2015

KANSAS ATTORNEY GENERAL
Derek Schmidt

Abuse, Neglect and Exploitation Unit
Kansas Fiscal Year 2015
Annual Report

July 1, 2014 – June 30, 2015

www.ag.ks.gov

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Executive Summary

The Abuse, Neglect, and Exploitation (ANE) Unit received 1,797 substantiated reports in the 2015 fiscal year. In addition to sharing statistical data for the reports received, this annual report highlights ways in which the Unit's work has resulted in intervention or investigation of the abuse of children and vulnerable adults. This largely manifests in situations where referrals have been lost in transition from one agency to another or where progress stalled within an agency for a variety of reasons. The annual report also highlights concerns identified as an impediment to the overall protection of children and vulnerable adults, with case examples depicting the concern. Lastly, the annual report identifies changes needed to ensure the ANE Unit receives essential information to review cases.

1. **Lack of effective monitoring by the Department of Children and Families' (DCF) contractors to ensure care and safety of children**

   The Unit has concerns about the level of monitoring happening in homes where children who are already in state custody reside, and are assigned to DCF contracting agencies. The Unit believes in many cases, if the level of monitoring was appropriate, the conditions would be resolved or the children would be removed from homes before the conditions deteriorated so severely that new DCF investigations and findings are generated.

   The Unit recommends stronger oversight of DCF contracting agencies and monitoring of children who have been placed in state custody. Consequently, the Unit is concerned by the transferring of foster care licensing from KDHE to DCF. Having a separate agency offered some measure of oversight to the care of children placed in DCF custody that is no longer available.

2. **Failure to report findings concerning possible criminal acts to a law enforcement agency**

   The Unit believes DCF fails to report crimes, especially concerning child abuse, to law enforcement authorities with any regularity or consistency. The Unit believes failure to do so prohibits criminal investigation and prosecution and as such, fails to hold perpetrators accountable for their actions. This can also leave their victims, as well as other children and vulnerable adults, open to further abuse.

   The Unit recommends dual reporting of child and adult abuse to both the appropriate state agencies and to local law enforcement when there is a belief a crime may have occurred. Those agencies should also follow up on their initial reports to verify receipt by the law enforcement agency. In absence of this, the Unit recommends DCF institute Rules and Regulations to incorporate the use of lethality checklists into policy to determine whether child abuse reports which constitute potential crimes should be reported to law enforcement, regardless of whether "serious physical abuse" occurs.

3. **Lack of agency communication**

   In some cases, it is apparent failure to fully communicate by investigating agencies is detrimental to thorough investigation and prosecution of cases, reducing accountability by alleged perpetrators and increasing risk to those who are, or will become, victims of abuse.

   The Unit recommends that while each agency serves a separate function, they recognize the value of joint, collaborative efforts, to work together in their individual capacities and improve communication and notification in this regard.

4. **Ineffective referral process for findings that are referred to law enforcement in adult cases**

   The Unit continues to see cases involving abuse of vulnerable adults "fall through the cracks" when those cases are referred to law enforcement. While agencies are required to send notice to law enforcement, such notices are often not followed up with contact to ensure receipt by the receiving agency. This can result in significant delay or failure to criminally investigate these cases.

   The Unit recommends all state agencies providing information to local law enforcement agencies develop policy requiring follow up on these referrals in a timely fashion to ensure the information is received. If legislative action is required to create a statutory obligation, this should be reviewed and considered. Further, local law enforcement agencies should develop internal policies so staff who might receive such notification recognize the purpose and nature of the forms and disseminate them appropriately for investigation. Law enforcement should make an independent determination regarding initiating a criminal investigation based on the merits of the report and the available evidence, rather than solely on the impression or opinion of a social worker who is not trained to conduct a criminal investigation.

5. **Findings not sent to the district or county attorney in the jurisdiction where the crime occurred**

   The Unit has previously identified a concern where findings had not been sent by DCF to the district or county attorney in the jurisdiction where child abuse had occurred. Though DCF has a previously established policy requiring such, they have ceased to do so, citing state and federal law. To fail to notify the appropriate jurisdiction where a crime occurred can prevent proper criminal investigation and prosecution of such crimes.

   The Unit recommends DCF develop policy to consistently require workers to send notice of finding to the appropriate district or county attorney and (if a potential crime occurred) to file a report with the law enforcement agency in the jurisdiction where the abuse occurred. Such notification should be documented in the case file. In the event that the abuse occurs out of state, a policy should be developed to minimally require a report to that state's child protection agency and obtain verification of whether that agency reported crimes to law enforcement. If legislative

amendment of pertinent statutes is required, this should be considered to ensure crimes against children are reported to law enforcement, fully investigated, and considered for prosecution.

6. **Sexual relations between caregivers and vulnerable populations**

   Of great concern is the safety of citizens who are dependent on others for their care. The ANE Unit continues to hear from constituents who worry about the well-being of their family members when they are dependent on others to meet their daily needs. A long-standing concern has involved the difficulty in prosecuting cases involving the sexual abuse of vulnerable adults due to questions regarding the vulnerable adult's ability to consent.

   The Unit recommends legislation which would legally prohibit caregivers in both residential and facility settings from engaging in sexual relations with their patients/clients, regardless of that person's ability to give consent. This may be effectively accomplished through modification of the Unlawful Sexual Relations statute. The Unit recognizes there may need to be an exception allowable for longstanding and marital relationships.

7. **Ineffective use of abuse registries to protect vulnerable children and adults**

   The Unit has identified a concern whereby substantiated perpetrators of abuse may still have the opportunity to obtain professional positions working with others who are in a vulnerable state due to a failure to cross-check similar registries maintained by other state agencies. This creates a gap allowing perpetrators to continue to obtain employment in some fields working with children or vulnerable adults.

   The Unit recommends agencies and facilities currently required to screen employees only via the Kansas Nurse Aid Registry be required to also check the DCF Central Registry of perpetrators of abuse, neglect and exploitation. Where consent of the employee is required, such should be a condition of employment.

8. **Failure of agencies to submit findings to the Unit in compliance with statutory requirement**

   K.S.A 75-723 requires agencies to submit their findings to the Unit within 10 days. Occasionally, lack of submission has been attributed to a training error. The Unit has found incidents where substantiated findings have never been submitted to the Unit as required.

   The Unit recommends agencies develop sufficient internal procedures to ensure compliance with statutory requirements. This should include regular training for both new and existing staff so that requirements are clear.

9. DCF's lack of compliance with timely findings

DCF policy requires investigations be completed and findings be issued within 30 working days, unless an exception meets specific criteria identified in policy. Policy also requires the reason for the delay to be identified in the narrative basis for finding. The Unit reviews many findings where this delay is not identified as required.

The Unit recommends DCF report the reasons for delay in issuing timely findings as required by policy. Where those reasons are allowable exceptions, the specific exemption should be clearly stated. Supervisors should ensure compliance upon review and approval of findings.

10. Failure to report by mandated reporters

The Unit has reviewed cases where there has been question of whether a mandated reporter failed to report abuse of a child or a vulnerable adult. Failure to do so is a class B misdemeanor, per K.S.A 38-2223(e)(1). The Unit is concerned in such cases that DCF has failed to ask any questions during their investigation in order to determine whether an individual is a mandated reporter who failed to report and/or has failed to notify law enforcement or the district or county attorney of this potential violation of law.

The Unit recommends implementation of policy requiring DCF workers to appropriately gather facts, secondary to their investigation, when there is involvement by a mandated reporter. When there is an indication the mandated reporter did not comply with law, DCF should provide notice to the district or county attorney separate from an abuse finding.

11. Failure to provide access to records and information within DCF

Exchange of information with DCF remains a significant challenge and is often an impediment to the Unit's mission. DCF has directed social workers not to respond to Unit inquiries directly and as such, the process the department has established for communications is cumbersome. This process often results in significant delay in the Unit receiving responses to inquiries and also frequently results in the Unit receiving incorrect or incomplete information. In addition, Central Office staff is no more successful in fulfilling these requests at quarterly meetings, which has resulted in many inquiries being repeatedly staffed at consecutive meetings for a year or more when personnel are unprepared for discussion. Furthermore, DCF has refused access to records the Unit believes should be provided in compliance with K.S.A 75-723, and in doing so, fails to be accountable by ensuring proper and thorough investigation of an abuse according to policy.

The Unit recommends DCF staff increase efficiency, accuracy and timeliness of response to all Unit inquiries and improve the transparency required by K.S.A. 75-723. Prompt, clear and complete response reduces the risk of children and adults remaining in dangerous and vulnerable positions.

Acknowledgements

In an effort to improve the overall response to vulnerable adults and children in Kansas, the ANE Unit works diligently to increase recognition, reporting and prosecution of cases involving abuse, neglect and exploitation. Since the Unit's creation by statutory mandate in 2006, this remains our mission.

During this reporting period, July 1, 2014 to June 30, 2015, the Unit received more than 1,800 reports. These reports were in the form of substantiated findings by state agencies and were also generated by constituent concerns. The Unit is staffed full-time by a Director and a Secretary III. In light of the extreme volume of reports received, we would like to acknowledge the assistance of the Kansas Department on Aging and Disability Services, Kansas Department of Health and Environment, Kansas Department for Children and Families personnel, as well as the district and county attorneys, their support staff, and local law enforcement agencies throughout the state, who routinely respond in a timely fashion to requests for information. The Unit is dependent upon their cooperation to effectively track actions and outcomes regarding reports received.

As we continue to strive to protect the welfare of our most vulnerable citizens, the value of collaborative working relationships cannot be underestimated.

K.S.A. 75-723
Chapter 75.—STATE DEPARTMENTS; PUBLIC OFFICERS AND EMPLOYEES
Article 7.—ATTORNEY GENERAL

75-723. Abuse, neglect and exploitation unit; confidentiality of investigations; reports forwarded to unit; report to legislature; rules and regulations; prohibition on use of funds; contracting. (a) There is hereby created in the office of the attorney general an abuse, neglect and exploitation of persons unit.

(b) Except as provided by subsection (h), the information obtained and the investigations conducted by the unit shall be confidential as required by state or federal law. Upon request of the unit, the unit shall have access to all records of reports, investigation documents and written reports of findings related to confirmed cases of abuse, neglect or exploitation of persons or cases in which there is reasonable suspicion to believe abuse, neglect or exploitation of persons has occurred which are received or generated by the Kansas department for children and families, Kansas department for aging and disability services or department of health and environment.

(c) Except for reports alleging only self-neglect, such state agency receiving reports of abuse, neglect or exploitation of persons shall forward to the unit:

(1) Within 10 days of confirmation, reports of findings concerning the confirmed abuse, neglect or exploitation of persons; and

(2) within 10 days of such denial, each report of an investigation in which such state agency was denied the opportunity or ability to conduct or complete a full investigation of abuse, neglect or exploitation of persons.

(d) On or before the first day of the regular legislative session each year, the unit shall submit to the legislature a written report of the unit's activities, investigations and findings for the preceding fiscal year.

(e) The attorney general shall adopt rules and regulations as deemed appropriate for the administration of this section.

(f) No state funds appropriated to support the provisions of the abuse, neglect or exploitation of persons unit and expended to contract with any third party shall be used by a third party to file any civil action against the state of Kansas or any agency of the state of Kansas. Nothing in this section shall prohibit the attorney general from initiating or participating in any civil action against any party.

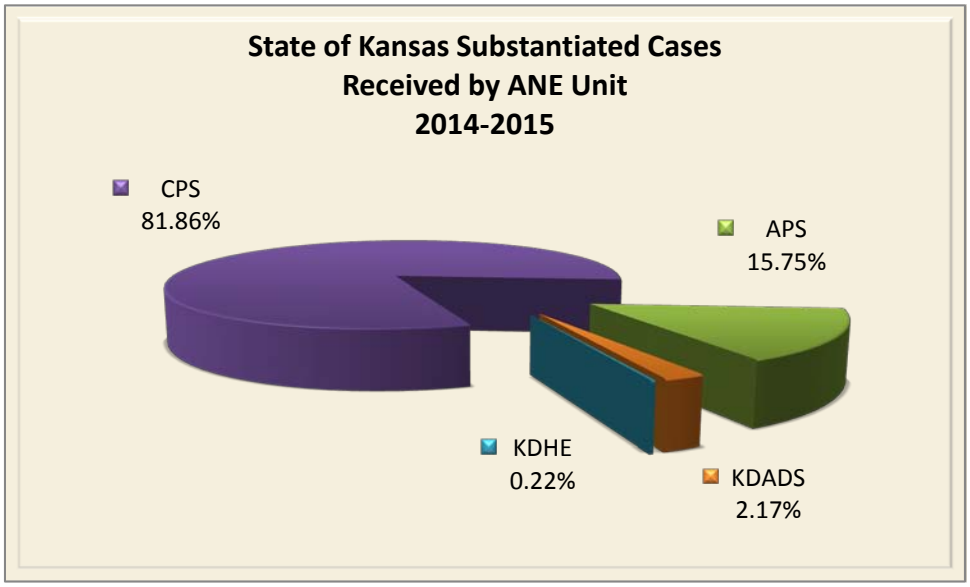
(g) The attorney general may contract with other agencies or organizations to provide services related to the investigation or litigation of findings related to abuse, neglect or exploitation of persons.

(h) Notwithstanding any other provision of law, nothing shall prohibit the attorney general or the unit from distributing or utilizing only that information obtained pursuant to a confirmed case of abuse, neglect or exploitation or cases in which there is reasonable suspicion to believe abuse, neglect or exploitation has occurred pursuant to this section with any third party contracted with by the attorney general to carry out the provisions of this section.

History: L. 2006, ch. 181, § 1; L. 2014, ch. 115, § 313; July 1.

Activities, Investigations and Findings

For the period July 1, 2014, to June 30, 2015, the ANE Unit received 1,797 reports of substantiated abuse, neglect or exploitation from the Kansas Department for Children and Families (DCF), Kansas Department on Aging and Disability Services (KDADS) and Kansas Department of Health and Environment (KDHE). The reports consisted of 1,471 from DCF Child Protective Services (CPS), 283 from DCF Adult Protective Services (APS), 39 from KDADS and 4 from KDHE.



