Tennessee State Government

Tennessee Commission on Children & Youth

Second Look Commission

2022 Annual Report

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Purpose

Tennessee's continued prosperity requires that we support healthy child development. The link between adverse childhood experiences (ACEs), and a broad range of negative outcomes is well documented. Data accumulated over the past two decades provides strong evidence that toxic stress and early childhood adversities can derail optimal health and development (CDC, 2019; Merrick et al., 2019). Moreover, the resulting financial toll is estimated to cost hundreds of billions of dollars every year (CDC, 2019). These adversities often build upon one another producing a cascade of issues which ultimately place the next generation at risk (CDC, 2019). With thoughtful reflection and strategic planning, it is possible to break this devastating cycle of trauma and provide the necessary supports to families across the state. Each child in Tennessee deserves to live in a safe, stable, supportive, and nurturing environment.

Research shows healing from ACEs and toxic stress occurs in the presence of safe, stable, and nurturing relationships (SSNRs) (Garner & Yogman, 2021). SSNRs buffer adversity and help build resilience. Through thoughtful interventions aimed at fostering SSNRs, Tennessee children can live healthier and more productive lives. Utilizing a public health approach, as recommended by a multitude of reputable organizations such as the Centers for Disease Control (CDC) and the American Academy of Pediatrics (AAP), resources should be employed for prevention, mitigation, and intervention. For maximal impact, universal prevention remains a key objective, but more intensive efforts are necessary for individuals known to be at a higher risk of ACEs (Garner & Yogman, 2021). Furthermore, effective implementation will require coordination across public service sectors, including health care, behavioral health, education, social services, justice, and faith communities (Garner & Yogman, 2021).

Research has identified factors that protect or buffer children from experiencing abuse and neglect, commonly referred to as protective factors. Consistently, supportive social networks, community environments, and family support emerge as protective factors (Fortson et al., 2106). Although no one factor can fully explain why abuse or neglect may occur in a child's life, these protective factors have proven to reduce the likelihood of these traumatic experiences. The CDC's

Preventing Child Abuse and Neglect: A technical package for policy, norm, and pragmatic activities identifies five evidence-based protective strategies including strengthening economic support to families, changing social norms to support parents and positive parenting, providing quality care and education early in life, enhance parenting skills to promote healthy child development, and intervene to lessen harms and prevent future risk (Fortson et al., 2016).

Supporting children, particularly those serving as the basis of this report who have already endured substantial hardships, while preventing additional children from enduring abuse and neglect, should be uncontroversial. They deserve to live fulfilling and productive lives. It is the responsibility of all Tennesseans to create communities where our families and children can thrive.

Unfortunately, this is not always the case and can result in children enduring abuse and neglect. The life-long impact of these experiences on children has long been studied, resulting in an increased risk of negative health, education, social and economic outcomes. As noted earlier, abuse and neglect have a substantial financial toll. Second Look Commission members have partnered with the University of Tennessee Boyd Center for Business and Economic Research to study the annual cost of maltreatment to Tennessee. The report will be modeled after research conducted in Alabama which found child maltreatment in 2018 cost the state of Alabama 3.7 billion dollars. Members have requested that in addition to the total cost of maltreatment, the report include the costs disaggregated by type of maltreatment and region. The SLC expects the report to be available in March 2023 and looks forward to presenting the findings.

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

The best outcomes will occur when the various child-impacting systems and stakeholders work collaboratively and inform the work of each other with the best interest of the child always being paramount. In continued efforts to facilitate collaboration and information sharing, the SLC sent its 2022 preliminary findings and recommendations to the following entities and departments to give them an opportunity to review the issues and have input into the solutions:

- Family and Children's Service
- Joint Task Force on Children's Justice
- Our Kids Center
- TennCare
- Tennessee Association of Chiefs of Police
- Tennessee Department of Education
- Tennessee Department of Health
- Tennessee Department of Human Services
- Tennessee Department of Mental Health and Substance Abuse Services
- Tennessee District Attorneys General Conference
- Tennessee Sheriff's Association

Reporting Requirements

In part, TCA§ 37-3-803(b) states, "The commission's findings and recommendations shall address all stages of investigating and attempting to remedy severe child abuse." The findings and recommendations included in SLC annual reports address all stages of investigating and attempting to remedy severe child abuse in Tennessee, including DCS and law enforcement investigations, provision of services and the prevention and mitigation of harm. TCA§ 37-3-803(d)(2) states, "The commission shall provide a report detailing the commission's findings and recommendations from a review of the appropriate sampling no later than January

1, 2012, and annually thereafter, to the general assembly. Such report shall be submitted to the governor, the judiciary and health and welfare committees of the senate and the civil justice committee of the house of representatives." The SLC has submitted the statutorily mandated report to the entire General Assembly, the Governor's Office and SLC members in a timely manner every year the SLC has been in existence. Additionally, the report is posted on the website of the Tennessee Commission on Children and Youth.

