TENNESSEE COMMISSION ON CHILDREN & YOUTH

Second Look Commission

2023 Annual Report

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Purpose

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."

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. This year the Second Look Commission and Tennessee Commission on Children and Youth partnered with The Boyd Center for Business and Economic Research at the University of Tennessee, Knoxville to study the economic cost of child abuse and neglect across Tennessee.

Economic Costs of Child Abuse and Neglect in Tennessee

In the study, published June 2023, the Boyd Center for Business and Economic Research found that the economic impact of substantiated claims of child abuse and neglect in Tennessee is between $3.33 and $4.97 billion annually. The report

found each year there are an average of 11,668 children who were first-time substantiated victims of abuse or neglect. This equates to a one-in-eight chance that a child in Tennessee is a substantiated victim of child abuse by the time they reach adulthood.

In addition to the annual cost to the state, the report evaluated the lifetime cost per victim and found it to be between $285,464 to $425,912. This calculation factors in costs associated with child mortality, special education, residential care, juvenile detention, childhood medical care costs, adult medical costs, lower productivity, adult criminality, and premature adult mortality.

Though services focused on prevention and intervention often require significant financial investment, the cost of maintaining the status quo is substantial. Even though the prevention of and treatment for child abuse and neglect has a return on investment that is slow and difficult to measure, the economic costs of child abuse are sufficiently large to warrant the state's attention on economic grounds alone.

The full report of The Economic Cost of Child Abuse and Neglect in Tennessee can be found here: https://haslam.utk.edu/publication/the-economic-cost-of-child-abuse-and-neglect-in-tennessee/

Stakeholder Feedback

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 2023 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 Public Defenders 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 2023 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.

2023 Second Look Commission Preliminary Findings, Recommendations, and Observations

Safety of Placements

Findings:

Key Finding: Members expressed concerns with the safety conditions at several contracted providers.

Findings related to this include:

- In one case, a foster home was initially approved for two placements, yet had six children placed there. Members noted concern about why this exception was made and why the policy was not followed.
- Members noted the opportunity for a more in-depth evaluation of foster homes when allegations of abuse or inappropriate discipline arise.
- In one abuse death instance, members noted that the children were the foster parents' first placement and were a complex placement for the first time. Members questioned what resources, services, and supports were provided to the foster parents.
- Members noted concerns regarding how the foster mother and case worker spoke about the alleged child victim in their care. Members noted the opportunity for additional training for both the placement and worker.
- Members noted that the description of the bruising appeared to resemble a slap mark, not matching the explanation for the marks provided by the foster parents.
- Members were concerned with allegations of abuse at a residential treatment center. In one case, there was staff sexual abuse at a facility.
- Allegations of contraband being provided by staff at a facility did not result in a law enforcement investigation or criminal charges.

Key Finding: In some cases, visitation or custody was granted to caregivers who had unresolved criminal charges or substantiations placing the children at risk of harm.

Findings related to this include**:**

- Members questioned why a grandmother had supervised visitation with a child when she has pending criminal charges and a severe abuse substantiation by DCS.
- Members had concerns that the mother had been substantiated and charged with severe abuse, yet the children were returned to her while she was on probation for the severe abuse charges.

Key Finding: In several cases, members noted that custody determinations or relative caregiver placements allowed contact with caregivers that presented an ongoing risk to the child's safety or stability.

- In one instance, the child was allowed to remain in the home of someone who resided with a person convicted of sexual offenses against a child and was a registered violent sex offender.
- Members stated concerns about the children remaining in the grandmother's home after multiple allegations of abuse.
- In one instance, the mother was deemed to be protective of the child, but was sending the child to their grandparent's house anytime the alleged perpetrator would come over. Members questioned how sustainable and protective that is.

Safety of Placements

Recommendations:

Recommendation: Establish in the Department of Children's Services Policy that if a Special Investigations Unit investigation leads to the substantiation of an abuse death or near death at a licensed provider, the Office of Child Welfare Licensing and Office of Continuous Quality Improvement will conduct a review of the provider's practices to ensure compliance and safety. Upon completion, the review will be provided to the Commissioner of the Department of Children's Services.

Recommendation: Members noted that first-time foster parents are experiencing a significant change and may need additional support during the transition. Currently, all new placements (regardless of the foster parent's tenure) are to receive a case worker visit within 3 days. New foster parents will receive a call and visit with the Foster Parent Support Worker and be connected to a Foster Parent Mentor. Considering the challenges that may arise as a first-time foster parent, members recommended requiring more frequent in-home caseworker visits for both DCS foster homes and third-party providers to ease the transition over the first 3 months.

Recommendations: Allegations of contraband being provided by staff to children at residential facilities should be investigated by law enforcement.

Recommendation: While custody is determined through the court, the judges make that determination based on the information provided to them through the various parties. Ensuring that the court has all of the available information to make the best decision possible regarding custody and visitation is critical to ensuring the best and safest outcomes for children.

Investigations

Findings:

Key Finding: In several of the abuse death cases, members noted the need for additional communication regarding autopsies and the challenges that arise when that does not happen.