DCF Child Protective Services (CPS) - Social workers, occasionally with the assistance of special investigators, investigate reports of child abuse, including physical injury, physical neglect, emotional injury or sexual acts inflicted upon a child. www.dcf.ks.gov

DCF Adult Protective Services (APS) - Social workers investigate reports and provide protective services to adults, with their consent, who reside in the community, adults residing in facilities licensed/certified by DCF, and to adults residing in adult care homes and other facilities licensed by KDADS when the alleged perpetrator is not a resident or employee of the facility. APS also investigates caregivers providing services to home and community based service (HCBS) clients. www.dcf.ks.gov

KDADS - Investigates reports of adult abuse, neglect and exploitation occurring in adult care homes (ACH). Examples: nursing home facilities, assisted living facilities, boarding care. www.kdads.ks.gov
In addition, the Aging and Disability Resource Center (ADRC) is now available and is a trusted source of information where people of all ages, abilities and income levels – and their caregivers – can go to obtain assistance in planning for their future long-term service and support needs. The ADRC website is found at http://kdads.ks.gov/commissions/commission-on-aging/aging-and-disability-resource-centers

KDHE - Investigates reports of adult abuse, neglect and exploitation occurring in medical facilities and non-long term care facilities. Examples: hospitals, ambulatory surgery centers, home health agencies, hospice, rural health clinics, outpatient physical therapy, portable x-ray units. www.kdheks.gov

In addition to the reports of substantiated abuse, the ANE Unit also received what have been classified as "other" reports. These are reports where investigations may have been originally denied or hindered and are generated by contacts from law enforcement, DCF, KDADS, KDHE, legislators or private citizens. The ANE Unit frequently receives complaints, concerns or questions from the public. For the period of July 1, 2014, to June 30, 2015, the ANE Unit received 23 "other" reports. Of the 23 "other" reports, 9 were child abuse related and 14 were adult abuse related. Reports of substantiated abuse combined with "other" reports accounted for a total of 1,480 reports of child abuse and 340 reports of adult abuse for a total of 1,820 reports reviewed. Reports may involve more than one victim and/or more than one perpetrator. Historically, the Unit has also received and counted corrective actions issued by KDHE. These do not rise to the level of a confirmed or substantiated finding. However, for this reporting year, the Unit did not receive any corrective actions. The Unit received or initiated more than 4100 contacts with other individuals or agencies in the form of calls, faxes, emails or other correspondence in an effort to carry out its mission.

More than 96% of the reports received by the ANE Unit originated either with DCF CPS or APS. Just over 1% came from various "other" sources, more than 2% came from KDADS, and less than 1% of the reports were from KDHE. (Figure A)

Child ANE comprised more than 80% of all reports received. The remaining reports were on vulnerable adults over age 18. (Figure B)

Figure A

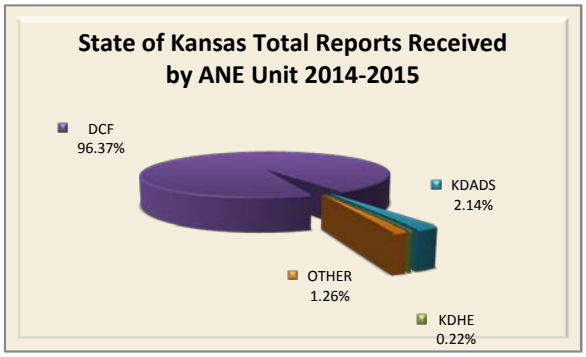
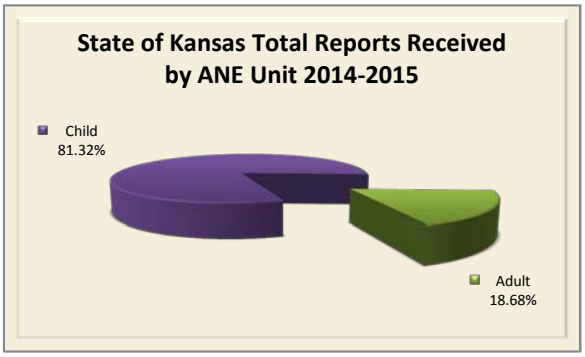


Figure B



In situations where unreported abuse is alleged, persons contacting the ANE Unit are encouraged to report directly to the proper investigative entity. When appropriate, referrals are made to the correct protection reporting center and to local law enforcement. Contacts such as these, where only simple referrals are made, are not assigned as "other" reports within the Unit.

Complaints and concerns are explored to determine whether a report was received by the appropriate agency and whether the investigation is progressing as expected or could be aided by intervention.

The ANE Unit regularly serves as a liaison, coordinating with local law enforcement, district and county attorneys, DCF, KDADS, KDHE and the general public as is possible within state and federal confidentiality restrictions. This exchange provides an important constituent service and oversight function. However, it is important to note that where concerns are found, the Unit has no authority to direct the actions of these agencies, nor is it empowered to impose any consequence or penalty for any agency's failure to act in accordance with established policy or the law. Nonetheless, the process allows for considerable insight into the functioning of each partner and often serves to educate the public as to the roles and responsibilities of each.

The ANE Unit consistently informs citizens that information obtained as a result of inquiries on their behalf cannot be shared with them, due to confidentiality restrictions. The follow up completed regarding their report does provide a source of collateral information and an outlet for their concern. The interaction and follow up information obtained also serves to help assess the impact of current policies and procedures on victims and their families.

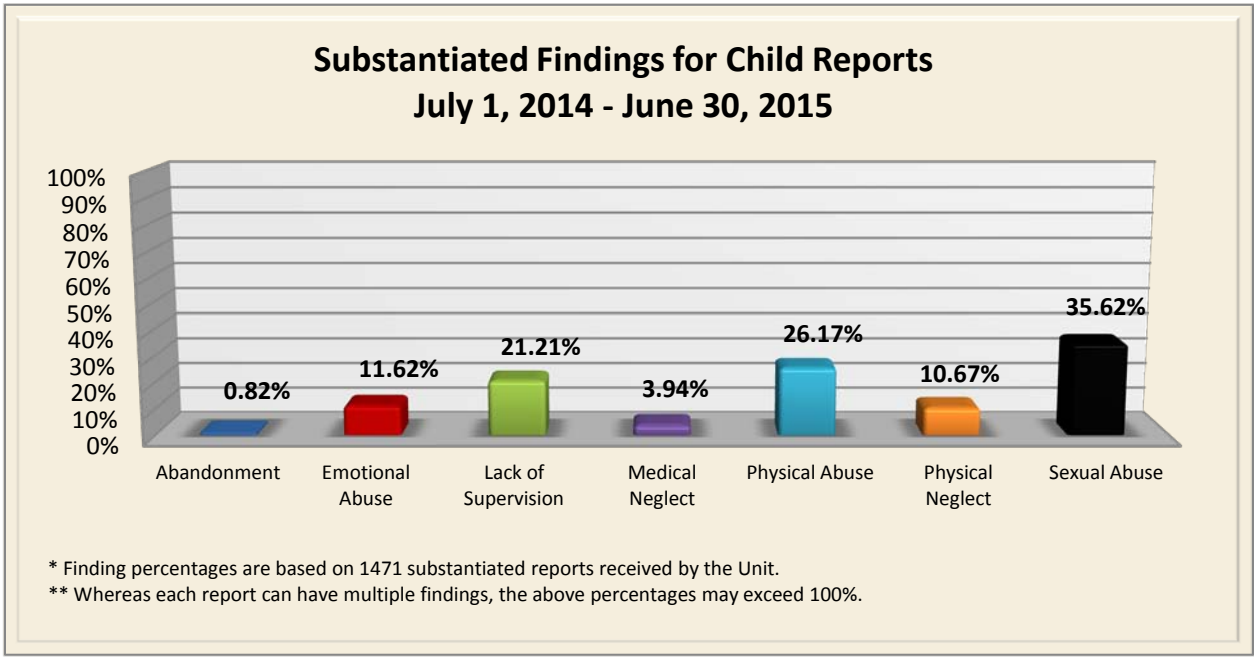
Ongoing discussions are held with state agency representatives to review policies, practices and procedures and to discuss system improvement and staff performance.

Progress toward establishing and maintaining working relationships and developing consistent reporting to meet statutory requirements continues. The ANE Unit would not be serving the citizens of Kansas should it simply serve as a rubber stamp for work already completed. Our inquiries reveal that there remains a need for system improvement and for the continued education and skill development of individuals who work within it. At the same time, it is important to clearly state that the majority of cases reviewed were handled within an expected range of outcomes.

The ANE Unit is dependent upon the information supplied by cooperating agencies as data is collected to meet the statutory requirements of this unit. We continue to identify and refine variables for reporting, especially as we continue to see an increase in reports received – something the Unit expects to see a significant jump in at the conclusion of the 2016 fiscal year – and will discuss in detail later in this report. We strive to cultivate positive working relationships with community agencies and we express gratitude to those who, in addition to their daily duties, take time out of their schedules to answer inquiries and provide information on outcomes. We recognize each piece of the wheel serves a different function while maintaining a common goal: the protection and safety of children and vulnerable adults. Though we may identify gaps in service and a need for system improvement, it is only through communication and collaboration that we can all focus on keeping Kansas families safe.

This report provides case examples to illustrate some areas of concern identified by the Unit during this reporting year and is not intended to be an all-inclusive list of every such case identified.

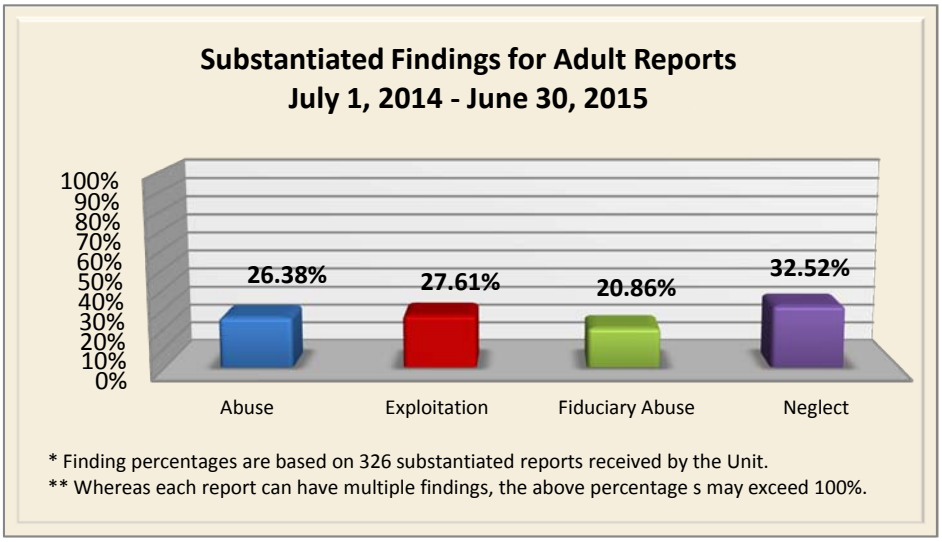
Findings recorded for the 1,471 substantiated reports of child abuse include: abandonment, emotional abuse, lack of supervision, medical neglect, physical abuse, physical neglect and sexual abuse. Some reports contained substantiations of more than one type of abuse or may have involved multiple victims or perpetrators. Sexual abuse continues to be the most frequently substantiated form of abuse.



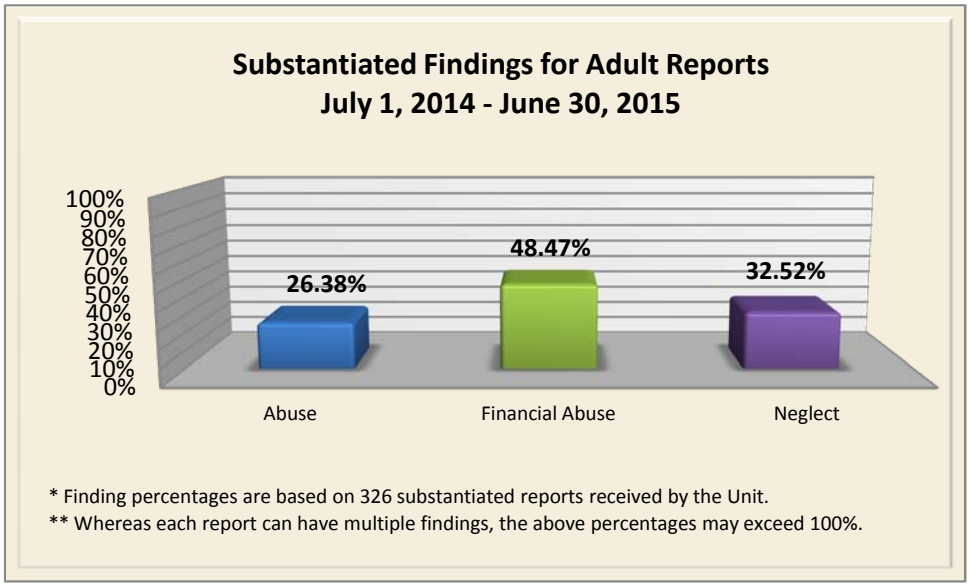
Compared to last year's findings, when 1,441 substantiated reports were received, the following variances are noted:

Abandonment	decreased 0.36%
Emotional Abuse	increased 1.56%
Lack of Supervision	increased 0.11%
Medical Neglect	increased 0.96%
Physical Abuse	increased 0.35%
Physical Neglect	decreased 0.92%
Sexual Abuse	decreased 1.92%

Findings recorded for the 326 substantiated reports of adult abuse include the following types: abuse, exploitation, fiduciary abuse and neglect. Some reports contained substantiations of more than one type of abuse or may have involved multiple victims or perpetrators. Nearly all the exploitation reports were related to financial exploitation. Fiduciary abuse is another type of financial abuse. It is distinguished by the perpetrator being a person who stands in a position of trust, very often someone given power of attorney.



By combining both financial exploitation and fiduciary abuse, the most frequently confirmed type of abuse was financial abuse of vulnerable adults, most often seniors. Compared to the 2013-2014 reporting year, when 422 substantiated reports of adult abuse were received, abuse findings increased 3.16%, while exploitation decreased 6.04% and fiduciary abuse decreased 5.44%. Neglect findings increased 2.64%.



The following are examples of investigations with which the ANE Unit became involved to facilitate further action or affect changes in outcome:

Lack of Internal/External Agency Communication and Safeguards

In numerous cases the ANE Unit obtained and facilitated delivery of information that was needed by DCF, KDADS, KDHE, local law enforcement, or county or district attorneys to assure that the case received full consideration. In some cases, it was evident a breakdown occurred while information transferred from one agency to another, while in other cases, reports were found to be stalled within an individual agency. Unit inquiry brought these cases back to the attention of persons who were able to take additional action which, in some cases, furthered investigations toward completion, if not prosecution.