The following observation, findings and recommendations of this report are based primarily on the severe child abuse cases reviewed by the SLC during the 2022 calendar year. It is our hope the proposed recommendations of the SLC will be embraced and implemented and will spur child protection professionals to engage in meaningful dialogue that will produce additional ideas for reducing repeat abuse of our children. The observations, findings, and recommendations are discussed below.

2022 Second Look Commission Preliminary Findings, Observations and Recommendations

Safety of Placements

- **Finding** – In several cases, members noted that a child was returned to their parents when the parents were only partially compliant with their permanency plan or had not yet completed the required services. **Recommendation –** While members acknowledge mental health and/or substance use challenges are often chronic brain disorders which may require ongoing treatment and recovery support services for optimal outcomes, it is critical when the court returns a child home after they have experienced abuse or neglect that they are in a safe, stable, and nurturing environment.

  Currently, TCA 37-1-130 states "no child who has been found to be a victim of severe child abuse shall be returned to such custody at any time unless the court finds on the basis of clear and convincing evidence that the child will be provided a safe home free from further such brutality and abuse." The SLC recommends expanding the requirement of clear and convincing evidence of a safe home in all adjudicated cases of abuse or neglect.

DCS Comment: Changing the burden of proof for courts to require clear and convincing evidence for all cases of child abuse, instead of only severe child abuse, will result in additional children entering custody or a delay in returning them to their parent(s).

- **Finding -** SLC members continue to see the need for additional post-placement support to the caregivers, to include daycare vouchers when needed and training similar to foster care parent training for noncustodial placements.
  Recommendation – Similar to recommendations in the last two annual reports, members recommend child abuse prevention stakeholders utilize community resources to connect relative caregivers and foster caregivers with adequate support.

  An example of this is the recent expansion of the Relative Caregiver Program, beginning in the spring of 2023 allowing certain relative caregivers to receive 50% of foster care board payments. Members are thankful that the Governor and his administration have provided funding and support for this expansion. SLC intends to review the success of this expansion to determine if further program expansion is warranted.

- **Finding -** SLC noted the need to reassess the safety of the child when the caregiver's, alleged perpetrator's or child's circumstances change.
  Recommendation- DCS utilizes the Family Advocacy and Support Tool as a safety and risk assessment. Protocol currently states, “A reassessment of the FAST may also occur at any time during the life of the case to indicate a change in safety, risk, trauma or service need.” Several states have policies in place requiring a safety assessment to be re-conducted as circumstances in the child's life change. Members recommend amending protocol from a permissive “may” to “shall” or “must”. Reassessing safety in light of changing circumstances is necessary to ensure children remain in a safe environment and their needs are sufficiently met.

DCS Response: Child Protective Services utilizes the Family Advocacy and Support Tool (FAST) which captures both the safety and risk factors as well as reassesses the family at critical intervals during the case. Initial safety is assessed within 5 days of the CPS intake and ongoing risk factors are assessed within 10 days of the intake to determine services and ongoing needs for the child and family. The following link

provides further detail to the policy FAST (tn.gov). This tool is used for non-custodial children while the CANs tool is used for custodial children.

Additionally, the Quality Reviews conducted by DCS on CPS cases for 6 months in 2022 indicates a compliance rate of 87% for the Assessment of Safety and Risk Tool.

- **Observation -** Continuity and appropriateness of services continued to be an opportunity for improvement.

Multi-Disciplinary Investigations

- **Finding -** In one case, the final autopsy report was completed approximately 15 months after the child died. There have been several cases reviewed by the SLC over the years that the autopsy has taken a substantial period of time to complete. In most instances, CPIT will not classify the case without the final autopsy report. During this time, if other children are involved, permanency may be delayed. Additionally, their safety may be compromised.

- **Finding -** SLC members noted limited interaction with the father in a matter. This observation has been made several times in the past. By failing to identify and locate these fathers, Tennessee may be missing an opportunity to provide a safe, stable nurturing environment for the subject child. Additional efforts and resources are warranted.
  Recommendation – In line with a multidisciplinary approach, SLC members recommend DCS and law enforcement need to do more work with and provide greater scrutiny to paramours and fathers generally. More specifically, when a mother states a father is not a part of the child's life, child abuse prevention stakeholders should ask additional questions to better ascertain what the mother means. Child abuse prevention stakeholders should check child support records and other resources that may be able to identify and locate fathers. Other resources include other family members and friends of the mother.

  If the child is old enough, the child may be able to provide some information. If the paramour is likely to continue to be a part of the mother's life, child abuse prevention stakeholders must determine whether the paramour should participate in services provided to the family.