Findings related to this include:

- Investigators were unable to get a preliminary autopsy finding in one case. If law enforcement had known smothering could have been a potential cause of death, they may have approached the investigation differently.
- Members noted the challenges that come when the investigating officer changes, particularly when there is not yet a preliminary or final autopsy available.
- In one abuse death case, the autopsy took three and a half years.
- Members noted these significant autopsy delays appear to be regional/location-specific. DCS has established a system to reach out to the medical examiner's office in the event of a delay.
- There is an opportunity for better communication from the medical examiner's office as autopsy results are pending.
- Members noted law enforcement in smaller counties often are not able to attend autopsies, making communication critical.

Key Finding: In several cases, members found opportunities for a more thorough investigation into the alleged abuse.

Findings related to this include:

- In one case, it appears that the former foster mother of the alleged perpetrator may have babysat the alleged child victim shortly before the child's death. It does not appear that the former foster mother was contacted as a part of the investigation into the death of the child.
- During the course of an investigation, the child disclosed sexual advances and grooming behaviors from their stepfather, but this was not followed up on. A year later, when they disclosed again there was an investigation, resulting in him being substantiated and charged criminally.

- Members had concerns that a hotline call alleging methamphetamine use and concerns of postpartum depression with psychotic features was screened in as a P2 Assessment.
- Upon review of case notes and findings, members expressed concern that decisions made and interpretation of evidence may have been impacted by confirmation bias in favor of the foster parents.
- Members questioned why there was not a hair follicle test done on the alleged child victim after several allegations of a drug-exposed child.
- Members noted concerns that the sibling in the home was not interviewed regarding sexual abuse after a disclosure from another sibling.
- Members noted the case had multiple allegations that were Unsubstantiated or No Services Needed. Members wondered if these multiple cases contributed to alarm fatigue.
- Members noted in one case there were repeated allegations of drug exposure that were not properly investigated.
- Members noted concerns that the grandmother would not allow the child to participate in a forensic interview. It does not appear that there was an effort made to court order the forensic interview.
- There was concern that a detective didn't act with enough urgency to interview the alleged perpetrator, members thought this two-month delay may have given the family members time to work out a consistent story.

Recommendation: Ensure that medical examiners understand the importance of a preliminary autopsy finding and the benefits it provides to the investigation process.

Recommendations: Evaluate current Child Protective Services (CPS) caseloads to determine the number of workers with over 20 open cases. Examine if the current policy of determining caseloads by a regional monthly average allows caseworkers enough time and capacity to conduct their investigations to the best of their abilities. In addition, while CPS and Foster Care, Juvenile Justice, Family Support Services, and Family Crisis Intervention Program caseworkers are to have no more than a regional monthly average of 20 cases, CPS worker's cases are counted by the family while all others are by the child. Considering this, DCS should evaluate if the number of cases for CPS workers should be decreased.

DCS Response: Specialty teams were created to account for more intensive and specialized approaches when working with families and certain populations. These teams include the Special Investigations Unit, Drug Teams, and Second Shift Teams. The specialized teams are able to have reduced caseloads and provide more intensive interventions. There are plans to fully integrate this approach in all regions when staffing resources are available. Additionally, last year all newly hired case managers were given a caseload cap of 10 cases during their first year with the agency. During the initial 12 months, casework was regularly evaluated and if they had acceptable performance, a waiver could be granted to gradually increase a caseload to no more than 20 cases. This mandate provided a reasonable time frame for newly hired case managers to incorporate training and experience into their casework practice.

Investigations

Observation:

Observation: Members noted that there were several drug-exposed allegations where the parents could not be located and then would appear a week or two later and provide a negative drug screen. There was discussion that the timing of this was suspicious.

Multi-Disciplinary Investigations

Findings:

Key Finding: Members noted concerns with the consistency regarding the availability of forensic interview recordings.

Key Finding: Members questioned if the Department of Children's Services ever partners with law enforcement investigators to search through cell phones or other devices for potentially sexually explicit materials or communication.

DCS Response: DCS created a consultant team comprised of former law enforcement experts that work directly with child protective services (CPS) to provide investigative expertise and assist frontline staff. This team continues to expand and serve numerous counties across the state. They also provide critical investigative training to CPS staff and local law enforcement. CPS recently created Special Investigator positions as a pilot program to attract candidates with specific investigative experience. They are currently placed in the middle TN counties and

efforts are underway to recruit and hire qualified candidates. These positions will be responsible for investigating severe abuse cases.

Key Finding: Members expressed a significant need for additional training on the complexities of abuse, particularly sexual abuse, among Child Protective Investigation Team members.

Findings related to this include:

- Members expressed significant concerns with members participating in CPIT and making determinations on substantiations without adequate training on abuse, particularly sexual abuse.
- Members had concerns about detectives not being adequately trained on the complexities of sexual abuse cases and disclosures from children.
- Members noted a need for additional training regarding all types of abuse, particularly sexual abuse and domestic violence.

Key Finding: While members felt the need for in-depth training for CPIT partners as mentioned above, they also expressed the need for additional or enhanced broad training available for patrol law enforcement who might respond to a domestic violence or runaway situation.