In support:

- In Douglas County, a mother was substantiated for lack of supervision of her two children, while her partner was substantiated for physical abuse of those children. It was alleged the mother's partner hit the children about the face, mouth and bottom with his hands and with an object. The investigating social worker observed bruising to the children. In follow up with Douglas County District Attorney staff in May 2015, the Unit was advised the office had no record of receiving the police report for this investigation, or any other investigation connected to the named parties.

  When the Unit followed up with Lawrence Police Department as to the status of the investigation, law enforcement reported the assigned officer was out of the office, but that he appeared to have completed a report alleging Abuse of a Child. The supervising officer indicated he would follow up with records staff as soon as possible to forward a report. Upon further follow up, the supervising officer then notified the Unit that the reporting officer had not completed an affidavit and would do so upon his return to the office. The following week, the reporting officer notified the Unit he had not completed an affidavit as he had previously determined the offense occurred in the county and outside of his jurisdiction. As such, he had forwarded his case to the Douglas County Sheriff's Office. In June 2015, the Unit contacted the assigned detective within the Douglas County Sheriff's Office. As a result of Unit inquiry, the detective discovered a charging affidavit had not been submitted to the district attorney's office. He indicated intent to do so and offered to notify the Unit when the process was completed. In August 2015, as a result of further follow up, the Unit was advised the case had been completed and submitted to the district attorney's office.

- In Ford County, a step-parent was substantiated in two DCF investigations for the sexual abuse of a child. While reviewing actions and outcomes of criminal cases, the Unit discovered that according to online records, two criminal cases had been filed and dismissed. The Unit contacted the county attorney's office to verify information and alerted staff, who indicated only one of the cases should have been dismissed and concluded there was a

clerical error in the second. Unit inquiry allowed county attorney staff to contact the clerk of the district court and correct the record. The Unit also verified that this error did not result in the release of the alleged perpetrator from custody.

- In Logan County, a Certified Nurse Aide (CNA) at a nursing facility was substantiated by KDADS during a previous reporting period for the abuse and neglect of a resident when it was alleged the CNA taped the resident's hand to the bar of a bath chair when the resident failed to stop scratching herself. Though the KDADS finding noted the incident was reported to law enforcement, when the Unit inquired of the responding officer, he indicated he believed it was forwarded for prosecution, but could not remember. The Unit subsequently inquired of the county attorney, who found no record of receiving a report in this matter. As a result, the county attorney requested a copy of the report from law enforcement and the CNA was later charged with one count of Mistreatment of a Dependent Adult.

- In Montgomery County, a 4-week-old child was substantiated as the victim of physical abuse at the hands of an unknown perpetrator after he sustained a spiral fracture to the femur. This occurred during a previous reporting year. When the Unit further researched outcomes in 2014, county attorney's office staff reported a criminal case had been submitted to their office naming the parents as suspects. Staff reported criminal charges had been declined; however records indicated the Kansas Bureau of Investigation (KBI) had sent the report back the local police department requesting additional information. The office had no indication the requested information was ever received.

  The Unit subsequently requested and reviewed the Coffeyville Police Department report, which indicated polygraphs administered to the child's mother and to his babysitter showed deception. The report noted that the KBI special agent declined to administer a polygraph to the child's father as the babysitter subsequently admitted to causing the injury to the child. The Unit contacted a detective at the police department regarding any request for follow up from the county attorney's office. As a result, the detective searched and subsequently found a request for additional information which had been previously received from the county attorney's office. He followed up with the Unit to explain that although the county attorney reported the office was awaiting polygraph reports, police department records indicated requested information had been submitted to the county attorney's office in February 2012 and again in March 2012. Though he could not explain why they were never received, he indicated he would facilitate a resubmission of the records to the office.

  In light of the evidence documented in the police report regarding the confession of an alleged perpetrator who was not even named within the DCF narrative as a suspect in the original investigation, the Unit contacted DCF regarding amendment of their finding to name a perpetrator based on the police report and therefore place the alleged perpetrator on the child abuse registry. Between December 2014 and February 2015, the Unit had no less than 14 contacts with various individuals and agencies in effort to facilitate exchange of the police

report between law enforcement and DCF. DCF eventually confirmed receipt of the police report on January 28, but did not amend their finding and place the perpetrator on the registry until June 12. The department did not explain the additional delay in amending their finding.

Since the end of this reporting period, the Unit again inquired about the charging status with the county attorney. The county attorney indicated that it did not appear his office had reviewed the file since the original declination. He also reported no record of receiving the substantiation from DCF. He advised the Unit he would pull their file to determine whether additional records had been received and would attempt to review the matter promptly.

- In Montgomery County, a mother's boyfriend was substantiated for lack of supervision of her 1-year-old and 3-year-old children after the children were found alone in their apartment, in the middle of the night, by law enforcement which responded to a welfare check. When researching agency response, the Unit contacted the county attorney's office and was advised by support staff that the office had no record of receiving a police report from Coffeyville Police Department. The Unit followed up with law enforcement in April 2015 and the Chief of Police reported the agency's records reflected the report was sent to the county attorney's office on August 15, 2014, and supplemental reports followed on August 18. The Unit contacted the county attorney's office again. The Assistant County Attorney (ACA) handling Child in Need of Care (CINC) cases referred the Unit to the county attorney after advising she only had information pertaining to the CINC case. She advised she would submit her copy of the police report to the county attorney. When the Unit subsequently attempted contact with the county attorney on the same date, support staff then indicated they had in fact received the report. Support staff also advised they would print the report and provide such to the county attorney for review. Five days later, the same support staff contacted the Unit and indicated the case was ready to be filed. The alleged perpetrator was subsequently charged with Aggravated Endangering a Child and Interference with a Law Enforcement Officer.

- In Leavenworth County, a mother was substantiated for lack of supervision of her children after it was reported she was found passed out in her vehicle on the side of the road, while her children were passengers in the car. This DCF finding was issued during a previous reporting year. When the Unit initially inquired with the county attorney's office as to a charging status, support staff in the office indicated they had not proceeded with charges as the mother had pending actions in other counties. When the Unit followed up again with the county attorney's office during this reporting period, the office was aware of disposition in one jurisdiction, but not the other. The Unit was able to provide the county attorney's office with disposition information from the second jurisdiction, upon which the office indicated their case would be filed. The alleged perpetrator was subsequently convicted on counts related to this finding in Leavenworth County.

- In Butler County, a brother was substantiated for fiduciary abuse of an involved adult (IA). APS found the alleged perpetrator, who was an authorized signer on his brother's bank account, was failing to consistently make payments to the nursing facility in which his brother lived. In addition, APS found a sum of money debited from the IA's account, for which the alleged perpetrator could not account and which appeared to be used for expenses other than those belonging to the IA. While reviewing actions and outcomes of this finding during this reporting period, the Unit made multiple inquiries to Andover Police Department regarding status or outcome of any criminal investigation. The Unit finally reached a detective and learned that the detective originally assigned to the case was no longer with the department. The detective reported their records showed the case was closed, but she was not comfortable with that disposition as there was no information to indicate why it was closed. Additionally, she had concern based on the history of the facility in unrelated reports. The detective indicated intent to request and review bank records as well as to interview the IA, in order to resolve the case to her satisfaction. Upon interviewing the IA, who declined to press charges and indicated the funds had been repaid, and upon confirming the alleged perpetrator was no longer DPOA and had no access to the IA's funds, the detective completed her investigation and closed the case without forwarding for prosecution. Unit intervention appeared to bring this case back to the attention of law enforcement who further investigated the case to ensure a complete and thorough review of the report.

- In Ellis County, an adult was substantiated for the sexual abuse of an unrelated 8-year-old child. The abuse was reported to have occurred when she was 4 years old. In researching actions and outcomes, the Unit learned the investigation originated in Barton County, where the child resided at the time of the report, but law enforcement in that jurisdiction forwarded their findings to the appropriate agency in Ellis County when they determined the abuse occurred in that location. The Unit contacted the investigating officer in Hays who reported he was in the process of finalizing his report to submit to the county attorney. The Unit advised the investigator that online records indicated the alleged perpetrator, who was incarcerated in another matter, was due to be released from custody the following month. The Unit further followed up multiple times with personnel at the county attorney's office, who pulled the report to ensure the matter had a timely review.

- In Sedgwick County, a step-father was substantiated in 2012 for the sexual abuse of a child. Upon review of the DCF finding, the narrative noted law enforcement and the assigned social worker made multiple attempts to interview the step-father, but were never able to locate him for an interview. Upon initial review of this finding, the Unit's research revealed the step-father had appeared in court in another matter in the month prior to this finding being issued. Furthermore, online records indicated he was on probation in at least two criminal cases and had a third pending at that time. The Unit contacted law enforcement to ensure they were aware of the step-father's whereabouts and that they were able to complete an interview for this investigation. In the interim, law enforcement reported they located the step-father and planned to work through his attorney to attempt an interview before submitting the case to the

district attorney the following week. Due to the volume of reports the Unit receives requiring review, as well as staff turnover, the Unit was unable to verify the outcome of this report at that time. When the Unit contacted the assigned detective during this reporting period, after the district attorney's office denied receipt of an investigation, the detective reported that because he was originally unable to locate the step-father, he lost track of the investigation. As a result of the Unit's recent inquiry, the detective searched and determined the step-father was currently incarcerated and due to be released soon. He indicated a desire to work with facility staff to schedule an interview with the alleged perpetrator prior to his release. The Unit's contact prompted the investigation to be completed and submitted to the district attorney for review.

- In Butler County, a son who was the durable power of attorney (DPOA) for his mother was substantiated in a previous reporting year for fiduciary abuse. APS determined that while the IA was hospitalized and later residing in a care facility, her son failed to pay her nursing home obligation, as well as bank loans his mother had taken out. In addition, there were multiple transfers and withdrawals from her account which were not expenses to meet her needs. The Unit left messages for the investigating law enforcement officer with Andover Police Department to inquire as to status of a criminal investigation, but no response was received. During this reporting year, the Unit again contacted law enforcement to determine outcome of this investigation. At that time, the investigator originally assigned to the case reported he had been unable to interview the son because he had left the state. Though records submitted to the Unit indicated notice of substantiation had been sent to law enforcement at the time of finding, the investigator denied ever receiving such from APS and indicated any interview the social worker may have completed with the alleged perpetrator would be useful for his investigation. The investigator advised the Unit he would contact APS to request a copy of their investigation and if there was sufficient evidence, he would complete a charging affidavit for the county attorney to review. The Unit has contacted the investigator again in March, April, June and August 2015. Messages were left which have not been returned. The Unit has attempted additional contacts with alternate personnel since that time and has been assured messages have been left for the investigator. The Unit continues to monitor outcomes in this matter.

- In Johnson County, an adoptive parent was substantiated for the sexual abuse of a child during a previous reporting period. The adoptive parent was subsequently charged with rape, but the case was dismissed. When the Unit inquired with the district attorney's office, the prosecutor handling the case reported the child was in therapy and that she planned to refile the case when the child was better prepared to testify. As a result of Unit inquiry, she reported initiating contact with the child's mother to verify the child's status and planned to continue to monitor progress. Likewise, the Unit continues to monitor outcomes in this case as of the writing of this report.

- In Montgomery County, parents were substantiated for physical neglect of their children after law enforcement responded to the home and determined the conditions to be unsafe. The initial report was for physical abuse, lack of supervision and sexual abuse. The Unit followed up with law enforcement regarding outcomes and brought the case back to the attention of the assigned officer so an investigation could be completed. In doing so, the officer also indicated he had been unaware DCF had completed and closed their investigation with a substantiated finding. In addition, he reported he had requested DCF records, as well as a second forensic interview with the alleged victim of sexual abuse, but indicated neither request had been met. When the Unit contacted DCF to follow up on this and to verify additional information, DCF staff reported only that the finding "was handed" to the assigned officer and they denied any further contact. When the Unit last inquired of law enforcement regarding status, the assigned officer reported gaining additional evidence through search warrant, but the case remained active and ongoing.

- In Dickinson County, a man was substantiated for the sexual abuse of two children. In August 2014, the Unit began inquiry into the status of any criminal proceedings with the county attorney's office. Support staff in that office initially advised the Unit their records did not reflect receipt of any case for review. The Unit then contacted Abilene Police Department, where a supervising officer reported an assistant county attorney signed for the report in April 2014. Throughout 2015, the Unit made multiple follow up inquiries to the county attorney's office, where it was consistently reported the case was under review. The Unit was unable to speak with a prosecuting attorney until September 2015, when the attorney reported she was awaiting a new probable cause affidavit, as none had been received, despite law enforcement previously reporting one had been sent. The Unit continues to monitor outcomes in this matter.

- In Crawford County, a mother was substantiated for the physical abuse of her 15-year-old child during a previous reporting year after it was alleged the child's mother spit on her, grabbed her by the hair, hit, kicked and attempted to strangle her. The child was observed with scratches and abrasions, while no injuries were observed to the mother. When the Unit inquired as to charging status after initially receiving the finding, the county attorney's office reported the case had been received to review for CINC only and no criminal case had been forwarded. The Unit requested and reviewed the police report, which contained an allegation of Battery. As a result of Unit contact, support staff in the office pulled the file and indicated the county attorney would be requested to review the matter for criminal charges. This was confirmed with the county attorney who reported the matter was not entered in their office as a criminal case, but would be processed as such and subsequently reviewed. Due to caseload volume, the matter was not reviewed again by the Unit until this reporting year. Upon further contact with the county attorney's office, the Unit learned a charging decision had never been made. As a result of continued contact, the case was ultimately further reviewed for a charging decision.

- In Barton County, a mother's boyfriend was substantiated for the sexual abuse of her child. The DCF narrative basis indicated the report was assigned for investigation within the department in January 2013, yet the finding was not made until May 2014, significantly outside the 30-day timeframe allowed in statute. In explaining the delay, DCF wrote such was "due to waiting for law enforcement reports and interview with (the alleged perpetrator)." The department wrote that the alleged perpetrator was not located by law enforcement or DCF and he did not respond to letters sent to him by mail.

