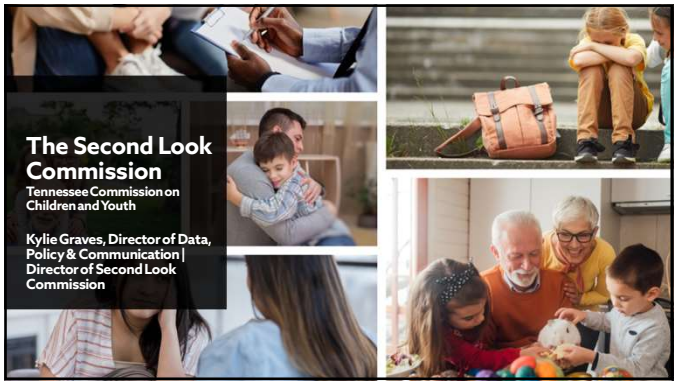

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About TCCY

Advocating for data-driven decisions to improve the lives of children and youth in Tennessee.

The Tennessee Commission on Children and Youth (TCCY) is an independent, nonpartisan agency created to ensure the state's policies and programs effectively promote and protect the health, well-being and development of children and youth.

Established by the Tennessee General Assembly as a permanent commission, TCCY is the state's centralized informational resource and advocacy agency for timely, fact-based information to aid policymaking and coordination of resources.

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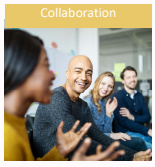
WHAT TCCY DOES

Data and Insights	Collaboration	Policy Advocacy	Public Awareness
			
Monitors various child and youth indicators to identify trends and areas of concern; keeps up with best practices for addressing issues affecting children and youth.	Convenes various agencies and organizations in leading efforts to improve services for children and youth.	Reviews data and outcomes of various policies related to children and youth to provide evidence-based suggestions for improvement.	Promotes public awareness about children's issues and advocates for community engagement in addressing these concerns.

3

3

WHAT TCCY DOES

Child Welfare & Youth Justice	Statewide Partnerships & Regional Councils	Data, Policy & Communication
Council on Youth Justice	Council on Children's Mental Health	Budget Recommendations
Implement Juvenile Justice Act Provisions	Home Visiting Leadership Alliance	County Profiles in Child Well-Being
Ombudsman Program	Resilient Tennessee Collaborative	FUTURE Data Dashboard
Second Look Commission	Regional Councils	Resource Mapping
	TN Young Child Wellness Council	State of the Child
	Youth Transitions Advisory Council	

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About the Second Look Commission

Membership

FY2023 Cases

Findings & Recommendations

5

What is the role of the Second Look Commission?

TCA 37-3-803 (a)

The commission shall review an appropriate sampling of cases involving a second or subsequent incident of severe child abuse in order to provide recommendations and findings to the general assembly regarding whether or not severe child abuse cases are handled in a manner that provides adequate protection to the children of this state.

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Membership of Second Look Commission

The Second Look Commission is a multi-disciplinary team comprised of representation from:

- Tennessee Bureau of Investigation
- Tennessee Commission on Children and Youth
- Tennessee Child Advocacy Centers
- Department of Children's Services
- Administrative Office of the Courts
- Tennessee General Assembly
- Law enforcement with experience investigating severe child abuse cases:
- District Public Defenders Conference
- District Attorneys General Conference
- Child Abuse Pediatrician
- Private Attorney
- Non-profit Advocates - Currently CASA and TN Voices

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What is the role of the Second Look Commission?

The commission's findings and recommendations shall address all stages of investigating and attempting to remedy severe child abuse, including but not limited to:

- The reporting, investigating and referring of alleged severe child abuse cases by state agencies and others;
- The risk of severe child abuse victims being returned to the custody of the child's abuser or placed by the state in an environment where the child is at risk of being abused a second or subsequent time;
- The procedures used by juvenile courts and courts exercising jurisdiction over criminal and civil child abuse, neglect and endangerment cases;
- The laws, rules, or guidelines used to determine whether or not an alleged perpetrator of severe child abuse is to be prosecuted;
- The causes of severe child abuse in Tennessee and any preventative measures that would reduce the number of severe child abuse cases in this state;
- The manner in which severe child abuse data is collected and used by multiple agencies within the state; and
- The representation provided to severe child abuse victims, including but not limited to, representation provided by attorneys, guardians and advocates

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Case Selection Process

SLC Case Criteria

- Substantiated instance of Severe Abuse in previous fiscal year.
- Prior substantiation
- List of all cases that meet this criteria is provided by DCS.

