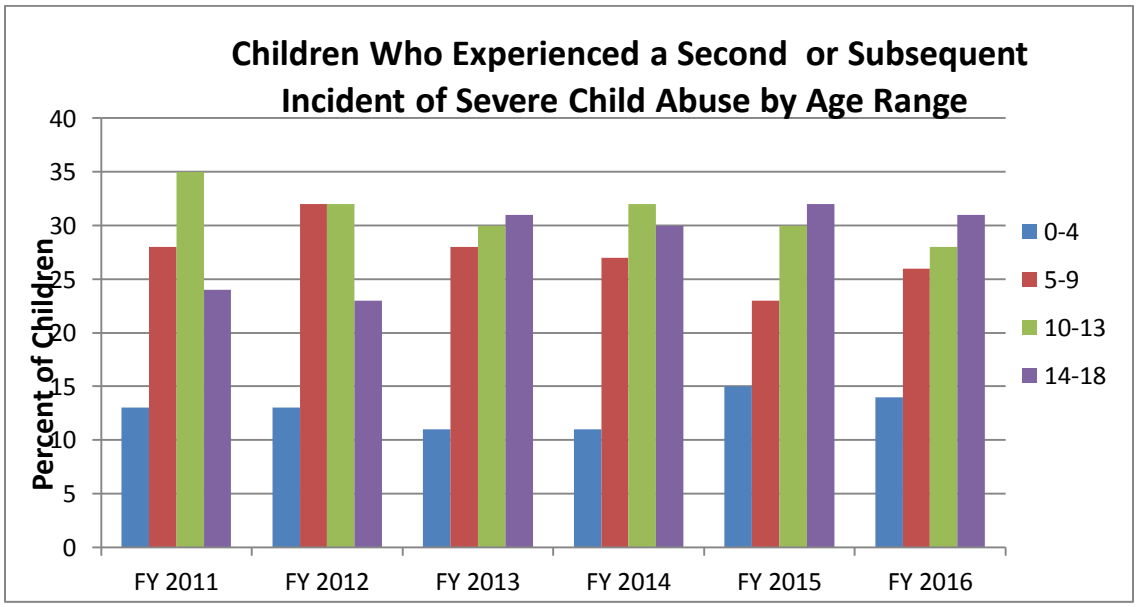
The racial composition of the victims of the total population of cases for FY 2016 is as follows:

- White: 69 percent;
- Black: 23 percent;
- Multiple/Unable to determine: 8 percent.

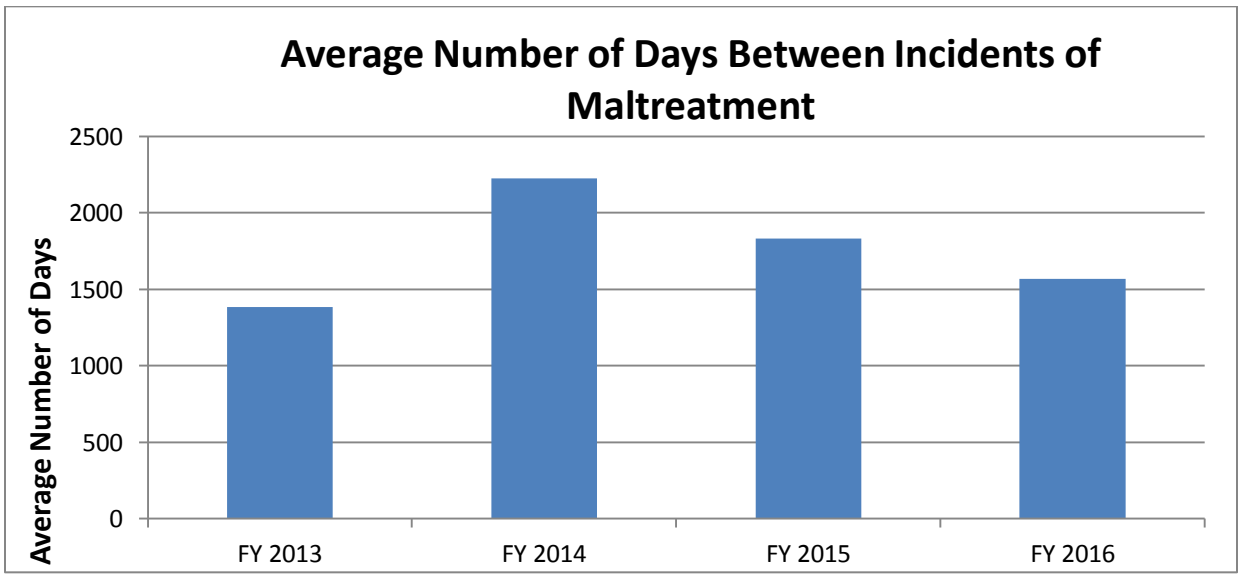


The age range composition of the children at the time of the incidents of abuse for FY 2016 is as follows:

- 0-4 years old: 14 percent;
- 5-9 years old: 26 percent;
- 10-13 years old: 28 percent;
- 14-17 years old: 31 percent.



The average number of days between incidents of maltreatment for FY 2016 is 1,568.



Number of individual children who experienced a second or subsequent incident of severe child abuse for fiscal year 2015-2016 reported in each county by judicial districts:

1st Judicial District

Carter	2
Johnson	0
Unicoi	2
Washington	10

2nd Judicial District

Sullivan	19

3rd Judicial District

Greene	8
Hamblen	9
Hancock	1
Hawkins	6

4th Judicial District

Cocke	10
Grainger	0
Jefferson	11
Sevier	6

5th Judicial District

Blount	13

6th Judicial District

Knox	39

7th Judicial District

Andrews	14

8th Judicial District

Campbell	6
Claiborne	2
Fentress	0
Scott	2
Union	6

9th Judicial District

Loudon	10
Meigs	2
Morgan	4
Roane	6

10th Judicial District

Bradley	7
McMinn	6
Monroe	5
Polk	2

11th Judicial District

Hamilton	23

12th Judicial District

Bledsoe	2
Franklin	10
Grundy	0
Marion	3
Rhea	8
Sequatchie	1

13th Judicial District

Clay	3
Cumberland	1
DeKalb	6
Overton	8
Pickett	0
Putnam	12
White	3

14th Judicial District

Coffee	12

15th Judicial District

Jackson	1
Macon	4
Smith	4
Trousdale	7
Wilson	12

16th Judicial District

Cannon	2
Rutherford	19

17th Judicial District

Bedford	13
Lincoln	10
Marshall	4
Moore	0

18th Judicial District

Sumner	10

19th Judicial District

Montgomery	17
Robertson	4

20th Judicial District

Davidson	52

21st Judicial District

Hickman	3
Lewis	5
Perry	0
Williamson	11

22nd Judicial District

Giles	5
Lawrence	8
Maury	9
Wayne	2

23rd Judicial District

Cheatham	3
Dickson	6
Houston	0
Humphreys	1
Stewart	5

24th Judicial District

Benton	8
Carroll	4
Decatur	1
Hardin	0
Henry	10

25th Judicial District

Fayette	0
Hardeman	1
Lauderdale	5
McNairy	1
Tipton	4

26th Judicial District

Chester	4
Henderson	3
Madison	7

27th Judicial District

Obion	5
Weakley	0

28th Judicial District

Crockett	1
Gibson	11
Haywood	0

29th Judicial District

Dyer	3
Lake	2

30th Judicial District

Shelby	92

31st Judicial District

Van Buren	0
Warren	10

Statute Summary

The Tennessee Second Look Commission is charged with reviewing an appropriate sampling of cases involving a second or subsequent incident of severe child abuse in order to provide recommendations and findings to the General Assembly regarding whether or not severe child abuse cases are handled in a manner that provides adequate protection to the children of this state. The Commission's findings and recommendations shall address all stages of investigating and attempting to remedy severe child abuse.

The Department of Children's Services (DCS) has the statutory obligation to submit to the Commission a table of cases meeting the criteria of the cases set forth in TCA §37-3-803 (severe child abuse). The Commission shall review the table of profiled cases submitted by DCS and submit a list of the cases to DCS after such review, setting out specific cases from the table that the Commission selects to review.

Notwithstanding any provision of law to the contrary, the Commission may access confidential information. Investigatory meetings of the Commission shall not be subject to the open meetings requirement and shall be closed to the public. Any minutes or other confidential information generated during an investigatory meeting shall be sealed from public inspection.