  Upon review of this finding, the Unit contacted law enforcement in November 2014, where the investigating detective indicated she had been unable to locate the alleged perpetrator for an interview. She reported she would like to complete her investigation, but had exhausted her options to locate him. The Unit researched available records online and learned the alleged perpetrator had been arrested on another matter in February 2014. He subsequently made a court appearance in May 2014, where he was sentenced to probation and then incarcerated in July 2014 after violating that probation. The Unit advised the detective of the alleged perpetrator's location at Larned and she indicated intent to arrange an interview.

  The Unit inquired with the detective three more times in March, April and June 2015, upon which the detective reported she still had not interviewed the alleged perpetrator and his location was once again unknown. The Unit searched the Department of Corrections website for an update and learned that in the interim, the alleged perpetrator had been moved twice more to different facilities. The detective was contacted again to share this information and messages were left for her in June, July, August and October 2015 with no further response. On two of those occasions, the messages advised her of a newly reported location within the Department of Corrections. As of the writing of this report, an additional call was made to the detective. She once again reported she was unable to locate the alleged perpetrator and he was not on probation supervision. The Unit advised her that according to the Department of Corrections website, he has been in custody since the summer of 2014 and is currently housed at Ellsworth Correctional facility, with an earliest possible release date of May 2016. The detective has once again indicated intent to arrange a courtesy interview at the facility in order to complete her investigation. The Unit continues to monitor this investigation for outcomes.

Failure to Issue Findings

While reviewing findings in some cases, Unit inquiry to DCF resulted in substantiated findings being issued in investigations which were previously unsubstantiated or where certain victims or perpetrators failed to be added to existing investigations.

In support:

- In Harvey County, a grandmother was substantiated for lack of supervision of her 1-year-old grandson after it was alleged the boy and his 3-year-old cousin microwaved foil packing and got into chemicals while the grandmother was sleeping. The children's grandmother admitted she woke up to smell something burning and asked the 3-year-old about it, but when the child did not answer her, she fell back to sleep. The children then proceeded to the second floor of the home, where they opened a bottle of bleach and a bottle of Pine Sol and poured both onto the floor. The Unit only received a substantiated finding pertaining to the 1-year-old and not the 3-year-old and therefore, inquired of DCF.

  The department originally responded that they did not substantiate the 3-year-old as an alleged victim because there was no harm and she was not injured. It should be noted PPM 0160 defines "lack of supervision" as follows:

  > *Acts or omissions by a parent, guardian, or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. This term may include the following, but shall not be limited to: failure to provide adequate supervision of a child or to remove a child from a situation which requires judgment or actions beyond the child's level of maturity, physical condition or mental abilities and that results in bodily injury or a likelihood of harm to the child. K.S.A 38-2202.*

  In their response, DCF quoted policy questions used to determine a substantiated finding. The department provided answers to those questions which appeared to support substantiation, including indicating a likelihood of harm to the children through potential for fire, potential for burns to the children and the potential for poisoning due to accessing cleaning chemicals. They also concluded the children were too young to have adequate self-care skills for the situation and they were left in a situation requiring judgments or actions beyond the children's level of maturity, physical condition or mental abilities. Furthermore, while the social worker was in the home interviewing the alleged perpetrator, the worker observed medication bottles on the stove within the reach of a child present in the home and had to redirect that child away from the microwave when the grandmother was not paying attention.

Direct supervisors, region supervisors and Central Office staff were copied on DCF's initial response and offered no intervention or correction to the outcome. As a result, the Unit forwarded the matter again to Central Office staff and expressed concern at the inconsistent application of policy in finding the same facts were present to meet the clear and convincing standard with regard to one child, but not the other, especially in light of the worker's answers to the questions quoted which appeared, more often than not, to support substantiation. One week later, the Unit received a second finding naming the 3-year-old as a substantiated victim.

Lack of Effective Monitoring by DCF Contractors to Ensure Care and Safety of Children

The Unit continues to see reports where concerns arise for the level of monitoring and supervision given to children who are receiving services through DCF contractors, whether due to placement in foster care, or when receiving services in the home, sometimes while in DCF custody. When necessary, such concerns are tasked to DCF to review for appropriate action and response.

In support:

- In Franklin County, a finding was issued in 2013 concerning lack of supervision of two children by their father. At the time the report was assigned for investigation in July 2013, the children were placed in the home, but had been in state custody since 2011. Though the conditions of the home were cited as contributing to their removal, DCF reported a physical neglect allegation was not added because it was not seen as an ongoing issue and KVC Behavioral Healthcare services were in place in the home to address the conditions. DCF reported KVC workers should have been in the home monthly while providing aftercare services, but DCF files did not contain records of those dates. The children were removed from the home in August 2013.

  The Unit received a second finding on these children in July 2014. In this event, both parents were substantiated for lack of supervision and physical neglect. DCF reported the family had been receiving services "non-stop" since September 2011. After being removed in August 2013 as a result of the previous finding, the children were returned home in October 2013 and remained in DCF custody with KVC services in place. DCF indicated KVC reported their workers were not allowed in the home unless a visit was scheduled in advance. A review of KVC logs contained in the DCF file reflected KVC was last in the home the week before this second report was received by DCF. The DCF finding described the home as having living conditions which were "atrocious with multiple safety hazards, including broken glass on the floor and food smeared all over." On the day law enforcement and DCF were in the home, one of the children had cut himself on this broken glass. DCF documented deplorable conditions which included piles of clothes on the floor and furniture, moldy food on the table and floor, prescription medication on the floor, a hole in the kitchen floor the size of an adult foot, a hole in the wall the size of a fist, dirty dishes stacked on the counter and stove, trash

on the floors and overflowing the trash cans and cupboards and a refrigerator without any food. The bathroom was described as filthy. The children's bedroom was reported to have a floor covered in trash, toys and clothes, with dried paint on the walls, on the curtains and on the floor and a used potty chair also on the floor. The Unit reviewed photos taken by both DCF and law enforcement which documented deplorable conditions that did not occur overnight. Yet, the notes from the KVC worker, who was in the home the previous week, made no mention of the conditions in the home at all, either good or bad. This second report originated because the children were observed to be walking down the street alone and "poorly dressed" and not because of a new report made by the KVC staff responsible for monitoring the home.

This concern was highlighted in the report produced by the Unit last year. The matter continued to be staffed with DCF Central Office at quarterly meetings throughout this reporting year – in October 2014, January 2015 and April 2015. In April, DCF reported the matter had been reviewed by the department's Deputy Director of Foster Care and was being addressed with the region contractor. However, when asked, DCF could not indicate with which specific concern the department concurred or the manner in which it was being addressed.

DCF's Failure to Respond Effectively in Child Abuse Investigations

The Unit routinely attempts to engage DCF region staff, as well as Central Office, in discussion to examine the department's response to investigations – especially where such appears contradictory to policy and/or best practice – and ways in which responses can be improved in order to better protect children and vulnerable adults.

In support:

- In Shawnee County, a step-father was substantiated for physical abuse of a child. It was alleged he pushed, slapped, choked and threw the child into the couch, then attempted to hit her in the face with a belt. Though DCF noted the child was reported to have a bloody lip, the child was not observed with injury as she was not interviewed by DCF until almost three weeks after the incident. Police were never notified, the safety of the child was not verified timely and any opportunity to observe injury was lost.

  This investigation was highlighted in the Unit's report last year due to a concern that this physical abuse was a criminal act which was not reported to law enforcement for investigation and possible prosecution. The concern continued to be raised with DCF Central Office at quarterly meetings throughout this reporting year – in October 2014, January 2015 and April 2015. The department finally responded in April of this year. While DCF Central Office staff do not waver in the opinion that policy does not require the department to report to law enforcement in cases such as this (in fact, staff stated it was the school's responsibility

to call) the department did concur the worker erred in not responding to the home and that the reported issue would be addressed with supervisors through coaching and mentoring.

- In Johnson County, a facility staff person was substantiated for the physical abuse of a child after it was reported the staff person grabbed the child, backed him into a corner, put his forearm under the child's chin and was strangling him. A nurse on staff found the child to have bruising to his arms and legs with a red area on his upper back. The DCF finding did not indicate other witnesses were interviewed. The finding reported this alleged perpetrator "has had prior incidents where this has occurred in other facilities", including a 2008 incident where, while working in what is only identified as a KVC facility, he "put (a) kid in a hold." After multiple inquiries by the Unit, DCF reported this facility was not a licensed KDADS or KDHE facility but did not identify its nature more clearly. Further, DCF denied investigating the previously-referenced 2008 incident and reported neither the facility nor DCF reported this current possible crime to law enforcement. The Unit requested and reviewed the DCF file and noted the department identified the facility as a Psychiatric Residential Treatment Facility (PRTF) facility licensed by KDADS and did notify a representative of the agency of the report. However, notice of finding did not appear to be sent to KDADS as is required in policy, per PPM 2544 C.

  This investigation was also highlighted in last year's annual report, categorized separately as concerns both due to failure to report possible crimes to law enforcement and due to difficulties in communications with DCF while attempting to receive information. Last year's report identified additional questions and concerns the Unit found and which DCF had, up until the writing of that report, failed to answer. Those concerns included:

  - DCF's initial denial the involved facility was a licensed one, contradicted in their file which reflects the facility is a PRTF licensed by KDADS. DCF has failed to address whether they sent notice of finding to KDADS as is required in policy, though KDADS staff has denied receipt of such notice.
  - DCF's apparent failure to follow up on a report that the same alleged perpetrator in this case may have committed similar behavior against another child while working at an unspecified KVC facility in 2008.
  - Failure of DCF to view and/or secure a copy of an available video recording of the incident by the facility; the existence of which is not noted in their basis for finding, but is reflected in the investigative file.
  - DCF's apparent failure to conduct interviews of witnesses present during the incident or to cite any portion of statements those witnesses gave to the facility in their narrative basis for finding.

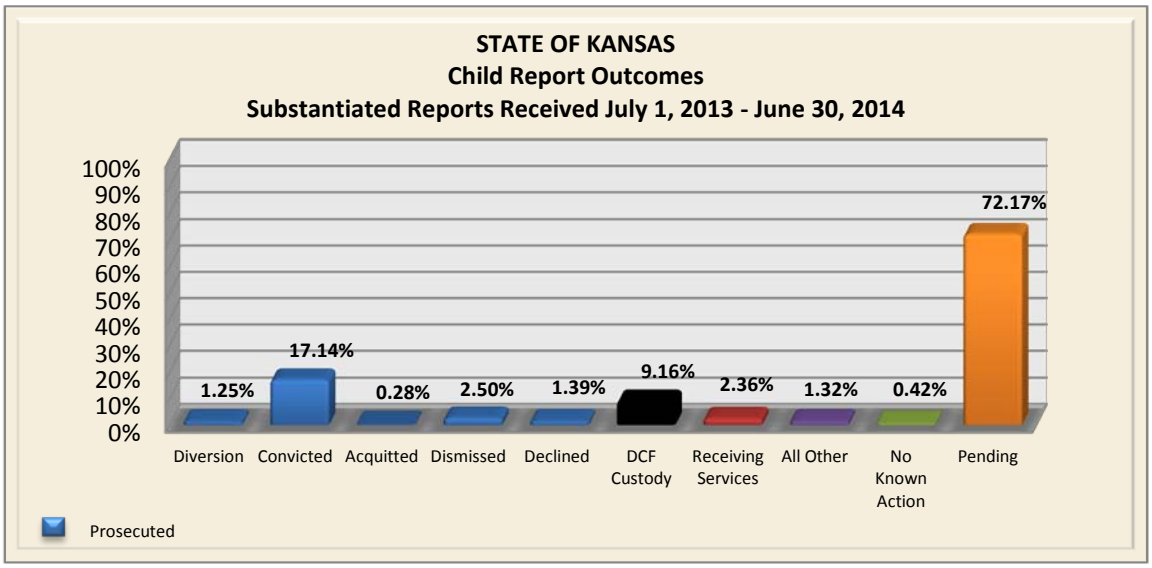
  The Unit escalated these concerns from region staff to Central Office by raising this matter at the quarterly meetings beginning in June 2014 and continuing through October 2014, January 2015 and April 2015 meetings. Ultimately, DCF did acknowledge the PRTF was a facility

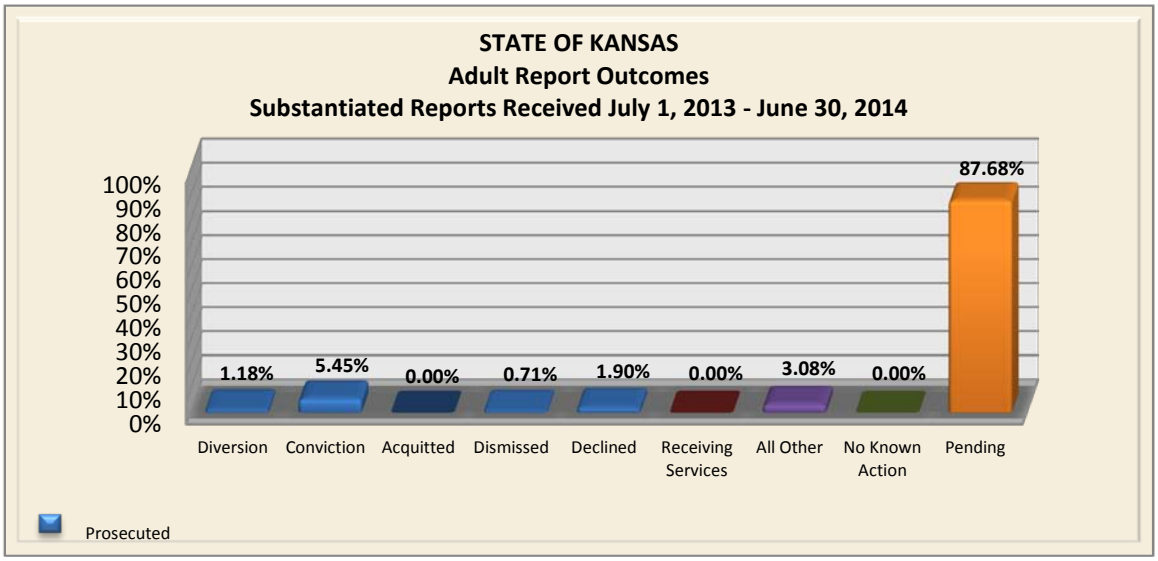
licensed by KDADS and as such, a notice of finding should have been sent to KDADS, an error which they subsequently reported correcting. The Unit remains concerned the region denied this was required when initially asked by the Unit and that this error took the department a year of repeated inquiries to correct, despite the facility being appropriately identified in the department's own file at the outset of their investigation. Central Office staff again maintain there is no requirement in policy to report to law enforcement and in fact, reported to the Unit that while it was "not the social worker's job" to notify law enforcement of crimes, they do notify law enforcement "where they believe law enforcement should file charges" and noted the PRTF facility also could have called law enforcement and did not.