Multi-Disciplinary Investigations

Recommendation:

Recommendation: The Child Advocacy Centers have begun using a digital evidence software, VidaNyx for forensic interviews. Members are hopeful that the implementation of this software will make forensic interviews more accessible for parties that need access while maintaining their security.

Recommendation: Considering the large number of stakeholders involved with children who have experienced maltreatment or victimization, the sharing of data and information is critical. Tennessee should evaluate how to best share data across stakeholders while maintaining appropriate privacy and protection.

Recommendation: The Department of Children's Services Office of General Counsel should establish a policy on when and how investigators can partner with law enforcement to extract evidence from phones or other devices.

Recommendation: Individuals investigating child abuse or participating in CPIT should receive annual training provided by the Child Advocacy Centers focused on the function of CPIT, changes to statutes, and the complexities of child abuse. In previous years, members noted the need to evaluate the state's current capacity to implement such training. The training should be developed in consultation with child abuse prevention stakeholders and approved by the Joint Taskforce on Children's Justice.

Recommendation: Even law enforcement who do not typically investigate instances of child abuse may be called to a scene with a child who has experienced abuse or significant trauma. Members recommended the Second Look Commission and The Joint Task Force on Children's Justice review the training material provided in P.O.S.T and provide recommendations.

No Contact Orders

Findings:

Key Finding: In multiple cases reviewed by the commission, an existing No Contact Order was violated placing the child in danger.

Findings related to this include:

- In one case, the alleged perpetrator was substantiated for a near-death case with the alleged child victim. A No Contact Order between the alleged perpetrator and alleged child victim was court ordered. The order was violated and led to the abuse death of the alleged child victim.
- Members have reviewed several cases where the mothers are not appropriately protective of their children who have been sexually abused, even violating court orders. This is particularly common when the alleged perpetrator is their spouse, boyfriend, or paramour.

Key Finding: Members found that when law enforcement or the Department of Children's Services are addressing a situation, they are often not aware of or able to easily access information regarding existing No Contact Orders between the caregiver and child.

No Contact Orders

Recommendations:

Recommendation: For many years, the Second Look Commission has noted violations of No Contact Orders placing children in danger. The Commission continues to reiterate the importance of courts clearly explaining, orally and in written word, the scope and duration of No Contact Orders. The courts should reiterate that the No Contact Order does not expire at the conclusion of the Department of Children's Service's case.

Recommendation: TCA 37-4-414 (e)(2)(b)(i) establishes a criminal offense specific to the violation of a No Contact Order by a Kinship Foster Placement. Since this is newly passed legislation, ensuring Kinship Foster Care placements are aware of the consequences they face if they knowingly allow the parent to violate a No Contact Order should be a high priority during the onboarding process.

Recommendation: The SLC recommends the creation of a database of No Contact Orders, from both General Sessions and Juvenile Court, to be accessed by law enforcement and DCS investigators. The members discussed the Tennessee Fusion Center as a potential partner. Members stressed the importance of the database staying up to date, both for the implementation of a new order and amendments to an existing order. This can either be achieved through an automatic system such as Quest in the juvenile courts or through legislation requiring courts to input the information within a given time.

Services

Findings:

Key Finding: Members found wrap-around services provided to families during challenging times to be a strength and potentially mitigate further abuse from occurring.

Findings related to this include:

- In one case, when the child was placed with another caregiver following the death of their sibling, the caregiver was given extensive family support services to ease the transition. Members noted this as a strength that likely prevented further challenges.

- Members were encouraged that the ACV had intensive in-home services from youth villages considering the trauma they had experienced.
- Members noted that when the mother had access to support from a Multi-Agency Collaboration things seemed to be going well.

Key Finding: Members felt parties in several cases would have benefited from additional services.

- Members noted one of the greatest challenges across cases reviewed is a lack of available and appropriate services across the state.
- In one case, members questioned if the mother had gone through enough services and treatment prior to the children returning home. Members noted anger management classes were not on the alleged perpetrator's permanency plan, but strongly felt they should be.
- Members noted concerns about not increasing services for a child. Upon review of the case information, members felt some of the behaviors being exhibited might have been stemming from mental health concerns, but services were not increased.
- Members noted that there is a continued need for more support and counseling for family members/caregivers.
- Members noted that it is not surprising that a child with multiple disclosures of sexual abuse ends up being sexually reactive.

Key Finding: For several years, members have noted the importance of engaging fathers in the custody process. Members noted that paternal extended family can be an important potential placement or support system.

Services

Recommendations:

Recommendation: Members were encouraged by the improvements seen when wrap-around support services were provided to caregivers. Members would like to see these programs expanded with a focus on evaluating the best way to safely and successfully transition caregivers out of services.

Recommendation: Access to appropriate services continues to be a need for children in the child welfare system. The General Assembly should commission a study to aggregate and analyze the existing reports regarding the service needs and

availability across the state. The study should include input from stakeholders such as the Department of Children's Services and other state agencies, juvenile courts, Child Advocacy Centers, children's hospitals, residential mental health providers, outpatient mental health providers, and children/families with lived experience in the child welfare system.