- **Finding –** SLC members noted the need for increased communication between child abuse stakeholders and the importance of multi-disciplinary investigations.
  Recommendation - SLC members recommend DCS and law enforcement do joint investigations for allegations of severe abuse.

DCS Comment: DCS is in the process of forming a specialized Human Trafficking Team, which will work in partnership with the TBI, local law enforcement and NGO's to investigate, prosecute and provide services to child victims of human trafficking. This new approach will offer the opportunity for multi-disciplinary team training and collaboration which will assist each agency in providing the necessary services and protections to the victims of human trafficking.

- **Finding -** In one matter, SLC members thought an investigation should have been substantiated by CPIT despite the absence of an interview with the alleged perpetrator.
  Recommendation: Members noted that in several cases there was an inconsistent understanding around the Department of Children's Services' classification of "Unsubstantiated". Members recommended training to reiterate that unsubstantiated does not necessarily mean abuse didn't happen, but the available information did not meet the standard of proof, a preponderance of the evidence. Although a case may be unsubstantiated, information collected in the case can provide valuable historical information for future child safety determinations.

  SLC members also noted the importance of understanding the varying levels of standard of proof for child abuse and neglect in DCS investigations, juvenile court, and criminal court. Although an allegation may not rise to the level needed for prosecution in juvenile or criminal court, the matter should still be substantiated if it meets a preponderance of the evidence.

  DCS Comment: The Office of Child Safety instituted an additional review process for child protective services (CPS) cases with persistent past CPS involvement. The reviewer will conduct a case file review on new CPS cases with 4 or more cases within the past 12 months and provide guidance to incorporate past CPS history into current case management decisions.

- **Finding –** Due to the variety of professionals that play a critical role in child abuse cases: ranging from the initial investigation to placement, prosecution,

or reunification, members noted the need for expanded and ongoing training to ensure all parties consistently implement best practices involving these challenging cases.

Recommendation:

1. Investigation training**-** Members recommend expanding law enforcement training regarding the investigation of potential abuse cases. SLC members noted the need for further investigation based on the facts of one case. However, further investigation did not occur. In this matter, child abuse prevention stakeholders called the alleged perpetrator to schedule an interview. The alleged perpetrator did not return any calls. Law enforcement went to the alleged perpetrator's job once. The alleged perpetrator called law enforcement and agreed to an interview. The interview never happened. SLC members understand alleged perpetrators are not required to cooperate with an investigation.

Members recommend individuals investigating child abuse or participating in CPIT receive additional on-going training. Members noted the need to evaluate the state's current capacity to implement such a training. Training should be developed in consultation with child abuse prevention stakeholders. Training should include education on all available investigative avenues for law enforcement and education on the determinations of substantiated or unsubstantiated made by CPIT.

2. Court Training- As noted in the earlier finding, members recommend using trainings to emphasize the importance of joint investigations and coordinating efforts to ensure the best outcomes for children. Members noted an apparent lack of communication, particularly when there are concurrent juvenile and criminal court proceedings.

3. Judiciary Training**-** With many newly elected judges, members recommend the Administrative Office of the Courts provides training at the annual Conference on Juvenile Justice regarding what judges should look for in petitions and factors to consider when determining placement.

- **Finding -** In a child sexual abuse case which was also reported as a Commercial Sexual Exploitation of a Minor case, the child received a medical examination at a public facility as opposed to an examination by a Child Advocacy Center.

  Recommendation – Children alleged to have experienced sexual abuse who

do not require an emergency exam for evidence collection or medical symptoms should have medical exams conducted at the CAC or appropriately trained partner entity.

- **Observation -** SLC members questioned when it is appropriate to request a hair follicle test in addition to or instead of a urine drug test.
  Recommendation: Members reiterate that there are many factors to consider when determining a child's safety. The presence or absence of a positive urinary drug screen should not be the only factor considered. Ensuring a child's safety requires a total assessment of the situation and other contributing factors.

CPIT Review concerns

- **Finding -** In one Abuse Death case, DCS and law enforcement did not seem to understand the severity of the child's medical condition. Additionally, SLC members questioned whether a parent should have been charged criminally in an Abuse Death case in which the parent failed to make medically responsible decisions to address the child's known condition. Medical staff repeatedly impressed upon the parent about the severity of the child's condition, and the parent failed to respond appropriately.
  Recommendation – Members are thankful to the 112th General Assembly for updating existing law to permissively include mental health and medical providers in CPIT review. TCA 37-1-607(a)(2) now 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 recognize the critical perspective medical examiners and pediatricians specializing in child abuse provide in CPIT reviews of all abuse cases, particularly in child death cases. Members recommend updating the statute further to require a medical examiner or appropriately credentialed medical provider to participate in CPIT reviews of child death cases.