The Commission is administratively attached to the Tennessee Commission on Children and Youth (TCCY), but for all purposes other than administration, is an independent commission. Among other things, TCCY is responsible for providing the Commission members with any relevant information and assisting the Commission in the preparation of reports.

Conclusion

The Tennessee General Assembly should be commended for its proactive stance regarding protecting the children of Tennessee. The General Assembly extended the SLC through June 30, 2021. The SLC continues to work with DCS and other stakeholders to provide and help implement findings and recommendations with the goal of Tennessee improving how it handles severe child abuse cases.

SLC members have consistently demonstrated the ability, willingness and desire to fulfill the SLC's statutory obligations. Even more than simply fulfilling its statutory obligations, the SLC consistently has gone above and beyond its statutory obligations to function with excellence. In addition to meeting more often than required by statute, SLC members read and review investigatory summaries before coming to the investigatory meetings. The investigatory summaries during 2017 averaged approximately 44 pages. The summary page numbers range from a low of 17 to a high of 106. SLC members work hard to comprehensively understand the issues identified in the cases to improve how Tennessee handles severe child abuse cases.

Tennessee is a national leader in the country music industry. Tennessee was the first state in the nation to make community college free for graduating high school seniors. Tennessee then became the first state in the nation to offer free community college to all adults without an advanced degree. Through the Tennessee ACEs Initiative and other collaborative efforts, Tennessee has emerged as a national model for how a state can promote culture change in early childhood based on a philosophy that preventing and mitigating adverse childhood experiences, and their impact, is the most promising approach to helping children lead productive, healthy lives and ensure the future prosperity of the state. In 2000, Children's Right, Inc. filed a petition, the Brian A. law suit, against then-Tennessee Governor Donald Sundquist and then-Commissioner George Hattaway of the Tennessee Department of Children's Services in their official capacities. After years of hard work, marshalling resources, collaboration and improving practices and infrastructure, Tennessee transformed an inadequate and troubled child welfare system into a system that is considered by to be a national model in many areas. In 2017, a federal court ordered that the agency can exit federal court oversight from more than 140 improvement requirements in the Brian A. law suit.

Unique issues in cases reviewed are becoming less frequent, however the incidents of a second or subsequent incident of severe child abuse have remained relatively constant. Excluding one finding, all of the findings in the 2017 SLC Report have been included in previous reports or identified in cases reviewed in previous years. The SLC is focusing on increasingly difficult issues to address. A lot of hard work, ingenuity, resources and collaborative efforts will be required to significantly reduce these recurring issues and better provide safe, stable nurturing environments for children in Tennessee. The SLC is confident child abuse prevention stakeholders across Tennessee are up for the task. Tennessee has a history of ingenuity, leadership and conquering tough tasks. By working together to address the findings and recommendations in the 2017 SLC Report, Tennessee can improve how Tennessee handles severe child abuse cases.

STATE OF TENNESSEE
SECOND LOOK COMMISSION
Andrew Jackson Building, Ninth Floor
502 Deaderick Street
Nashville, Tennessee 37243-0800
(615) 741-2633 (FAX) 741-5956
1-800-264-0904

MEMBERSHIP
December 21, 2017

Representative Mark White, Co-Chair
TN General Assembly

Carla Aaron, Executive Director
TN Dept of Children's Services
Office of Child Safety

Charme Allen
District Attorney General, 6th District
TN District Attorneys General Conference

Representative John J. DeBerry
TN General Assembly

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

David Doyle, Esq.
District Public Defender, 18th Judicial District
District Public Defenders Conference

Senator Dolores R. Gresham
TN General Assembly

Trudy Hughes, Director of Regional Advancement
East Tennessee Foundation

Karen Jointer, Executive Director
Tennessee Chapter of Children's Advocacy Centers

Debra Quarles Mills, M.D.
East Tennessee State University
James H. Quillen College of Medicine
Department of Pediatrics

Linda O'Neal, Executive Director
Tennessee Commission on Children and Youth

Valerie Schabilion, Youth Services Officer
Wayne County Juvenile Court

John Simmons, Special Agent in Charge
Tennessee Bureau of Investigation

Deborah Taylor Tate, Executive Director
Administrative Office of the Courts

Patty Tipton, Investigator
Knoxville Police Department

Cynthia Wyrick
Private Attorney