Recommendation: The Administrative Office of the Courts develops Bench Cards each year. These cards are provided to the courts and outline the services and providers available in the community. Although these are designed to be a service and support to the court, they are publicly available and can be a resource for others in the community looking for information regarding service availability.

Medical

Findings:

Key Finding: An alleged child victim presented to a pediatrician's office once for being difficult to arouse or potential sedation and once for bruising on their ear. Both situations are concerning for abuse, but do not appear to have been reported.

Key Finding: Members noted that although a cause of death was found to be undetermined, pediatricians treating the child's injuries reiterated that while the level of injury could be caused by an adult falling, it would not be possible for that to occur by a child of that size falling.

Medical

Recommendations:

Recommendation: Training and reminders on the typical injuries or signs associated with child abuse should be provided to all professionals working in medical facilities, especially pediatrician's offices.

Recommendation: Communication and mutual understanding between medical examiners and medical providers is critical in determining the appropriate cause of death.

Medical

Observations:

Observation: Members noted the long-term healthcare challenges and potential shortened lifespan the alleged child victim could experience when dealing with chronic medical conditions such as diabetes with multiple instances of medical neglect. Members questioned what it takes to terminate parental rights based on medical neglect.

Recommendation: Member discussed how the long-term impact of medical neglect should be considered in addition to the immediate risk when determining the best interest of the child.

Observation: Members noted the challenge that it is medically reasonable to have a 3-month gap in follow-up medical visits to appropriately address changes, however, it becomes difficult for DCS to keep the case open for that long between medical visits.

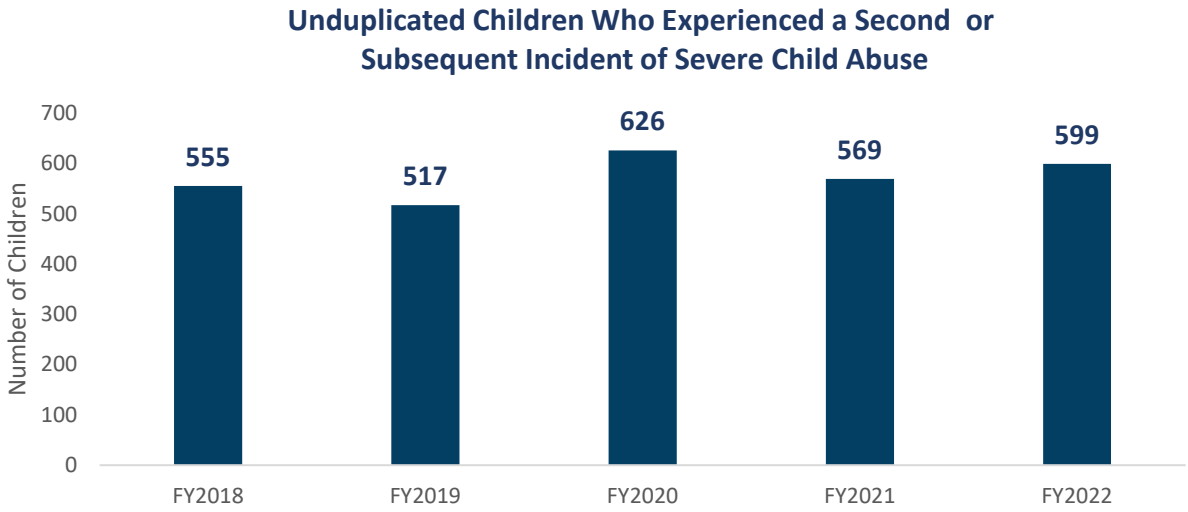
Recommendation: Members discussed the value of Family Support Services in challenging cases such as this. The importance of exploring all options to maintain in-home services while the family works to stabilize medical risk through a case management model was discussed.

Recommendation: When medical maltreatment/medical neglect is severe Family Support Service workers need to maintain a degree of vigilance to be supportive yet also consider using other means (court, removal, etc.) to assist the child in receiving necessary medical care.

Repeat Child Abuse Data

The reported number of children who experienced a second or subsequent incident of severe child abuse for FY 2022 is 599. The number of children who were subjected to a second or subsequent incident of severe child abuse represents an increase from FY 2021. Though lower than the five-year peak of victims in FY2020, the cases this year reflect an increase from pre-pandemic numbers.

The fiscal years listed reflect the disposition date. In many cases, these fall into the same year as the occurrence of abuse, however sometimes with more complicated cases, such as an abuse death, there is a longer timeframe between the occurrence and the disposition.