- **Finding** - SLC questioned whether a termination of parental rights petition should have been filed in an abuse death case to protect the other children involved. In this case, the documentation did not indicate the parents were in compliance with the permanency plan. The parents were partially compliant.
  Recommendation – While members had concerns in several cases they reviewed this year regarding a lack of full compliance with permanency plans, members felt the need to draw particular attention to the priority child

death cases require. The process for receiving a final adjudication can be lengthy as the case makes its way through the criminal court process. During this time, as the juvenile court reviews permanency plans, ensuring the child's safety and placement stability remain of the utmost importance after such a traumatic event.

Criminal Court concerns

- **Finding -** The decision to not prosecute child abuse was discussed in several cases. SLC member discussed the need for child abuse-specific training for assistant district attorneys and additional resources including personnel dedicated to prosecuting child abuse.
  Recommendation - Each county, or at least each judicial district, should have an ADA dedicated to handling cases involving crimes against children. Additionally, the General Assembly should form a committee to research what additional resources DAs may need to appropriately address crimes against children.

- **Finding -** Based on reports the SLC received from the Judiciary Committee of the Senate, 22 out of 31 district attorneys submitted reports referenced by TCA §37-1-607(a)(1)(A) and (B) in 2021. Of the 22 reports submitted, 7 of them appeared to substantially comply with the statute, and 12 appeared to mostly comply.
  Recommendation - The report by the district attorney mandated by TCA § 37-1-607(a)(1)(A) and (B) should contain specific information and be easily accessible. Necessary information includes:
  a) The number of reports received for investigation by type (i.e., sexual abuse, serious physical abuse, life-threatening neglect);
  b) The number of investigations initiated by type;
  c) The number of final dispositions of cases obtained in the current reporting year by type of disposition as follows:
     I. Unsubstantiated, closed, no service;
     II. Unsubstantiated, referred for non-custodial support services;
     III. Substantiated, closed, no service;
     IV. Substantiated, service provided, no prosecution;
     V. Substantiated, service provided, prosecution, acquittal; or
     VI. Substantiated, service provided, prosecution, conviction.
  d) Age, race, gender, and relationship to the victim of perpetrators identified in cases that are included in (a)(1)(C)(iii)-(vi); and

e) The type and amount of community-based support received by child protective teams through linkages with other local agencies and organizations and through monetary or in-kind, or both, donations

SLC supports the ongoing collaboration between the District Attorney's Conference, Child Advocacy Centers, and Administrative Office of the Courts to modernize data collection. As stakeholders work together to expand data collection, we can gain a better understanding into how to adapt our policies and practices to better protect children across the state. The SLC will annually review the reports submitted to the Judiciary Committee of the Senate.

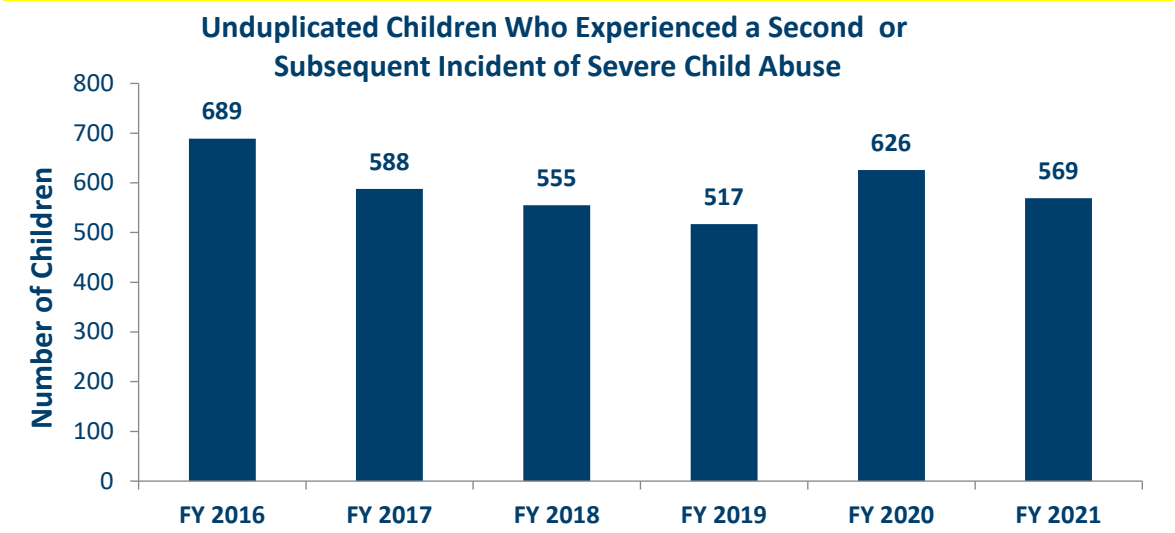
Community concerns

- **Finding-** Individuals continue to fail to report child abuse without consequence. In one abuse death case, a neighbor failed to report child abuse to the DCS. Nothing in the reviewed record indicated law enforcement or DCS followed up with the neighbor regarding the neighbor's responsibility to comply with the mandatory reporting law.
  Recommendation- Tennessee already has one of the strongest mandatory reporting laws in the nation. Members noted the need is not to strengthen the statute, but rather to strengthen public participation and knowledge regarding their duty to report. SLC members recommend a public awareness campaign aimed at preventing abuse and educating the public on the importance of ensuring children's safety by making reports when the child might be in a dangerous situation.