Collaboration with Other AG Divisions for Investigation/Prosecution

While receiving and reviewing substantiated findings as well as concerns from constituents, ANE Unit involvement resulted in identification of certain cases which were not being actively investigated or prosecuted. When such cases met the requisite criteria for the Attorney General's Office to become involved, the Unit was able to refer these matters to the appropriate division within the Office of the Attorney General. The Unit continues to receive referrals from other divisions or requests for assistance as well.

While the bulk of reports come into the ANE Unit from substantiated finding reports by the investigating agency, those situations where a finding has not been made or where the case may still need further investigation create the majority of the work. It is a labor-intensive process to clarify and confirm facts of the investigations in order for the Unit to proceed with its mission, even in cases where investigations appeared to proceed as would be expected. In those cases where the Unit identifies clear concern for the systemic response, especially in complicated investigations, reviews may require significant personnel hours in order to reach a closure disposition. Original findings are recorded and cases are tracked for outcomes. Disposition information is primarily obtained through direct contact with the agencies, prosecutors' offices and through online court information. 22.55% of child cases from the previous fiscal year are known to have been reviewed for prosecution at this time, while 8.82% of adult cases from the previous fiscal year are known to have been reviewed for prosecution at this time.





Concerns and Recommendations

Lack of Effective Monitoring by DCF Contractors to Ensure Care and Safety of Children

The Unit has become increasingly aware of findings being issued for children who are already in state custody and whom are either in foster care or being monitored in their home. In all cases highlighted here, the Unit has developed concerns about the level of monitoring happening in these homes by the assigned DCF contracting agencies. The Unit believes in many cases, if the level of monitoring was appropriate, the conditions would be resolved or the children would be removed from homes before the conditions deteriorated so severely that new DCF investigations and findings are generated.

In support:

- In Sedgwick County, DCF received a report of physical neglect and lack of supervision of a 4-year-old child after it was alleged the mother left the child home alone while she ran errands. The report stated when law enforcement was called to the home, "the home was found in deplorable condition, with health hazards present. There was no food in the home." According to DCF, St. Francis Community Services (SFCS) Family Preservation Services were in place in the home due to a report of physical neglect and medical neglect the previous year. Despite one family member advising the DCF worker that law enforcement placed the child in Police Protective Custody (PPC) due to the home's conditions, and that this family member witnessed "rotten food everywhere, food containers with bugs in them and no food or access to water", DCF unsubstantiated the mother for physical neglect.

  Based on review of the DCF narrative basis for finding, this unsubstantiated finding appears to be solely justified by the SFCS contention that five days prior to this report, when SFCS was last in the home, the home was "appropriate", with only a "messy" bathroom and no indication the home was unsafe. Upon inquiry by the Unit, DCF confirmed the investigating social worker did not speak to law enforcement, did not recall whether she had reviewed photos taken of the home by law enforcement, and when asked to provide a copy of the police report or photos, if such were contained in the DCF file, the department only responded by providing the police report number. The Unit subsequently requested and reviewed the police report and photos from the law enforcement agency, which did support the observations, noted by the family member and did reflect what could be considered "deplorable" home conditions.

  The Unit has questions as to whether the home could deteriorate to such a state in the five days since SFCS was in the home, as well as concerns regarding the quality and completeness of the abuse investigation completed by DCF. As of the writing of this report, the Unit has provided DCF with copies of the photos taken by law enforcement and requested a review of the finding outcomes in this investigation. We await further response from the department.

- In Shawnee County a child was substantiated as the victim of sexual abuse while in a respite placement for foster care. The substantiated perpetrator was an 11-year-old juvenile who did not reside in the home. The narrative basis for finding completed by DCF also indicated that the social worker conducting the investigation was informed by law enforcement "there were five previous sexual abuse investigations in (the foster home);" however, further explanation or outcome of that statement was not provided. As a result, the Unit began inquiry to determine the DCF response to that statement, whether there were any previous investigations by DCF, and whether there were or should have been compliance concerns on the part of KDHE. Inquiries have been ongoing, both with DCF and KDHE, since April 2015 and information received has been incomplete, inconsistent and unclear. As of the writing of this report, the Unit's examination of this investigation, as well as the home's history, continues.

- In Shawnee County, parents and a grandparent were substantiated in July 2013 for lack of supervision and physical neglect of a child. The child was removed from the home by law enforcement after a parent and the grandparent were found to be intoxicated and the home conditions described as "disgusting and in total disarray." When DCF responded to the home, it was described as having a smell of decay, with floors covered in trash, mouse feces, a dead mouse, cockroach feces, dirty clothing and miscellaneous items. The kitchen counters were "piled" with dirty dishes and covered in roach feces. The carpet had large amounts of mouse feces and the floor in the parents' bedroom was so cluttered with trash, dirty clothes and other items that the floor was not visible. DCF reported a previous investigation in January 2013 for physical neglect was unsubstantiated and the family refused services at that time. As a result of this event, the child was placed in DCF custody and the family was reportedly working with contractors TFI and KVC, with the goal of reintegration.

  The Unit received a second finding pertaining to this child during this reporting year, in July 2014. Again, the same perpetrators were substantiated for physical neglect after law enforcement was called to the home in reference to a fight. At that time, law enforcement noted observing a rat on the kitchen counter, gnats all over the kitchen surrounding dirty dishes and rotten food, a layer of mouse feces on the refrigerator shelves and a lack of running water in the home. DCF later noted the living area was cluttered to the point it restricted movement and the clutter included clothing, old food containers, open aluminum cans, plastic bottles, beer cans and papers, along with dishes of old food with mold, and that two doors to the kitchen were held closed with knives at door knob level. Also observed throughout the home were jugs full of yellow liquid which law enforcement reported was urine. KVC was last reported by the mother to have been in the home two weeks prior to this, whereby she reported the worker had no concerns and everything "looked good". With regard to the lack of water in the house, the mother reported she did not discuss this with KVC because she had been told in the past by the worker that assistance with bills was not the role of aftercare. The family reported they were told the same thing when seeking assistance finding employment.

The Unit requested and reviewed KVC logs in the DCF file. The last log made available for review documented a visit to the home 17 days before the child was placed in police protective custody. The June 4 log completed by the KVC therapist made no mention of the conditions of the home, either good or bad. Though the log indicated the therapist would continue to meet with the family once a week until August, there were no other logs provided to document any visits between June 4 and when the child was placed in police protective custody on June 21. The Unit inquired with DCF to determine whether any additional logs existed and if so, to obtain them. Additional logs were ultimately received on April 1, 2015 and did not address the gap in service. The records provided indicated that although the KVC therapist was to meet with the family once a week after June 4, no logs were included documenting further contact until June 23, when the mother called KVC to inform them of the child's removal by law enforcement. It is unknown whether action was taken by DCF regarding these failures to act in the best interest of children.

- In Finney County a 16-year-old foster child was substantiated for the sexual abuse of two other foster children sharing the same placement; one 11-years-old and the other 12-years-old. Event #1 involving the 11-year-old was reported to have occurred in 2013 or early 2014, while event #2, involving the 12-year-old, appears to have occurred after event #1 became known to the foster parent. The Unit actually received the substantiated finding for event #2 first and as such, developed concerns for the monitoring of these children within this home, given not only the prior history of each of them before coming into placement, but also based on any interventions that happened or should have happened after the event #1 became known.

  Regarding the narrative basis for finding pertaining to event #2, the summary of the interview with the foster mother indicated she reported the alleged perpetrator in this event had "issues" with another foster child in the past (later confirmed to be the alleged victim from event #1) and as a result, the foster mother did not allow any children in the home to be in a room together unsupervised, nor were they allowed to get up in the morning until she told them to. Despite stating the alleged perpetrator had a previous history in her home, the foster mother told DCF she didn't believe the alleged perpetrator had the "capacity to plan something like that out" with the alleged victim in event #2 and that she believed the alleged victim to be lying. The foster mother also reported to DCF that when the alleged victim told her law enforcement advised the victim what happened to her wasn't her fault, the foster mother told the alleged victim she didn't agree with that. The foster mother went on to say she was aware the alleged victim had a history of being sexually abused and though the alleged perpetrator's mother told her he had sexually abused a younger sibling, she "didn't feel it was true" and "never dreamed they would have issues" between the two children.

  In further researching how events transpired in this home, the Unit learned the foster parent did report the earlier event #1. However, while it was indicated the foster parent purchased door alarms, DCF cannot confirm any DCF or contracting staff verified the alarms were installed and properly working. When asked why this could not be verified, DCF did not directly respond to this question. Furthermore, it remains unclear to the Unit, based on information provided, whether the alarms were purchased after the first incident or after the second.

In addition, the Unit has some concern regarding the foster parent exercising judgment as to whom she believed was truthful in these allegations and who was not, especially where it concerns voicing these opinions to the children. The foster mother claimed, according to one DCF narrative, that though the alleged perpetrator's mother had told her he had a history of perpetrating, she did not believe the mother. Yet, children in custody travel to placements with what is termed to be a "Red Book" which is to document such history. It is imperative all foster families be aware of the history of the children entrusted to them, especially when those who have perpetrated are in placement with those who have been victimized. DCF and the child placing agencies (CPA) have a responsibility to ensure foster families are duly informed and appropriate precautions are taken if such children are required to be placed in homes together. When DCF was asked to confirm whether the foster mother was officially informed of the child's history and whether such was appropriately noted in his "Red Book", the department did not directly respond to the questions. Instead, DCF indicated the department reported any known issues on the initial out-of-home referral and indicated the CPA was aware of issues that brought them into custody. DCF wrote, "This information is passed on to the foster homes at the time of placement and is to be documented in their Red Books." The Unit does not interpret this as clear confirmation that the sexual abuse histories of the children involved in these specific investigations were properly documented in their individual Red Books.

Finally, the investigation pertaining to event #1 was assigned by DCF July 7, 2014, but a finding was not issued until December 9, 2014. The explanations provided for why this finding was issued beyond the 30-day timeframe allowed in statute included "due to law enforcement involvement" and "due to locating the victim for interview". When the Unit inquired as to why law enforcement involvement delayed this finding until December, when the second event had been concluded a month prior, DCF reported law enforcement wanted to interview the victim, who had been moved several times between July and October, and had directed DCF not to complete an interview. However, the department simultaneously reported asking other regions for courtesy interviews in July, August, September and October. When asked why the investigating worker would have had difficulty locating the current placement for a child in DCF custody, the department responded, "We do not have additional answers."

- In Sherman County, a mother was substantiated for medical neglect of a 4-year-old child due to what was reported to be untreated, rampant tooth decay. The finding noted the child was scheduled for treatment after custody was subsequently granted to a family member. The Unit found nothing otherwise noteworthy upon initial review of this finding. However, in the routine course of investigating whether any criminal actions were pursued as a result of this DCF investigation, the Unit discovered this child's parents had been previously charged with Aggravated Child Endangerment in 2012. The Unit had no previous history on the parties and as a result of this discovery, inquired about family history with DCF.

  Subsequently, DCF reported issuing two previous substantiations in 2012. The Unit found no record of receiving these from DCF in 2012, per statutory mandate, and DCF could find no documentation in their file to corroborate submission of the findings as required. Furthermore,

DCF initially reported its own hard copies of the investigatory files for these events could not be found and only submitted those documents which could be reproduced by their database.

The first of these two events, based on a report received in October 2011, substantiated both parents for physical neglect and the mother for lack of supervision due to allegations regarding the conditions of the home and that the mother was sleeping, leaving four children, ages 4 and under, unattended. One concern mentioned in the narrative basis was that upon initial visit to the home in October, twins under a year old were sleeping together in one play pen. This finding was not issued until March 2012, outside the timeframe allowed in statute and without a reason allowable in DCF policy. The second substantiation found both parents neglectful of three children based on a report received in March 2012 (while the first investigation was still open) after law enforcement responded to the home on a report of a child not breathing – one of the twins died "as a consequence of overlay by (the) twin sibling in the same bed." The findings indicated SFCS Family Preservation services were in the home at the time of the second report.

Throughout the course of requesting and reviewing additional records, the Unit learned the following:

- The October 4, 2011, report was made after DCF conducted a follow up visit on September 30 to yet another open event from August 2011 which alleged medical neglect of a different child due to untreated tooth pain. That event was unsubstantiated October 6, 2011; delayed without a reason allowable in policy, after it was confirmed the child received dental treatment.

- In response to the October 4, 2011, report, the children were released from PPC by the court and a referral to SFCS Family Preservation Services was made on October 5. SFCS completed an initial family meeting on the same date.

- Though records indicate the DCF social worker investigating this allegation attended the SFCS family meeting on October 5, there is no other indication of activity in this investigation on the part of DCF, within the file the department provided, before the finding was issued on March 29, after the death of one of the children.

- The March 22, 2012, report was received, as indicated above, after law enforcement responded to the home on March 18 due to a report of a child not breathing. The child was pronounced dead and the autopsy indicated cause of death was due to "aspiration of gastric contents with laryngospasm and bronchospasm due to, or as a consequence of overlay by twin sibling in the same bed." Law enforcement also reported the child "had what appeared to be feces and/or dirt on her body and in her fingernails and her body was observed to be very dirty." At the time, it was also noted the home had choking hazards throughout all rooms which included cigarette butts, dirty diapers and other trash throughout the home, plastic bags on the floor and "extreme filth" throughout. This

finding was also not completed timely, issued on June 15, 2012. There was no specified reason for the delay in finding.

- A review of SFCS documents provided by DCF indicated the Family Preservation contractor completed the initial family meeting on October 6 and a home visit on October 13. The scheduled home visit to complete a case plan on October 20 was rescheduled to October 25. It is noted the DCF worker was not in attendance for this meeting. Home visits by SFCS subsequently occurred on November 1, November 9, November 16 and December 1. On either December 20 or December 29, the CINC case was dismissed upon recommendation of SFCS due to what they described as "good progress" and a lack of concern, even though SFCS had not been in the home for the previous three weeks.