SLC Selection of Cases to Review

- All abuse death cases, has historically been between 2 to 8 cases per year.
- From the full list, SLC will filter for instances in which the first substantiation happened within 3 years.
- Sometimes members will request to focus a meeting on a certain type of case or pattern.
- If we do not have a specific focus, then a stratified random sample is pulled.
- We review between 3 to 4 cases each meeting.

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Once a case is selected

- We will review the child's entire history.
  - Including cases occurring prior to three years ago and unsubstantiated cases.
- We will pull all the available documentation in TFCATS
  - Case recordings, hotline calls, hotline screen outs, permanency plans.
- After reviewing TFACTS documentation, we develop a list of alleged/potential perpetrators
- From that list, we send out records requests to juvenile court, criminal court, police & sheriffs departments.
- All of this information is then compiled into chronological order for members to review before the scheduled meeting.
- At the meeting, a brief synopsis of the case is provided and then it is opened up for members to provide thoughts on ways the case was handled well, things that could be improved, note when policy is not followed and ask questions.
- From there, we compile a list of preliminary findings and recommendations.

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2024 Second Look Commission Annual Report

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FY 2023 Case Data

623
Unduplicated victims of second or subsequent severe abuse

4%
increase in cases from FY2022.

40%
of combined cases were Drug Exposed Infant/Child

12

Currently Reviewing – FY2024

720
Unduplicated victims of second or subsequent severe abuse

15.5%
increase in victims from FY2023.

43%
of combined cases were Drug Exposed Infant/Child

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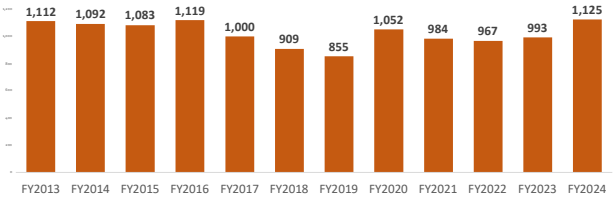
Individual Substantiated Allegations



Example: If in one DCS investigation it was found that a child was sexually abused by their step-father and exposed to substances by the mother, grandmother and step-father that would be 4 individual substantiated allegations.

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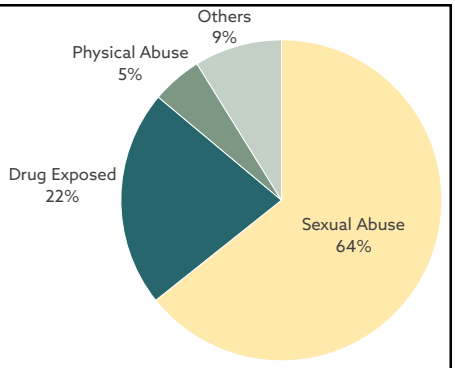
TYPES OF MALTREATMENT

For FY 2023 (second instance only)



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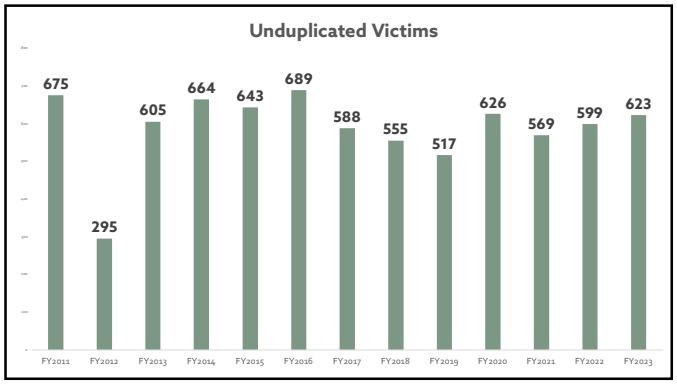

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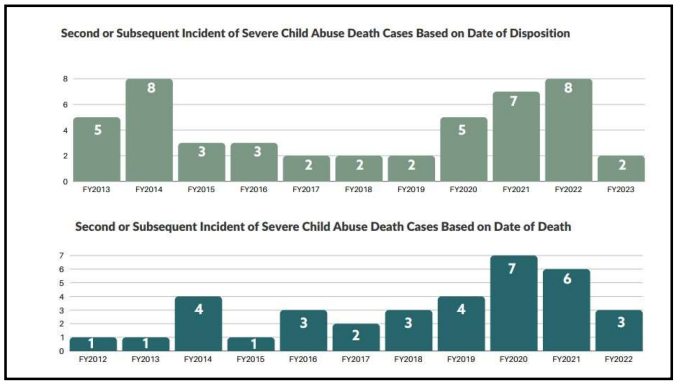