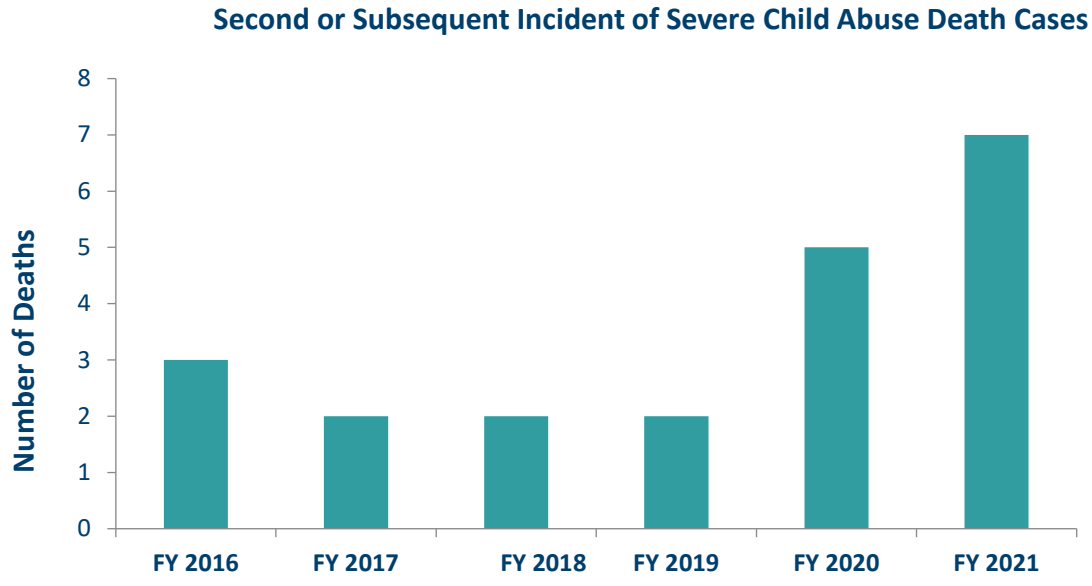
- **Finding -** SLC members continue to see the need for birth control education, particularly long-acting reversible contraception.
  Recommendation– Tennessee needs to continue to educate families about the use of long-acting reversible contraception.

Repeat Child Abuse Data

The reported number of children who experienced a second or subsequent incident of severe child abuse for FY 2021 is 569. The number of children who were subjected to a second or subsequent incident of severe child abuse represents a decrease from FY 2020 but an increase from the previous two pre-pandemic years. The data from FY 2016, 2017, 2018 and 2019 shows a downward trend. In FY2020 the number of cases began trending up and in FY2021 we see that begin to trend back down.



The number of second or subsequent incident of severe child abuse death cases for FY 2021 is 7. This represents another increase from previous years.



The types of maltreatment for FY 2021 (the second or subsequent incident) are as follows:

Abandonment
0.2%

Abuse Death
1.1%

Drug Exposed Child
15.6%

Environmental Neglect
0.4%

Lack of Supervision
2.6%

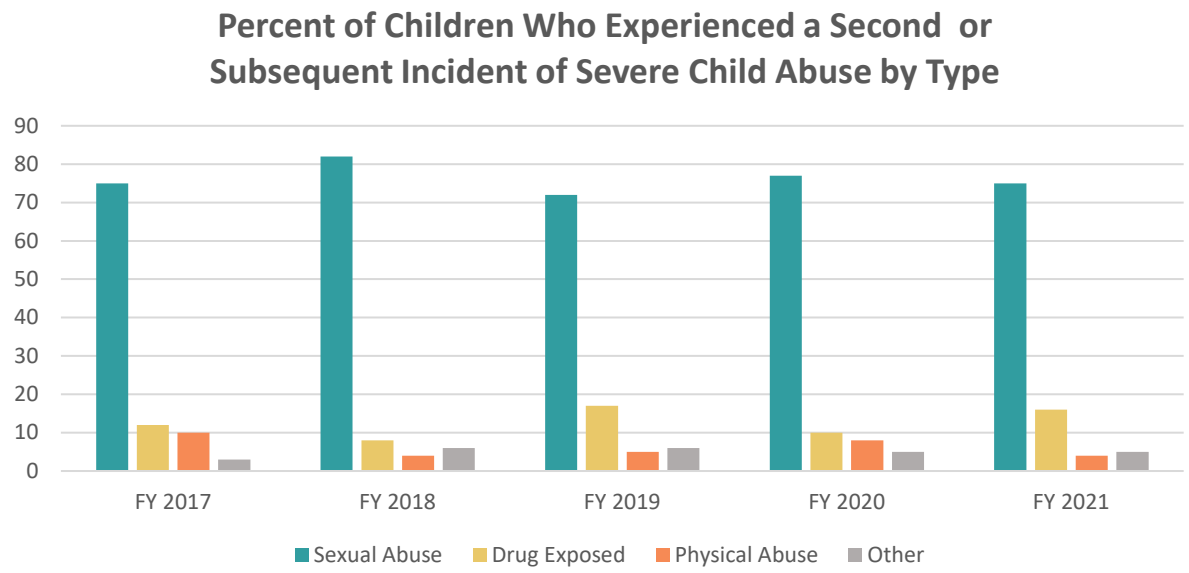
Medical Maltreatment
0.5%

Nutritional Neglect
0.2%

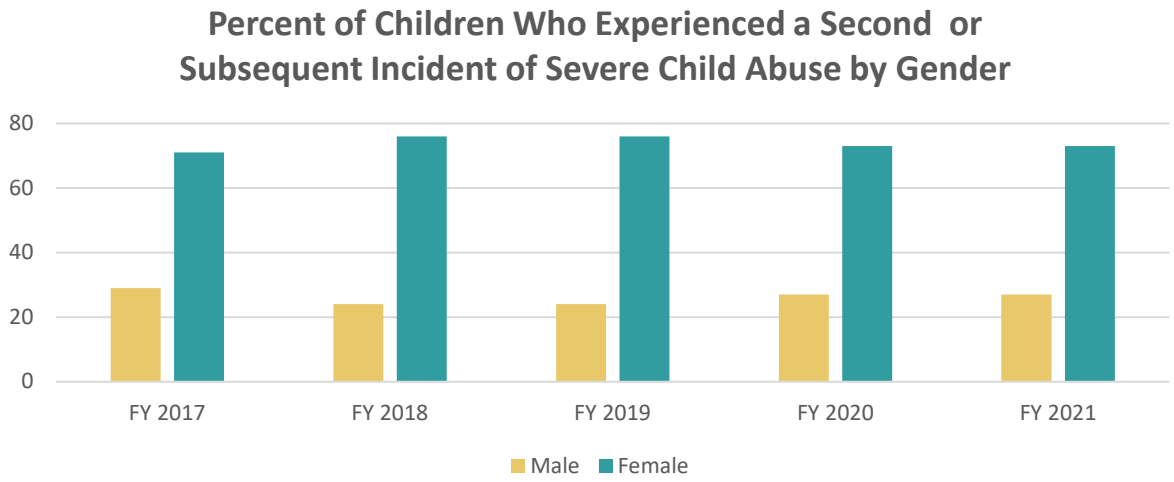
Physical Abuse
3.9%

Psychological Harm
0.3%

Sexual Abuse
75.2%



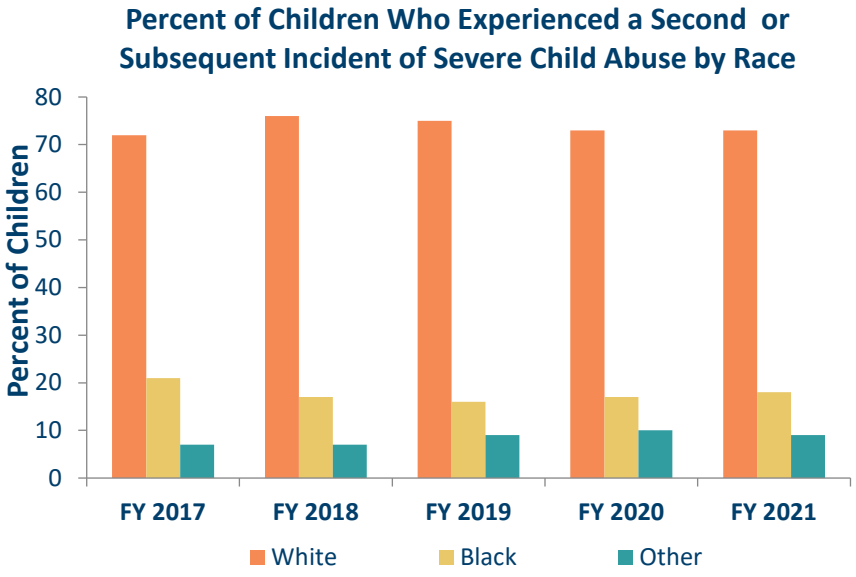
This chart is solely based on the second or subsequent incident of severe child abuse. It is important to note sexual abuse accounted for approximately 31 percent of the combined maltreatment type set forth in the FY 2021 list of cases. The most prevalent type of child abuse, including the first and second incidents, on the FY 2021 list of cases was Drug Exposed Child/Infant. Drug exposure accounted for approximately 42 percent of the combined maltreatment type set forth in the FY 2021 list of cases.