- A case review completed by the Family Preservation Program Director in February 2012 indicates there was found to be a gap in services between December 1 and December 29 – that a Family Support Worker (FSW) did not make expected visits to the home and "this raises the obvious concern of the reliability of our FSW" and "suggests there is a lack of case consultation happening between the therapist and the FSW." The document also finds concern with the FSW's failure to schedule the next home visit during a current visit. It is unknown what prompted this case review.

- Another case review completed on March 21, 2012, after the child's death does not have the author identified, but takes the same format as the February case review and can only be presumed to have also been completed by SFCS. This review documents a home visit on February 9, 2012, by SFCS and notes the home was "in disarray" but had no safety concerns and indicates the mother was directed to "clean up the clutter." SFCS log notes appear to contain additional detail on this visit, noting the home "was in disarray with clothes and toys all over the home. No safety concerns with condition of the home." When asked to check "yes" or "no" on the form with regard to the home being free of safety concerns, the SFCS worker checked "yes". When asked to check "yes" or "no" on the form with regard to the home being "relatively clean", the worker checked "no". The worker noted one child "had no bruises or bite marks. The other children were clean and appeared to have clean diapers on. The home had a different smell to it, worker thought it was possibly the iguana cage. [FSW] thought it was [mom's] niece smelling like urine. This worker was not close enough to the niece to determine if it was her or not."

  The case review goes on to note DCF did make a visit to the home on the following day and as a result, DCF advised SFCS that the children were "likely going into PPC due to the conditions of the home and children. Children were dirty, dirty diapers laying [sic] around and a large pile of dog feces in the middle of the floor…" However, on February 11, the review indicates DCF notified SFCS the children would not be placed in PPC and instead, the family would resume intensive services from SFCS. SFCS did not return to

the home until February 14 and reported there were no "safety/sanitary issues" on that day.

- DCF log notes completed in accordance with a screened out event by the DCF social worker regarding the visit of February 11 do not document any concern for the home conditions, nor do they document contact between the SFCS worker and the DCF worker, as is reported in the SFCS case review memo. The DCF social worker also does not document this visit at all within the log notes in the earlier event remaining open from October 4, despite some of the same concerns reportedly being present. Though an internal DCF email identifies that on February 10, the DCF social worker found home conditions "to be quite similar to what they were on October 4" these concerns do not appear to be documented in any available log notes provided to the Unit, nor was this email contained in the case files provided by DCF, which were open at the time that the email communication was composed. (During the writing of this report, DCF subsequently submitted a second set of log notes. This second set differs from the first in that they are handwritten, cover different dates of contact, and identify concerns for the condition of the home on February 10. DCF has been asked to explain the discrepancy and has yet to respond to the Unit.)

- This review notes that on February 13, 2012, the SFCS worker "staffed with supervisor the need for another pack and play for the family due to the twins sleeping together. Supervisor approved the purchase of a pack and play. [Worker] will discuss further with the family at visit on 2/14/12." On February 14, the family declined the offer of the agency to purchase a second Pack 'N Play and indicated an unwillingness to separate the twins. The SFCS worker noted during a visit on March 15, the twins were observed to once again be in the Pack 'N Play while they were "suppose(d) to be taking nap…." The worker noted she and several members of the family went outside the home so the children could sleep. There were "no safety issues noted, except for cigarette butts on the floor of the children's bedroom." This visit occurred three days before the child's death.

The Unit finds failures to act in several areas.

- Firstly, DCF opened an investigation regarding this family in August 2011, which was not completed timely in policy until after a subsequent report was received in October 2011.

- The October 2011 report was also not completed timely until after a fourth report was received in March 2012, due to a child death. In the interim, a third report was received in February and screened out, which caused the social worker to visit the home. However, this visit is not documented in the file provided by DCF for the October 2011 event and though concerns about the condition of the home are mentioned in an internal DCF email

provided with the screened out event, those same concerns are not documented in the worker's log notes for the screened out event.

- The Unit finds no documentation in the workers log notes to reflect any activity on the October investigation almost from its very inception until after the child died in March 2012. Rather, DCF Central Office has responded that the department "contracted with St. Francis to provide (Family Preservation) services. The St. Francis staff are to be the contacts in the home. DCF does not continue contact once an investigation is completed and contractors are in the home." However, this response fails to acknowledge that this investigation was not completed, but was rather still open and active.

- The system further failed when St. Francis first recommended the Child In Need of Care action be dismissed when the agency hadn't been in the home in three weeks and when the FSW failed to schedule regular appointments to be in the home.

- SFCS log notes reflect a visit to the home on February 9, where the staff noted the home was in disarray and was not "relatively clean", but indicated there were no safety concerns. Documentation from this same visit suggests that even amongst SFCS staff in the home that day, there was acknowledgement of a "different smell" in the home, but disagreement as to the cause (whether it was animals or a human source) with no apparent investigation to examine this further. The very next day, DCF had sufficient concern to consider removing the children, where SFCS had no concern.

- Finally, DCF identified a concern in October 2011 regarding the twins co-sleeping in the same Pack 'N Play. SFCS documentation shows the contracting staff approved the purchase of a second Pack 'N Play, but the family declined to accept the assistance and no apparent further action was taken. On March 15, the twins were observed in the same Pack 'N Play where they were supposed to be napping. Just three days later, one of the twins died due to what records identified as "overlay by the twin sibling in the same bed". Conditions in the home that day included choking hazards throughout all rooms including cigarette butts, dirty diapers and "extreme filth" – conditions which had been observed repeatedly by DCF and SFCS on previous visits, though with some apparent disagreement on severity.

- The Unit, in its request for records from DCF, has not been provided with any photos taken during the course of several months of agency involvement other than photocopies of photos taken September 30 and October 4. The photos are of a reduced quality which makes it impossible to review the conditions of the home. The Unit requested color copies from DCF, but as of the writing of this report, only received photos from September 30 and not from October 4. When asked if photos were taken when conditions were later found suspect on February 10 and if not, why not, DCF only responded that photos were not taken and offered no explanation as to why.

The Unit has not been provided with information regarding steps taken by DCF to hold the contracting agency accountable for their failures in this case, nor has DCF advised the Unit whether any actions were taken regarding the worker's failure to investigate these cases timely.

- In Crawford County, a grandmother was substantiated for lack of supervision of her 5-year-old grandchild after it was reported the child was playing and riding her bike in a heavily-trafficked street alone. It was reported the grandmother had not checked on the child for 45 minutes to an hour. A review of the narrative basis for this finding indicated the child was in DCF custody at the time of the incident and suggested an unknown level of involvement by a contracting agency, KVC.

  Upon request and review of additional records, the Unit learned the family had been receiving services from KVC, but the family's whereabouts were unknown to the agency, and therefore presumably to DCF, in whose custody the children were placed. KVC log notes initially provided by DCF indicated KVC staff made no visits to the family's home between March 18 and June 17, 2014. On each of those dates, the family resided at an address in Carona, KS. The report for this finding was made on July 14 and occurred in Pittsburg. A subsequent request and review of yet additional records revealed DCF had received an earlier report of sexual abuse of this child on July 7. The Unit has attempted to inquire as to the DCF response to that report and why it appears KVC was not notified of the sexual abuse report and the family's whereabouts in the intervening week. While DCF has confirmed that it appears KVC was not seeing the children with the required frequency, at the writing of this report, the Unit continues to examine the responses of both the CPA and DCF in this matter. This is being hampered by the department's response to record requests, which will be explained more fully in another section of this report, on page 52.

- In Barton County, a mother was substantiated for the physical abuse of two of her children after it was reported "their mother hit (one child) and threw her up against a cabinet, and that they were going back to the old ways of discipline of mom drowning the kids in the bathtub." DCF went on to state, "the report indicates the mother would stick the children's heads in a tub filled with water as punishment…the report further alleges mother tells the children she didn't want them and has threatened to slit their throats if they tell." This report was originally assigned by DCF in September 2014 and unsubstantiated in November 2014, despite disclosures to family and multiple school staff.

  However, in February 2015, DCF amended its finding to substantiated. The narrative basis for such indicated that at the end of January 2015, DCF received a "case log entry" from SFCS, the contracting provider, which indicated the children's mother admitted to SCFS during a case plan meeting on September 25 to holding the children's heads under water in the past. DCF reported "this information had not been shared with DCF prior to 1/27/15". The department re-interviewed the mother on February 12, where she admitted to such action.

  The Unit subsequently requested and reviewed this DCF file in order to attempt to determine how the department was unaware of the mother's admission on September 25. Contained within the DCF file was a note from social worker, dated September 25, 2014, documenting face-to-face

contact with the mother when the "SW attended Initial Family Meeting/48 hour meeting with [SFCS worker] and [mom]. SW reviewed allegations. [Mom] had no comments or questions." This is believed to be the same meeting where the mother made her disclosure to SFCS, and yet no notation is made of such within the DCF worker's notes regarding this meeting. It is also unclear what prompted SFCS to suddenly submit their own log note regarding the mother's admission to DCF some four months later.

In follow up with DCF, the Unit noted no other SFCS logs than the one regarding the September 25 meeting were contained in the file and inquired about the discrepancy between the two workers' notes for the same meeting, as well as how and why this information was made known to DCF, seemingly out of the blue. After months of requests, DCF only reported the investigating social worker was not present for the entire meeting and the mother's disclosure came after the worker's departure from the meeting. DCF goes on to state they were contacted "at a later time" by the SFCS worker. The department provided no explanation for the breakdown in communication regarding a serious and significant disclosure.

Recommendation: The Unit recommends stronger oversight of DCF contracting agencies and monitoring of children who have been placed in state custody. Consequently, the Unit is concerned by the transferring of foster care licensing from KDHE to DCF. Having a separate agency offered some measure of oversight to the care of children placed in DCF custody that is no longer available.

Failure to Report Findings Concerning Possible Criminal Acts to a Law Enforcement Agency

The Unit has continued to identify a concern where cases alleging possible criminal acts are not reported to a law enforcement agency for proper criminal investigation. The Unit believes failure to review such cases for criminal prosecution fails to hold perpetrators fully accountable for their actions and inhibits an effective system response to the abuse of children and vulnerable adults. This can lead to lack of protection from further abuse.

PPM 2210 requires, in part, "joint investigations between DCF and the appropriate law enforcement agency or agencies are mandated by statute (K.S.A 38-2226(b)) when a report alleges serious physical harm to, serious deterioration of or sexual abuse of the child; and action may be required to protect the child." Furthermore, the definition of "physical abuse" in PPM 0160 is identified as "infliction of physical harm or the causation of a child's deterioration, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health is endangered. K.S.A 38-2202."

While agencies empowered to investigate these cases like DCF and KDADS have civil remedies available to them as well as the ability to offer services to individuals and families, failure to properly investigate and prosecute crimes can send a message to perpetrators that such actions do not hold a measureable consequence. The Unit understands not all of these cases would result in prosecution and for some, it may not be the best course of action, but when facilities and state agencies fail to report such cases to law

enforcement, those agencies are preventing the criminal justice system from conducting its own investigation and inhibiting authority to review the cases based on the available evidence.

In support:

- In Crawford County, a step-father was substantiated for physical abuse of a child when it was alleged he grabbed the child by the hair after the 12-year-old failed to walk his 10-year-old sister to her destination. Furthermore, it was reported the step-father told the child that if (the child's sister) was his daughter, "you'd be buried in the garden…." The step-father also reported to the worker that if he had been wearing a belt, he would have "beat" the child with it and if the child's sister was his daughter, he "would have punched (the child) square in the face." The step-father was also substantiated for emotional abuse of the 10-year-old sister when it was reported she "became so upset she was crying and yelling at (the step-father) to leave (her brother) alone, so much so that she lost her voice."

  Of further concern, is what all parties agreed was the excessive consumption of alcohol by the step-father. The step-father stated he was not going to quit drinking and demonstrated no remorse for his actions. These risk factors are compounded as the narrative basis also reported the step-father was a convicted felon who continued to keep guns "laying around" the house. The narrative indicated the guns were kept loaded and an earlier report received by DCF indicated the step-father had "jokingly" pointed a gun at them, causing fear. DCF did not involve law enforcement in this investigation, notify law enforcement of the finding in this investigation (which constituted potential criminal acts), nor did DCF report the fact that the step-father was a convicted felon in possession of firearms. DCF reported that upon conclusion of their investigation, both the step-father and the firearms remained in the home. The Unit is alarmed in a case such as this, when there is a convicted felon armed with guns and children at risk, that no action is taken to get federal agents involved, and further, that such risk would not be deemed worthy of reporting to local law enforcement.

- In Crawford County, a mother was substantiated for physical abuse of her son after it was reported she hit him in the head and grabbed him by the ear while they were in temporary shelter. DCF reportedly observed video where the mother continued to grab and lead her son by the ear in the presence of shelter staff and despite the staff's attempt to redirect her behavior. DCF reports law enforcement was not involved in the investigation, nor were they forwarded notice of finding. No safety plan was completed and no other interventions were had when the mother declined services and moved to another county.

- In Wyandotte County, a father was substantiated for physical abuse of his child after it was reported the child had bruising on her legs from being hit with a belt. Upon interviewing the child, DCF reported observing "a large linear bruise on [the child's] right upper thigh, about 4 inches in length and an inch wide … the worker also observed a circular bruise on [the child's] left upper leg about the size of a quarter." DCF reported the child's mother indicated she felt the father "crossed the line" and he "does not see how serious this is." Nonetheless,

the child's mother reported she did not have concerns about the father providing care for her children. The father refused to meet with the DCF social worker in person and said he did not feel the child's bruises were serious. The Unit obtained and reviewed photos of the significant bruising to the front of the child's thighs which were taken by DCF. The department did not report the incident to law enforcement.

- A father was substantiated for the physical abuse of his son after it was alleged his father grabbed him which resulted in bruising to the child's shoulder. DCF did not report the incident to law enforcement, did not complete a safety plan and did not offer services to the family as the department reported the father accessed therapy. However, within the course of the three months their investigation remained open, outside of the allowable timeframe, DCF reports the father only attended one solo therapy session and one session with his son. The father was reported to be a law enforcement officer. Due to safety concerns for the child, the Unit will not identify the county of origin in this report.

These cases have continued to be raised with DCF. The department has long maintained that they are fulfilling their statutory requirement to report to law enforcement by notifying the "chief law enforcement officer" in their jurisdiction: the district or county attorney.