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Key Findings

Observed Strengths

- When members focused on instances of substance-exposed children, they were encouraged by the response and support provided to parents who were having challenges with substance use.
- Members frequently referenced the success seen in Safe Baby Courts and the need to implement the practices and philosophy of Safe Baby Courts in cases with older youth.
- In several cases, members noted the engagement and positive impact that the caseworker had on a child.
- Members noted the specialized teams created by DCS appear to be working well for complex or special populations.
- Due to the many stakeholders involved in child abuse cases, members were encouraged by instances when all parties involved in the case collaborated effectively.

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Key Findings

Foster Homes/Placements

- Members found opportunities for additional support for families caring for children, particularly relative or kin caregivers.
- Members expressed concerns regarding the safety, supervision, and care provided to children in placements.

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Recommendations

Foster Homes/Placements

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

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

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

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Key Findings

Services

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

Recommendations

Foster Homes/Placements

- Access to a variety of mental health services including outpatient, residential and varying needs of acuity continue to be a need for children across the state. The state should continue to prioritize funding mental health services and initiatives to expand the mental health workforce in Tennessee. The state should take into consideration local resources, needs and funding streams. Members discussed building off existing services such as Tennessee Child and Adolescent Psychiatry Education and Support which supports the integration of mental health care into pediatric primary care.
- The state should evaluate existing mental health providers who provide services to children and accept TennCare. They should assess the acuity of care provided, modality in which it is provided and their ability to provide appropriate services to children who have experienced severe abuse. This evaluation can assist in determining any coverage gaps or need for additional providers and investment.

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Key Findings

Transition Homes

- Members noted challenges with documentation of children's placement and time at transition homes.
- Members were concerned regarding the safety and supervision of children in transition homes.

Recommendations

Foster Homes/Placements

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

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Recommendations

Foster Homes/Placements

- The Department should ensure that the placement of children in transition homes is appropriately tracked, and those records are retained. DCS should ensure the protocols in place for reporting placement changes are being consistently followed and the location of the child is easily accessible to those working with the child in TFACTS.
- Due to the complex backgrounds, situations, and behaviors many children in transition home are facing, it is critical that those working with children in these settings have all of the appropriate information. The Department should ensure the Child Daily Log for Transition Homes is being completed for every child, every day and that those records are being retained appropriately.
- Many transition homes rely on a variety of individuals including volunteers and third-party providers. Due to the trauma and vulnerability already experienced by many youths in transition homes, the Department should ensure that all adults in transition homes with children have background checks as outlined in Protocol for Delegated Authority (DA) Sitter Services Vetting.

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Key Findings

Missed Opportunities for Earlier Intervention

- Members continued to notice a pattern of multiple prior allegations of sexual abuse resulting in later sexual behaviors exhibited by the child.
- In several cases, members felt earlier, and appropriate intervention could have changed outcomes.
- In particularly complex cases, members felt there was a missed opportunity for the Department to use additional available resources.
- In certain cases, members felt efforts to continue to involve biological parents were preventing permanency.
- Members continue to find instances in which engaging the fathers can provide permanency for a child.
- Members noted that engaging multi-disciplinary collaboration can help lead to better responses and services for children.

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Recommendations

Missed Opportunities for Earlier Intervention

- There is a need for additional services as well as clearer understanding of who is currently providing services for youth with sexual behaviors across the state. The Department of Children's Services & Department of Mental Health and Substance Abuse Services should work together to establish a database contains information of providers who offer services for youth with sexual behaviors.
- Currently, when a child is receiving services that are not being billed through DCS, such as those provided by the Child Advocacy Centers, that information is not easily or quickly accessible in TFACTS. It often requires looking though case documentation or permanency plans. As the Department implements a new case management software, they should consider implementing a feature that would allow for quick access to all services a child is receiving, both those billed to the department and not.
- The Second Look Commission should review data from the Department of Children's Services regarding permanency and family member IPAs in 2025.