The types of maltreatment for FY 2022 (the second or subsequent incident) are as follows:

Abuse Death
1.3%

Drug Exposed Child
18.9%

Domestic Violence
0.5%

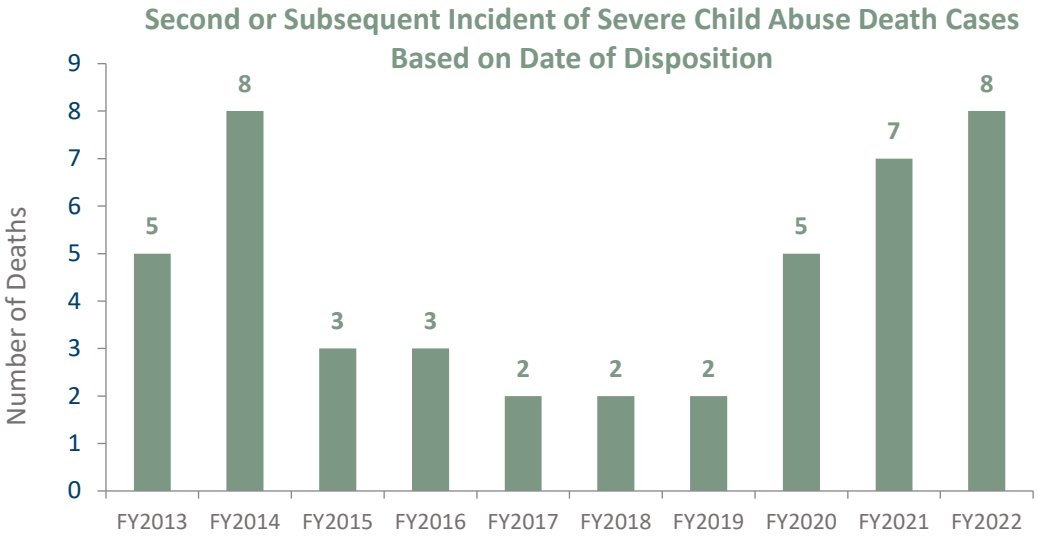
Lack of Supervision
2.0%

Medical Maltreatment
1.0%

Physical Abuse
6.5%

Psychological Harm
0.7%

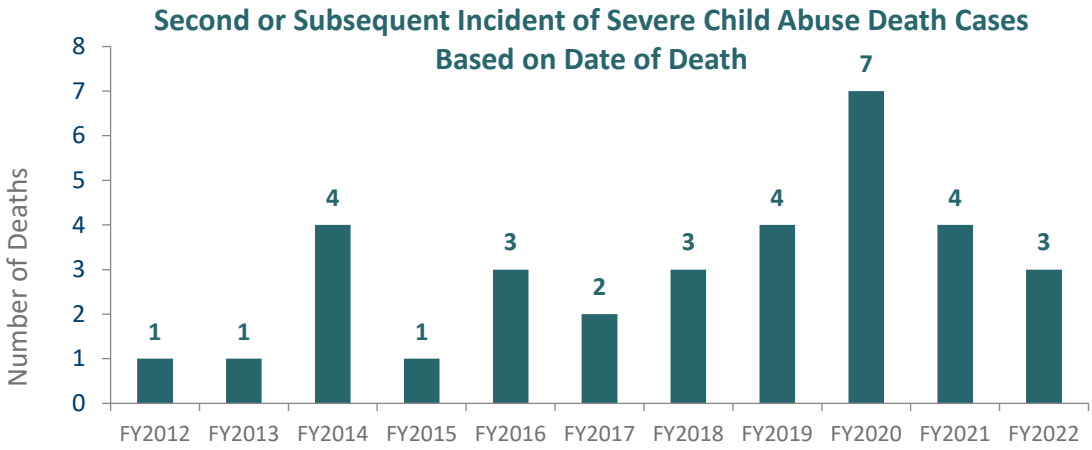
Sexual Abuse
69.1%



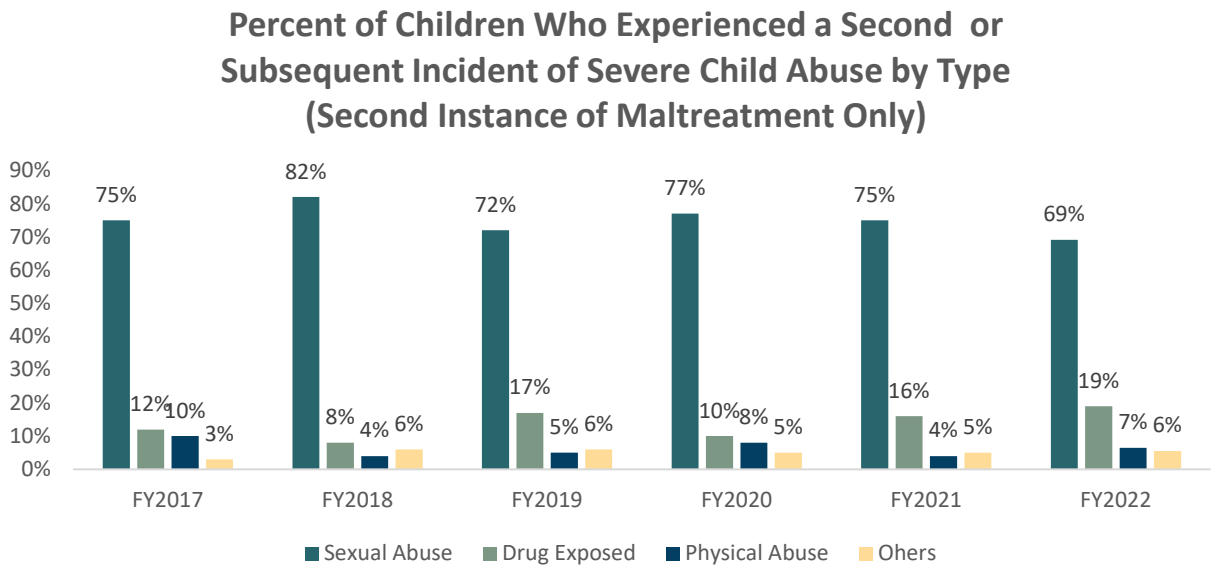
There were eight instances of a second or subsequent incident of severe child abuse resulting in a death in the SLC's FY 2022 case review. This represents another increase from previous years, matching FY2014 for the highest number reviewed by the SLC.