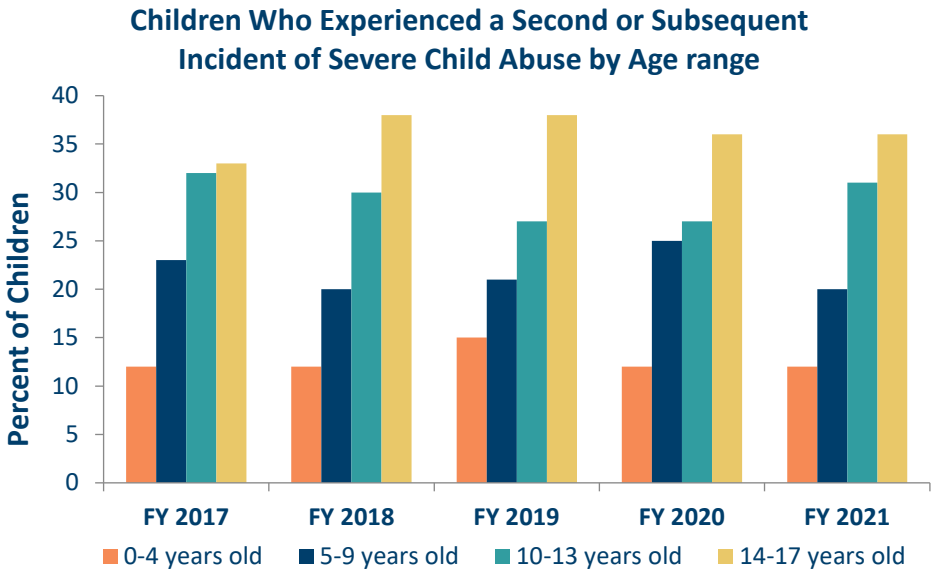
The gender composition of the victims of the total population of cases for FY 2021 is as follows: female: 73 percent; male: 27 percent. For the calendar years 2018 through 2021, male children were approximately 51 percent and female children were approximately 49 percent of the total population of children in Tennessee. Based on the total population of children, female children are disproportionately represented among children who have a substantiated second or subsequent incident of severe child abuse.

The racial composition of the victims of the total population of cases for FY 2021 is as follows:

- White: 73 percent;
- Black: 18 percent;
- Multiple/Unable to determine: 9 percent

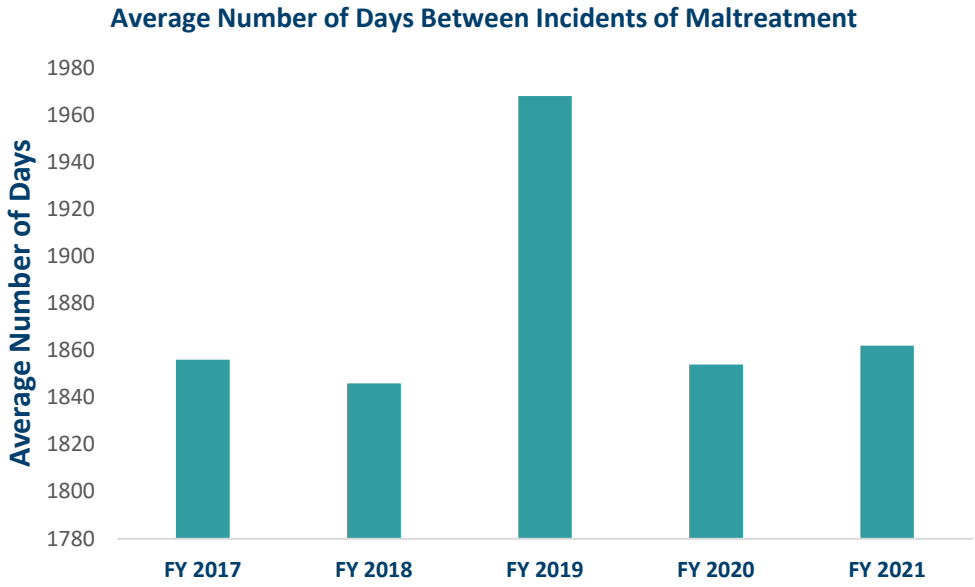


The age range composition of the children at the time of the incidents of abuse for FY 2021 is as follows:



- 0-4 years old: 13 percent;
- 5-9 years old: 20 percent;
- 10-13 years old: 32 percent;
- 14-17 years old: 36 percent.