It remains a concern that while some child cases may be forwarded to the juvenile Child in Need of Care divisions within the district or county attorney's office, if these cases have not been reported to a law enforcement agency for criminal investigation, they may not be screened for criminal charges. Further, though some juvenile CINC divisions within the district or county attorney's offices may refer appropriate cases to their criminal division for charging, not all offices have an internal practice for this as a matter of routine. Additionally, critical evidence of the incident could be lost by the time the case is reviewed by the district or county attorney's office and referred back to a law enforcement agency for criminal investigation.

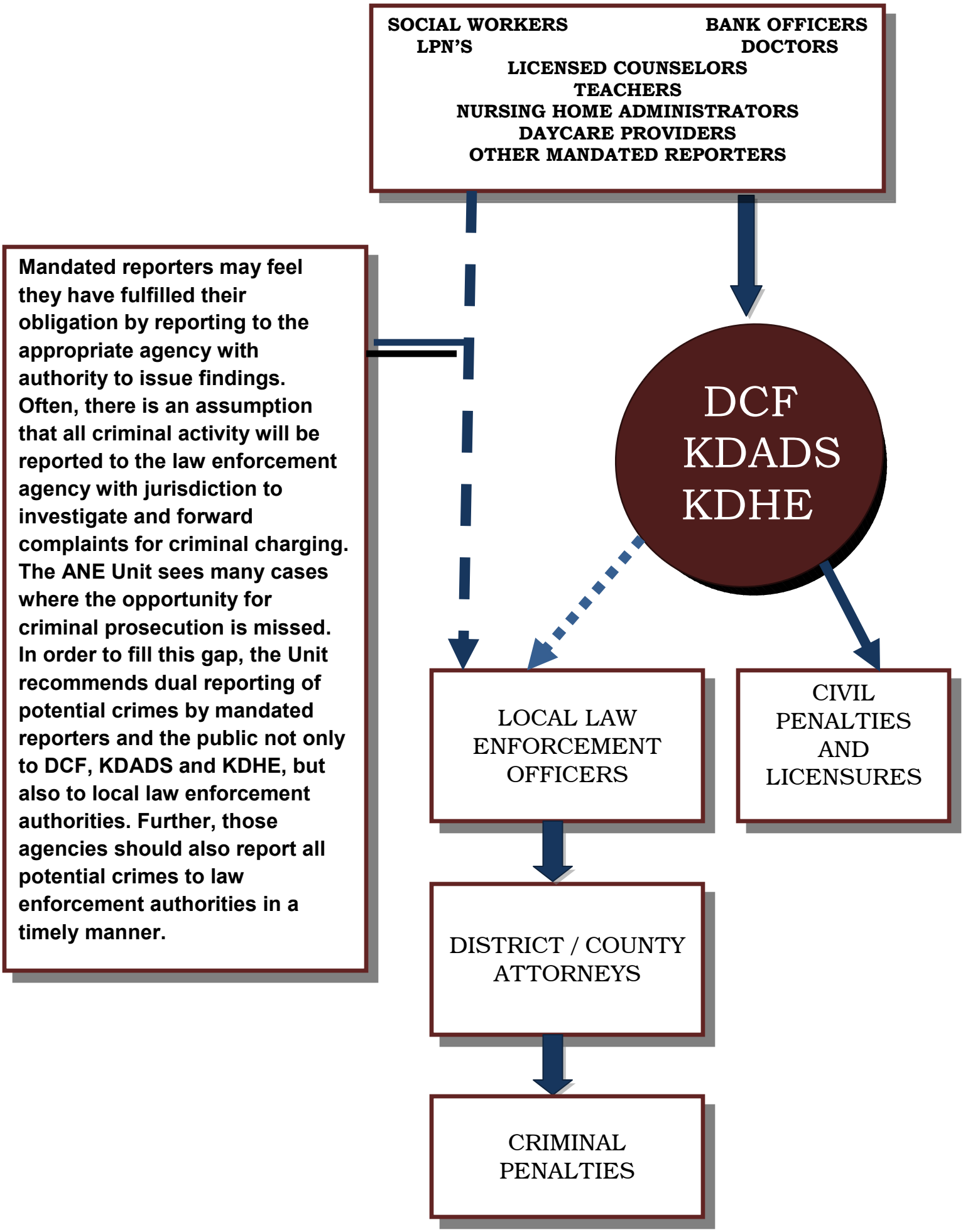
The ANE Unit believes it is more in keeping with the criminal justice process for those reports to be made to the appropriate local police departments or county sheriff's office by DCF, in addition to forwarding the reports to the district or county attorney.

For the first time, during ongoing discussions with DCF in January 2015, a member of Central Office staff represented some agreement with the recommendation to report crimes to law enforcement and a desire to work with the Unit toward this goal. However, by April, this representative later defended the department's failure to notify law enforcement in two of the physical abuse cases cited in this report and deflected responsibility, having stated that other officials or facilities could have made reports. There has been no interest represented on the part of Central Office staff since to encourage a better reporting of crimes by the department.

Meanwhile, the Unit does see many cases of physical abuse where evidence of injury is present and law enforcement only completes Child In Need of Care reports as opposed to offense reports which are forwarded to the district or county attorney with charging affidavits. While officers can and should retain

this discretion, the Unit would encourage law enforcement not to overlook the possibility of submitting criminal affidavits as well, where warranted.

Recommendation: The Unit continues to recommend dual reporting of child and adult abuse to both the appropriate state agencies and to local law enforcement when there is a belief a crime may have occurred. Those agencies should also follow up on their initial reports to verify receipt by the law enforcement agency. In absence of this, the Unit recommends DCF institute Rules and Regulations to incorporate the use of lethality checklists into policy to determine whether child abuse reports that constitute potential crimes should be reported to law enforcement, regardless of whether "serious physical abuse" occurs.


SOCIAL WORKERS
BANK OFFICERS
LPN'S
DOCTORS
LICENSED COUNSELORS
TEACHERS
NURSING HOME ADMINISTRATORS
DAYCARE PROVIDERS
OTHER MANDATED REPORTERS
Mandated reporters may feel they have fulfilled their obligation by reporting to the appropriate agency with authority to issue findings. Often, there is an assumption that all criminal activity will be reported to the law enforcement agency with jurisdiction to investigate and forward complaints for criminal charging. The ANE Unit sees many cases where the opportunity for criminal prosecution is missed. In order to fill this gap, the Unit recommends dual reporting of potential crimes by mandated reporters and the public not only to DCF, KDADS and KDHE, but also to local law enforcement authorities. Further, those agencies should also report all potential crimes to law enforcement authorities in a timely manner.
DCF
KDADS
KDHE
LOCAL LAW ENFORCEMENT OFFICERS
CIVIL PENALTIES AND LICENSURES
DISTRICT / COUNTY ATTORNEYS
CRIMINAL PENALTIES

Lack of Agency Communication

In some cases, it is apparent failure to fully communicate by investigating agencies is detrimental to thorough investigation and prosecution of cases, reducing accountability by alleged perpetrators and increasing risk to those who are, or will become, victims of abuse.

In support:

- In Montgomery County, parents were substantiated for physical neglect of their children after law enforcement responded to the home and determined the conditions to be unsafe. The initial report was for physical abuse, lack of supervision and sexual abuse. The Unit followed up with law enforcement regarding outcomes and brought the case back to the attention of the assigned officer so an investigation could be completed. In doing so, the officer also indicated he had been unaware DCF had completed and closed their investigation with a substantiated finding. In addition, he reported he had requested DCF records, as well as a second forensic interview with the alleged victim of sexual abuse, but indicated neither request had been met. When the Unit contacted DCF to verify additional information, DCF staff reported only that the finding "was handed" to the assigned officer and they denied any further contact. This finding was previously discussed on page 19.

- In Miami County, a family member was substantiated for the sexual abuse of a child. Upon review of the finding received from DCF, the department denied sending notice of their finding to law enforcement, though they noted law enforcement was involved in the investigation. When the Unit contacted law enforcement to determine the status of a criminal investigation, the assigned detective noted she had not been notified by DCF that their investigation had been substantiated and had only been aware of the outcome when the alleged perpetrator sent her a copy of his notice. The detective reported to the Unit she seldom receives notice of the outcomes of joint investigations, but is frequently "inundated" with requests for information regarding the status or outcomes of her investigations by DCF.

Recommendation: The Unit recommends that while each agency serves a separate function, they recognize the value of joint, collaborative efforts, to work together in their individual capacities and improve communication and notification in this regard.

Ineffective Referral Process for Findings That Are Referred to Law Enforcement in Adult Cases

The Unit continues to see a significant opportunity for cases involving abuse of vulnerable adults to "fall through the cracks" when those cases are referred to law enforcement. For APS and KDADS, this referral process involves sending written notice to a law enforcement agency. However, for the most part, there is no follow up to these documents to verify they were received, let alone acted upon. For the Unit, two

concerning patterns have emerged: 1) law enforcement cannot verify receipt of any notice, or 2) they express concern at not being brought into the process at the outset of an investigation.

APS is mandated by law to report possible criminal acts to law enforcement (K.S.A 39-1404). In accordance, APS workers complete a written Notification to Law Enforcement. This may be sent to law enforcement at the outset of an APS investigation (Form 10210) and again upon completion of that investigation to inform of a finding (Form 10350). This form may include a lengthy summary, with supporting documentation attached, or more often contain only a few sentences with instructions for law enforcement to contact the worker to receive additional information. Notices may simply be directed to the agency, to a division within the agency, or occasionally, to the attention of a specific individual. APS does not have a consistent process by which all workers submit notice to their local law enforcement agency. The process varies within the regions and may be submitted in any manner, including by fax, by mail or by email. Though some workers are excellent at following up with law enforcement about documenting a report, others believe the act of sending notice fulfills their reporting requirements according to policy and are resistant to doing anything further.

Tracking further actions by law enforcement has proven difficult for the Unit. Often we are receiving the information after some significant time has passed. If there is not a documented report on file, the law enforcement agency's ability to locate information and verify any response is limited. The Unit has also not been able to determine a consistent contact point within law enforcement agencies designated to receive such information. Though APS has agreed to supply copies of fax transmittal forms in cases where the reports are referred by fax, these are not always received and provide no assistance when notices are sent in another format.

When workers do not follow up with law enforcement to ensure the information is received, referrals can often be lost in transition and hinder efforts at addressing abuse.

In the past, there has been similar difficulty tracking actions on cases referred by KDADS. However, changes in federal regulations in recent years require certain individuals employed or contracted by long term care (LTC) facilities to make a report of any reasonable suspicion of a crime committed against a resident or person receiving care from the facility. This has resulted in the Unit receiving a higher number of KDADS substantiations where actual police reports have already been made and report numbers are able to be provided to the Unit.

The Unit remains highly concerned the referral process between APS and law enforcement creates a significant opportunity for cases alleging abuse against adults to get lost in the system and to have no action taken. Nonetheless, there is a clear reluctance by APS to require staff to follow up on these referrals or to advance policy beyond what they believe is minimally required by statute.

In addition, when APS fails to notify law enforcement as soon as it becomes apparent there is a possibility a crime was committed, it can further hinder a criminal investigation. Time passes, evidence may be lost

or destroyed, witness statements may become tainted, and victim statements can be lost altogether when victims pass away in the course of an investigation or their physical or mental health deteriorates.

The ANE Unit does not believe all cases resulting in findings of abuse, neglect or exploitation will rise to the level of a crime. Even if the cases meet criteria set forth in a criminal statute, there may be extenuating circumstances that may justifiably cause a prosecutor not to charge a criminal offense. However, law enforcement agencies should be allowed to make that determination. They, and subsequently, the district or county attorney cannot act with regard to criminal penalties if the information is not presented to them in a timely fashion.

Recommendation: The Unit recommends all state agencies providing information to local law enforcement agencies develop policy requiring follow up on these referrals in a timely fashion to ensure the information is received. If legislative action is required to create a statutory obligation, this should be reviewed and considered. Further, local law enforcement agencies should develop internal policies so staff who might receive such notification recognize the purpose and nature of the forms and disseminate them appropriately for investigation. Law enforcement should make an independent determination regarding initiating a criminal investigation based on the merits of the report and the available evidence, rather than solely on the impression or opinion of a social worker who is not trained to conduct a criminal investigation.

Findings Not Sent to the District/County Attorney in the Jurisdiction where the Crime Occurred.

The Unit has previously identified a concern where findings had not been sent by DCF to the district or county attorney in the jurisdiction where child abuse had occurred. In recent years, there was a DCF policy requirement that workers issuing substantiated findings send notice to the district or county attorney both in the jurisdiction where the child resided and in the jurisdiction where the abuse occurred. However, citing state statutes and Federal law, DCF reversed this position as of July 2012, and revised policy. PPM 2547 currently requires only that "notice shall be promptly provided to the county or district attorney for consideration of a child in need of care petition."

The Unit does not believe it would be the intent of any law, or within the spirit of the law, to restrict a child protection authority with knowledge of crimes against children from reporting those crimes to a law enforcement agency or a prosecutor's office with jurisdiction to investigate those crimes.

Recommendation: The Unit recommends DCF develop policy to consistently require workers to send notice of finding to the appropriate district or county attorney and (if a possible crime occurred) to file a report with the law enforcement agency in the jurisdiction where the abuse occurred. Such notification should be documented in the case file. In the event the abuse occurs out of state, policy should be developed to minimally require a report to that state's child protection agency and obtain verification of whether that agency reported crimes to law enforcement. If legislative amendment of pertinent statutes is required, this should be considered to ensure crimes against children are reported to law enforcement, fully investigated, and considered for prosecution.

Sexual Relations Between Caregivers and Vulnerable Populations

Of great concern is the safety of citizens who are dependent on others for their care. The ANE Unit continues to hear from constituents who worry about the well-being of their family members when they are dependent on others to meet their daily needs.

Though those who hold professional licenses may face disciplinary action and loss of license for any act of abuse, neglect or exploitation confirmed by agencies like DCF and KDADS, criminal prosecution may be hampered regarding a vulnerable adult and his/her ability to give consent.