As mentioned earlier, there is often a longer timeframe to reach a disposition in child death cases meaning in many of the cases reviewed by the SLC, the death did not occur in the same fiscal year as the disposition. The chart above outlines the number of cases reviewed by SLC (based on the date of disposition) whereas the chart below outlines the trends by date of death.

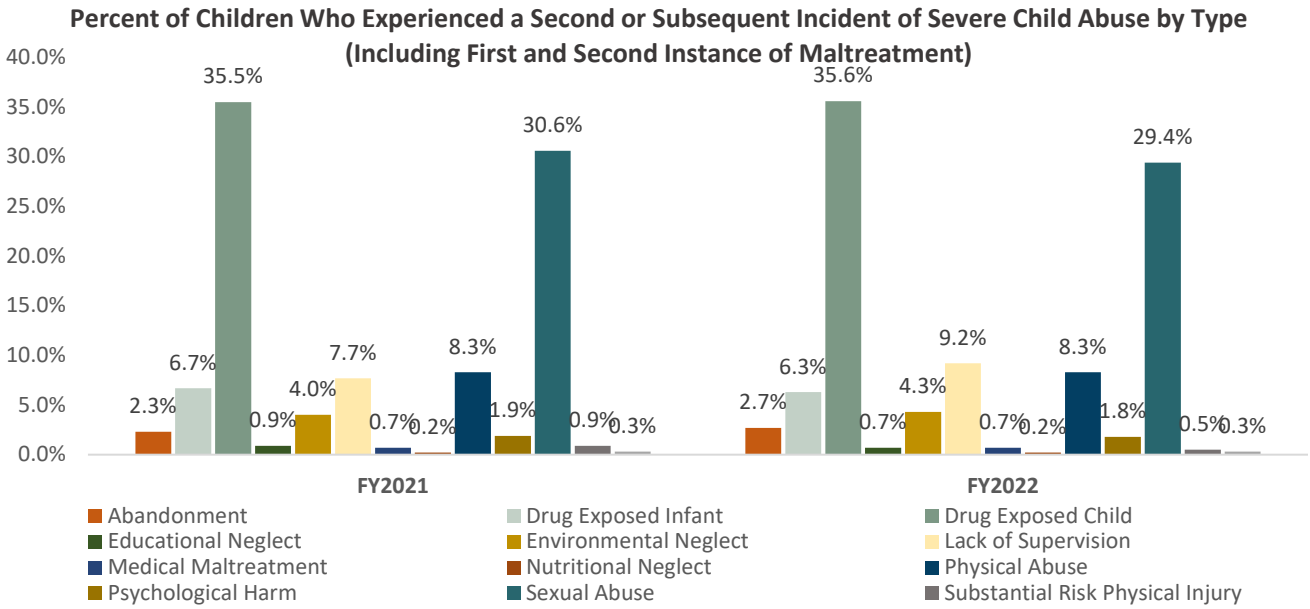
The number of cases listed here do not reflect all instances of child abuse deaths, just those that meet the Commission's statutory authority, meaning the child had experienced a previous incident of substantiated abuse prior to their death.

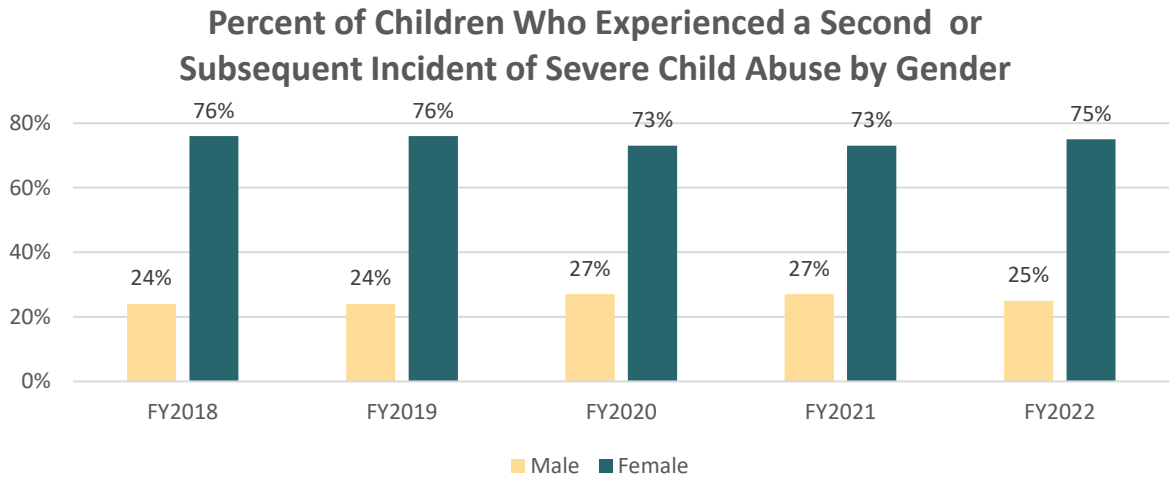


The SLC reviews every abuse death that meets the commissions statutory authority. In this year's review of abuse death cases, included eight deaths that occurred between 2018-2022. Based upon the timeframe to reach dispositions in abuse death cases, it is not clear if the decline in 2021 and 2022 is a true decline or if those cases are still being investigated.