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Recommendations

Missed Opportunities for Earlier Intervention

- The Department should establish a policy that once a case has a certain number of referrals or overlapping investigations, a multi-disciplinary team meeting shall occur. During that meeting, it should be determined if a third-party review such as the Centers of Excellence should be brought in for assistance.
- The Second Look Commission should review DCS guidelines regarding custody decisions and continue to encourage familial placements, including paternal contacts.

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Key Findings

Courts/Legal

- Members discussed additional opportunities for communication and follow-up regarding criminal charges.
- Members expressed concerns regarding processes and procedures related to custody and Child Protective Investigative Teams.
- Members found need for additional support and increased access to legal processes.
- Members found opportunities for increased documentation.
- Members noted several scenarios in which the child appeared to be at risk of further victimization

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Recommendations

Courts/Legal

- The SLC recommends offering additional training to courts on the newly developed Pro Se D&N Petition filing forms to ensure that everyone is aware of their existence. Additionally, training around the requirement to accept Pro Se filings should be provided to all court staff.
- Members noted that TCA 37-1-607(a)(5) requires "within fifteen (15) days of the completion of the district attorney general's investigation, the district attorney general shall advise the department and the team whether or not prosecution is justified and appropriate in the district attorney general's opinion in view of the circumstances of the specific case." However, there is opportunity for this to be more consistently and regularly followed. The District Attorney's General conference should work together with local District Attorneys to capture data on decisions of whether to move forward with prosecution following a recommendation from CPIT.
- Members recommend funding a study, either through existing grant funds or General Assembly appropriations, to examine the effect of the recently passed Protecting Children from Social Media Act (Public Chapter 899) on social media concerns specific to foster care children, runaway youth, and human trafficking.

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Key Findings

Medical

- Members noted that the delay in getting an autopsy impacted the investigation and prosecution of the case.
  - Note that there has been an improvement in autopsy delays after legislation that was passed last year.
- Members noted it was odd to include the term "reasonable degree of medical certainty" in a DCS report as that is typically a legal term.
- Members noted that although secondary brain bleeds can occur after a minor injury, they are not often fatal.
- Members stated that due to the lack of information available, it was difficult to determine if the injury was accidental or inflicted.

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Recommendations

Medical

- Members recognize the importance of multi-disciplinary conversations to reach the appropriate CPIT determination.
- Members recommend more consistent participation in CPIT meetings by law enforcement partners. TCA 37-1-607(a)(2) states "Each team may also include a representative from one (1) of the mental health disciplines and one (1) appropriately credentialed medical provider, as needed." SLC members recommend encouraging CPIT members to obtain direct information from medical providers evaluating the child including medical examiners for accurate interpretation of the information in team decisions.

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Key Findings

Department of Children's Services

- Members noted the following items as opportunities at the Department of Children's Services.
  - Members noted that DCS' absconder unit recorded repeated visits to the mall looking for a child. Members questioned how effective this is.
  - Members noted that caseworker changes occurring at DCS resulted in the TFACTs entries and timeline of the case recordings being incorrect.
  - Members noted a need for more support for DCS caseworkers.
- Members noted opportunities for increased consistency and thoroughness of hotline responses.

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Recommendations

Department of Children's Services

- The Department should change existing policy to require the referent be contacted for additional information on hotline referrals that are screened out to be added to an open case.
- The case management system that is replacing TFACTs should be developed with the ability to include the current case manager's name and other relevant information for the referent when a hotline referral is screened out to be added to an open case.

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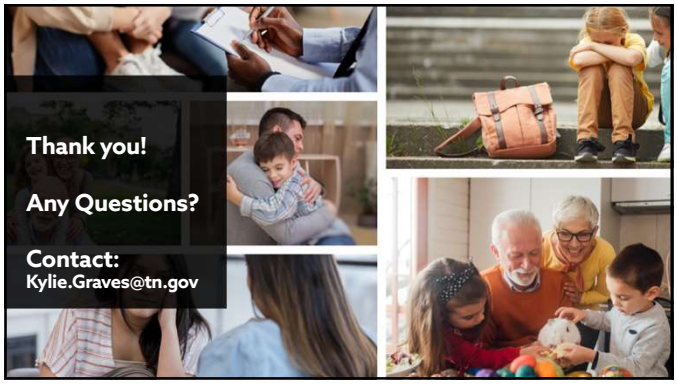

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