The average number of days between incidents of maltreatment for FY 2020 is 1,862.



Number of individual children who experienced a second or subsequent incident of severe child abuse for fiscal year 2021 reported in each county by judicial districts based on the list of cases provided by DCS:

1st Judicial District

Carter	5
Johnson	3
Unicoi	2
Washington	5

2nd Judicial District

Sullivan	20

3rd Judicial District

Greene	6
Hamblen	6
Hancock	1
Hawkins	1

4th Judicial District

Cocke	8
Grainger	2
Jefferson	4
Sevier	3

5th Judicial District

Blount	12

6th Judicial District

Knox	33

7th Judicial District

Anderson	7

8th Judicial District

Campbell	4
Claiborne	0
Fentress	7
Scott	3
Union	3

9th Judicial District

Loudon	6
Meigs	0
Morgan	3
Roane	10

10th Judicial District

Bradley	2
McMinn	2
Monroe	4
Polk	1

11th Judicial District

Hamilton	6

12th Judicial District

Bledsoe	1
Franklin	4
Grundy	0
Marion	2
Rhea	4
Sequatchie	5

13th Judicial District

Clay	2
Cumberland	5
DeKalb	9
Overton	7
Pickett	1
Putnam	13

White	9

14th Judicial District

Coffee	10

15th Judicial District

Jackson	1
Macon	4
Smith	3
Trousdale	2
Wilson	1

16th Judicial District

Cannon	2
Rutherford	19

17th Judicial District

Bedford	5
Lincoln	1
Marshall	4
Moore	1

18th Judicial District

Sumner	9

19th Judicial District

Montgomery	22
Robertson	8

20th Judicial District

Davidson	42

21st Judicial District

Hickman	1
Lewis	0
Perry	1
Williamson	3

22nd Judicial District

Giles	3
Lawrence	8
Maury	2
Wayne	3

23rd Judicial District

Cheatham	2
Dickson	14
Houston	0
Humphreys	3
Stewart	3

24th Judicial District

Benton	1
Carroll	8
Decatur	7
Hardin	3
Henry	7

25th Judicial District

Fayette	0
Hardeman	2
Lauderdale	4
McNairy	4
Tipton	8

26th Judicial District

Chester	0
Henderson	8
Madison	6

27th Judicial District

Obion	3
Weakley	7

28th Judicial District

Crockett	2

Gibson	12
Haywood	0

29th Judicial District	
Dyer	4
Lake	0

30th Judicial District	
Shelby	64

31st Judicial District	
Van Buren	2
Warren	9

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 FY2021 represents a decline from the increase seen in FY2020. Prior to the pandemic, Tennessee had been experiencing a decline in the number of children who have experienced a second or subsequent incident of severe abuse. Although higher than pre-pandemic numbers, the FY 2021 numbers represent a significant drop from FY2020. The number of children who suffered a second or subsequent incident of severe child abuse decreased from 626 in the FY2020 data to 569 in the FY2021 data. Substance use disorder continues to be a primary contributor to the abuse of children in Tennessee. Continuing to improve how Tennessee responds to and reduces drug exposure of children is imperative. After a decrease between FY 2019 and FY 2020, Drug Exposed Infant/Child as the second incident increased back to FY 2019 levels. Drug Exposed Infant/Child combined with the first incident of child abuse increased by 7.9 percent.

Sexual abuse as the second incident of severe child abuse decreased by 2.5 percent from FY2020 to FY2021, representing approximately 56 fewer incidents of sexual abuse. Sexual abuse combined with the first incident of child abuse increased 11.7 percent. After an increase of almost 43 percent between FY2019 – FY 2020, physical abuse as the second incident of severe child abuse decreased by 50 percent from FY2020 to FY2021. Physical abuse combined with the first incident of child abuse decreased 10.8 percent.

Tennessee must continue to address all forms of child maltreatment and use data to focus its efforts. The FY2021 data represents a decline from the increase seen in FY2020. However, it is still an increase from FY2019 and child abuse prevention stakeholders still indicate that they are seeing some of the impacts of the pandemic. The SLC will continue analyze the data over time to help Tennessee focus its resources in areas of greatest needs. The SLC is committed to helping improve the many systems that impact how Tennessee handles severe child abuse.

The SLC would like to thank all child abuse prevention stakeholders for their support and the opportunity to work with them to improve the lives of children and families in Tennessee. Additionally, the SLC would like to thank the Tennessee General Assembly the opportunity to continue this vital work.

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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

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