This chart is solely based on the second or subsequent incident of severe child abuse. It is important to note sexual abuse while sexual abuse accounted for nearly 70 percent of second or subsequent incidents of maltreatment, it was approximately 30 percent of the combined maltreatment type outlined in the FY 2022 list of cases. The most prevalent type of child abuse, including the first and second incidents, on the FY 2022 list of cases was Drug Exposed Child/Infant, shown in the chart below. Drug exposure accounted for approximately 42 percent of the combined maltreatment type outlined in the FY 2022 list of cases.

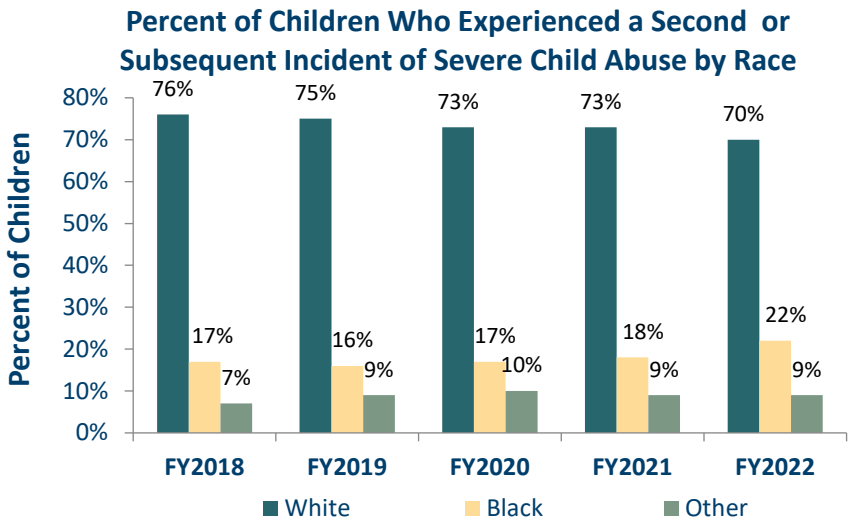




The gender composition of the victims of the total population of cases for FY 2022 is as follows: female: 75 percent; male: 25 percent. For the calendar year 2022, male children were approximately 51 percent and female children were approximately 49 percent of the total population of children in Tennessee. 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.

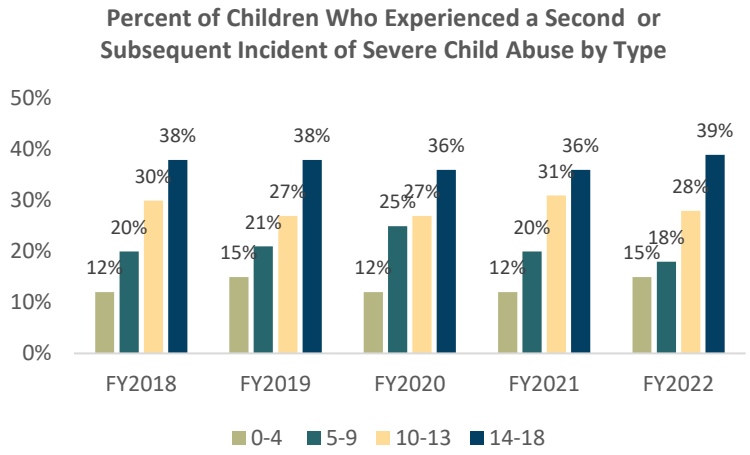
The racial composition of the victims of the total population of cases for FY 2022 is as follows:

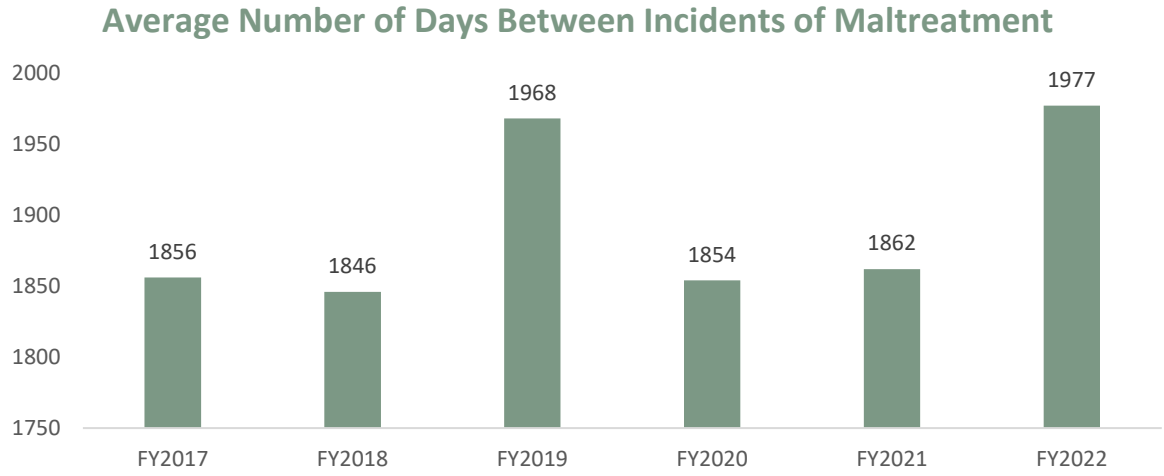
- White: 70 percent;
- Black: 22 percent;
- Multiple/Unable to determine: 9 percent



The age range composition of the children at the time of the incidents of abuse for FY 2022 is as follows:

- 0-4 years old: 15 percent;
- 5-9 years old: 18 percent;
- 10-13 years old: 28 percent;
- 14-17 years old: 39 percent.





The average number of days between incidents of maltreatment for FY 2022 is 1,977. The median number of days was 1,473.

Number of individual children who experienced a second or subsequent incident of severe child abuse for fiscal year 2022 reported in each county by judicial districts based on the list of cases provided by DCS:

1st Judicial District

Carter	6
Johnson	2
Unicoi	0
Washington	9

2nd Judicial District

Sullivan	12

3rd Judicial District

Greene	5
Hamblen	3
Hancock	2
Hawkins	4

4th Judicial District

Cocke	4
Grainger	0
Jefferson	9
Sevier	13

5th Judicial District

Blount	14

6th Judicial District

Knox	52

7th Judicial District

Anderson	10

8th Judicial District

Campbell	3
Claiborne	5
Fentress	0
Scott	2
Union	3

9th Judicial District

Loudon	5
Meigs	2
Morgan	3
Roane	4

10th Judicial District

Bradley	4
McMinn	5
Monroe	6
Polk	0

11th Judicial District

Hamilton	8

12th Judicial District

Bledsoe	1
Franklin	6
Grundy	2
Marion	1
Rhea	5
Sequatchie	3

13th Judicial District

Clay	1
Cumberland	5
DeKalb	10
Overton	6
Pickett	0
Putnam	8
White	8

14th Judicial District

Coffee	6

15th Judicial District

Jackson	1
Macon	7

Smith	5
Trousdale	0
Wilson	6

16th Judicial District

Cannon	6
Rutherford	21

17th Judicial District

Bedford	12
Lincoln	1
Marshall	3
Moore	1

18th Judicial District

Sumner	7

19th Judicial District

Montgomery	27
Robertson	4

20th Judicial District

Davidson	32

21st Judicial District

Hickman	2
Lewis	2
Perry	0
Williamson	5

22nd Judicial District

Giles	4
Lawrence	9
Maury	8
Wayne	2

23rd Judicial District

Cheatham	2
Dickson	10
Houston	1
Humphreys	4
Stewart	3

24th Judicial District

Benton	4
Carroll	3
Decatur	3
Hardin	8
Henry	2

25th Judicial District

Fayette	0
Hardeman	1
Lauderdale	3
McNairy	5
Tipton	5

26th Judicial District

Chester	3
Henderson	5
Madison	12

27th Judicial District

Obion	3
Weakley	4

28th Judicial District

Crockett	0
Gibson	3
Haywood	1

29th Judicial District

Dyer	3
Lake	0

30th Judicial District

Shelby	87

31st Judicial District

Van Buren	1
Warren	2

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 FY2022 represents an increase from the pre-pandemic numbers in FY2018 and FY2019. Before the pandemic, Tennessee had been experiencing a steady decline in the number of children who have experienced a second or subsequent incident of severe abuse. The number of children who suffered a second or subsequent incident of severe child abuse increased over the last year as well, from 569 in the FY2021 data to 599 in the FY2022 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.

Drug Exposed Infant/Child comprised 19 percent of the second incidents of maltreatment, the highest percentage in the last five years.

Sexual abuse as the second incident of severe child abuse decreased by 6 percentage points from FY2021 to FY2022, representing approximately 14 fewer incidents of sexual abuse. After a decrease in sexual abuse cases among combined maltreatment types (first and second incident) in FY2019 and FY2020, the percentage of sexual abuse cases has returned to approximately 30 percent in both FY2021 and FY2022.

Physical abuse comprised 7 percent of all second incidents of maltreatment, up from 4 percent in 2021. Across combined maltreatment, physical abuse remained the same at 8.3 percent.

Tennessee must continue to address all forms of child maltreatment and use data to focus its efforts. The FY2022 data represents an increase from the previous year and the second-highest number of children experiencing a second or subsequent incident of maltreatment in the last five years. The SLC will continue to analyze the data over time to help Tennessee focus its resources in areas of greatest need. 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 for the opportunity to continue this vital work.

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