The Unit has long recommended legislation which would legally prohibit caregivers from engaging in sexual relations with their patients/clients, regardless of that person's ability to give consent. It would seem most logical to do so through modification of K.S.A 21-5512, the criminal statute prohibiting Unlawful Sexual Relations. In 2014, section 7 of this statute was modified as follows:

> (7) the offender is an employee of the ~~department of social and rehabilitation services~~ *Kansas department for aging and disability services or the Kansas department for children and families* or the employee of a contractor who is under contract to provide services in ~~a social and rehabilitation services~~ *an aging and disability or children and families* institution or to the ~~department of social and rehabilitation services~~ *Kansas department for aging and disability services or the Kansas department for children and families* and the person with whom the offender is engaging in consensual sexual intercourse, lewd fondling or touching, or sodomy is a person 16 years of age or older who is a patient in such institution or in the custody of the secretary ~~of social and rehabilitation services~~ *for aging and disability services or the secretary for children and families*;

This modification makes it a crime for employees of KDADS, as well as their contracting employees, to engage in these specific sexual acts with a patient in any aging and disability institution. However, these protections still do not extend to residents of long term care or nursing facilities, which – even though they are licensed by KDADS – are privately owned institutions. Presumably, the intent of these modifications was to simply accommodate facilities which were previously under the direction of the Department of Social and Rehabilitation Services, but have since been reorganized by Executive Order to fall under the jurisdiction of KDADS and to also recognize the renaming of these agencies.

Recommendation: The ANE Unit continues to encourage legislation that would legally prohibit caregivers in both residential and facility settings from engaging in sexual relations with their patients/clients, regardless of that person's ability to give consent. This may be effectively accomplished through modification of the Unlawful Sexual Relations statute. The Unit recognizes there may need to be an exception allowable for longstanding and marital relationships.

Ineffective Use of Abuse Registries to Protect Children and Vulnerable Adults

In previous reporting years, the Unit identified a concern whereby substantiated perpetrators of abuse may still have the opportunity to obtain professional positions working with others who are in a vulnerable state.

When a perpetrator is substantiated by DCF for abuse against a child or a vulnerable adult, his or her name is placed on the Central Registry maintained by DCF. Those who are subject to investigation and finding by KDADS are entered on the Kansas Nurse Aide Registry (KNAR) when they are identified as perpetrators.

While nursing facilities are required to check the KNAR regarding the licensure status for certified nurse aides (CNAs), certified medication aides (CMAs) and home health aides, they are not required to check the DCF Central Registry. In the past, APS has reported sending notices of finding to KDADS. However, APS Central Office staff believes these findings are not acted upon or responded to with regard to existing or prospective employees. In follow up with KDADS, it was reported "few" referrals were nurse aides and the requirements for substantiation between the nurse aide registry and the DCF registry made it difficult to simply add those on the DCF registry to the KNAR registry.

The Unit continues to believe this process creates a gap whereby, for example, perpetrators who are substantiated by DCF for abuse, neglect or exploitation of children or vulnerable adults, are able to go on to obtain positions in health care facilities. This exposes a new group of potential victims to those who have already been known to perpetrate upon individuals who cannot necessarily protect themselves.

Recommendation: Agencies and facilities currently required to screen employees via the KNAR registry only should be required to also check the DCF Central Registry of perpetrators of abuse, neglect and exploitation. Where consent of the employee is required, such should be a condition of employment. Staff of the Office of Attorney General continues to participate in discussions with relevant agencies in order to collaborate on ways to address this identified gap.

Failure of Agencies to Submit Findings to the Unit in Compliance with Statutory Requirement

The Unit has continued to monitor case findings to ensure they are received timely. K.S.A 75-723 requires agencies to submit their findings to the Unit within 10 days. Though the language does not specify whether such is required to be calendar days or business days, in the interest of good faith and allowing the maximum timeframe, the Unit has considered this requirement to be business days. While staffing and database abilities, along with caseload volume causes difficulty in ensuring this factor is documented for every finding received, the Unit has been able to determine that during this reporting year, a minimum of 88 findings submitted by agencies were received outside statutory requirement. Seventy of those were submitted late by DCF-CPS staff, while 16 were from DCF-APS staff. The remaining two were submitted by KDHE. This equates to a rate of at least 4.76% for CPS and 5.65% for APS.

In past years, the Unit has discovered findings have not been submitted timely for such reasons as social workers mistakenly waiting for the perpetrator's appeal period to pass, or for completion of corrective action plans. Other cases were discovered to have never been sent until the Unit discovered them as a result of receiving subsequent investigations or as a result of inquiries from other divisions.

In support:

- In Douglas County, a mother was substantiated for lack of supervision of her children. Review of the narrative basis for finding in this event revealed the existence of two previous substantiated findings for this family in 2011 – one for sexual abuse and one for lack of supervision. While the Unit had record of receiving the sexual abuse finding, no record was found for receipt of the lack of supervision finding. The Unit inquired of DCF and subsequently received the second finding which had been previously issued in 2011. Though DCF had a cover sheet dated accordingly, the department could offer no verification this finding was submitted timely to the Unit in the form of email, fax transmittals or other notes in the file.

- In Shawnee County, a woman was substantiated for fiduciary abuse of her mother-in-law in December 2014, based on an APS report received in October 2014. The Unit was unaware of this finding until a notice was received in May 2015 which reversed the previously substantiated finding based on the alleged perpetrator's completion of a Corrective Action Plan (CAP). The Unit subsequently requested and received the original finding, wherein it was identified the alleged perpetrator used nearly $1,500 of the IA's funds for her own benefit. In addition, notices of this report and finding were also not sent to law enforcement until May 2015.

- In Johnson County, a woman was substantiated for the medical neglect and physical abuse of her 2-year-old child after it was alleged the child suffered burns and bruises to his body which were left untreated. The narrative basis for finding indicated the burns were discovered when a DCF social worker traveled to the home to pick up the child after he was placed in DCF custody "due to prior concerns". The Unit inquired and learned DCF had issued an earlier finding for an investigation of lack of supervision during roughly the same time period. The lack of supervision reportedly occurred when the child was found alone on a curb. A passerby spent 30 minutes with the child before contacting law enforcement. When the child was found, he had a bruise on his face, a full diaper, and wet pants. DCF reported the worker had departed the agency and their file did not contain any documentation to support the finding had been previously submitted to the Unit in accordance with statutory requirement.

- In McPherson County, a mother and step-father were substantiated for emotional abuse of a child after it was reported the mother allowed the step-father back in the home after he was previously substantiated for sexually abusing the child. It was reported the child had been coerced and manipulated to lie and recant her disclosures and the mother had failed to get the child therapy. Upon review of this finding, the Unit noted we had no record of receiving the previous sexual abuse finding and inquired of DCF. The department subsequently forwarded the finding for

review and indicated although their file had record of the finding being sent to the county attorney's office, there was no record it had been previously submitted to this Unit in accordance with statute.

- In Sherman County, a mother was substantiated for medical neglect of a 4-year-old child due to what was reported to be untreated, rampant tooth decay. The finding noted the child was scheduled for treatment after custody was subsequently granted to a family member. The Unit found nothing otherwise noteworthy upon initial review of this finding. However, in the routine course of investigating whether any criminal actions were pursued as a result of this DCF investigation, the Unit discovered this child's parents had been previously charged with Aggravated Child Endangerment in 2012. The Unit had no previous history on the parties and as a result of this discovery, inquired about family history with DCF.

  Subsequently, DCF reported issuing two previous substantiations in 2012. The Unit found no record of receiving these from DCF in 2012, per statutory mandate, and DCF could find no documentation in their file to corroborate submission of the findings as required. Furthermore, DCF initially reported its own hard copies of the investigatory files for these events could not be found and only submitted those documents which could be reproduced by their database. Review of these two events determined the first investigation was open beyond timeframe allowed in policy when the second investigation was received. The second investigation alleged a child death due to similar circumstances which were present in the home and caused the first investigation to be opened. These cases were discussed earlier in the report in detail on pages 30-35.

DCF Central Office staff is provided with a list of cases every quarter which are submitted outside the statutory requirement. While APS has incorporated questions regarding this factor in quality management, we have received no information regarding any steps being taken to correct this concern with CPS staff. The Unit remains concerned whenever an agency appears to fail to comply with statutory requirements for no reason other than social worker error.

Recommendation: The Unit recommends agencies develop sufficient internal procedures to ensure compliance with statutory requirements. This should include regular training for both new and existing staff so requirements are clear.

DCF's Compliance with Timely Findings

DCF policy with regard to child findings (PPM 2511) directs that a case finding shall be made within 30 working days from the date the report was accepted for assessment. Policy cites specific exceptions to this requirement as follows:

- A delay is requested by law enforcement, a county or district attorney, the court, health care professionals, mental health professionals or for similar exceptional circumstances documented in the case file.

- Failure to receive medical or mental health information which has been requested from professionals or other relevant person may be considered exceptional circumstance justifying a delay in finding.

PPM 2511 also directs that for any investigation held open beyond 30 days due to outstanding requests for information, the case will be reviewed by a supervisor every 60 days and documented in the case file. The Unit sees many instances where such has not occurred.

PPM 2531 further states that for any finding issued outside of the established timeframe, an explanation will be given in the basis for the decision. It also states if the finding is delayed for a reason not allowable in policy, "the following statement shall be documented on the PPS 2011; 'The case finding is delayed due to a non-allowable reason per policy.'"

Despite these requirements, the Unit continues to receive findings issued outside of the timeframe established in policy which contain no explanation, or contain an explanation which contradicts other information obtained. The ANE Unit provides DCF with a list of cases received every quarter where this policy requirement does not appear to be met. Recently DCF Central Office staff has reported in the quarterly meeting that workers are now instructed to not identify a reason for delay if that reason is non-allowable, and has requested the ANE Unit assume the reason is non-allowable when no statement is indicated. This appears to be in direct contradiction with written policy.

While some delays may ultimately still occur for reasons allowable in policy, others may not. In many cases, where workers did not follow policy in stating the reasons for delay, the Unit had to request this information. In some cases, where reasons for the delay are stated in compliance with policy, the listed reasons have turned out to be inaccurate or incorrect. Such situations test the credibility of information provided to the Unit by DCF.

In fulfilling its mission of examining the systemic response to abuse, neglect and exploitation, it is helpful for the Unit to be aware if the lack of cooperation by other involved agencies causes social workers to delay findings beyond the established timeframes. In a case where this occurs, it is imperative that DCF clearly and correctly indicate the reason for delay.

With policy revisions that went into effect in July 2013, DCF made changes to the cover sheet social workers use to send substantiated findings to the Unit. A check box was added to the form in an effort to prompt workers to ensure the findings clearly state the reasons for delay where applicable. However, the Unit continues to see cases where workers fail to check the box, the box is checked incorrectly, or where workers continue to use out-of-date forms where this prompt is not included at all.

Recommendation: The Unit strongly encourages DCF to report the reasons for delay in issuing timely findings where required by policy. Where those reasons are allowable exceptions, the specific exemption should be clearly stated. Supervisors should ensure compliance upon review and approval of findings.

Failure to Report by Mandated Reporters

K.S.A 38-2223(a) specifies an identified group of individuals are required to make a report whenever that individual "has reason to suspect that a child has been harmed as a result of physical, mental or emotional abuse or neglect or sexual abuse…" Section (e)(1) of the same statute specifies "willful and knowing failure to make a report required by this section is a class B misdemeanor. It is not a defense that another mandatory reporter made a report." While the consequence of failing to report is clearly established in statute, the Unit has a growing concern the failure of mandated reporters to file such reports is itself, often unreported.

Defining "reason to suspect" is difficult to do. Available evidence of such is subjective in many cases and determining where the line is for cases that are not so egregious as to be obvious is impossible. One often ascribes to the old adage: You know it when you see it. It seems reasonable to expect mandated reporters to err on the side of caution. The question then becomes, how does one know if a mandated reporter fails to report? The Unit has reviewed cases in the past where questions have been raised as to whether parties involved should have made abuse reports at earlier stages. While it is right and appropriate that investigating the act of abuse should be a priority for entities like DCF, the Unit questions whether altogether ignoring the possibility of a failure to report is the best recourse. DCF Central Office staff have indicated there is no requirement in policy for social workers to report the failure of a mandated reporter to law enforcement or the district or county attorney and that these facts are evaluated on a case-by-case basis between the worker and DCF legal staff.

Recommendation: The Unit recommends implementation of policy requiring DCF workers to appropriately gather facts, secondary to their investigation, when there is involvement by a mandated reporter. When there is an indication the mandated reporter did not comply with law, DCF should provide notice to the district or county attorney separate from an abuse finding.

Failure to Provide Access to Records and Information within the Department for Children and Families

Exchange of information with DCF remains a significant challenge and is often an impediment to the Unit's mission. As stated in past reports, the internal process established by DCF Central Office for responding to Unit inquiries is cumbersome, with questions and answers being funneled through multiple staff via email, while the social workers who have handled the investigations are prohibited from responding directly to the Unit. This has significantly extended the time it takes for information to be shared with the Unit. It has also resulted in the Unit having to make repeated inquiries to DCF staff when responses haven't been received at all. The delay in receiving clear, correct and sufficient information to determine a further action plan extends the amount of time required by the Unit to subsequently follow up with other agencies and contributes to cases being open for review for an excessively long period of time. This lack of timely response could leave children and adults in a compromised position vulnerable to further abuse and hinders accomplishment of the Unit's mission to provide a thorough and timely review of every report.

As reported previously, examples of information the Unit commonly has to request upon receipt of finding includes:

- Confirmation of the safety and custody/placement of the child or vulnerable adult.
- In lieu of any indication of court action, whether services were recommended or accessed.
- Cover sheets designed to provide basic information are often incomplete or incorrect. For example, they may indicate a lack of law enforcement involvement where there is indication of such in a narrative. This requires further follow up and inquiry by the Unit for confirmation or clarification. There have also been cases where law enforcement contact or report is not indicated at all, but when the Unit inquires, the social worker will indicate otherwise.
- Narratives establishing a basis for finding may reference additional events with no action, status, or outcome of those events noted. Inquiring further in these instances has revealed earlier findings that should have been received by the Unit, but were not found in our records.

The Unit continues to find inconsistencies in the parties' names on documents sent by DCF or pages missing from the packet of documents. All of this requires further follow up by the Unit with DCF in order to have the most basic complete and accurate information from which to begin a review of the finding and the subsequent systemic response. However, the Unit is not staffed sufficiently to confirm such basic facts on each and every case it receives.

We do appreciate those workers and region supervisors who are eager to provide prompt, accurate and complete information. These individuals are invaluable.

The Unit continues to meet quarterly with DCF Central Office staff to discuss ongoing concerns. Though in the past, this has resulted in such changes as implementation of revised cover sheets used by DCF in order to include custody and placement information regarding children, as well as the aforementioned prompt regarding the reasons for delay in issuing finding, the Unit continues to see workers failing to complete this information or many who continue to use older, outdated forms which do not contain these prompts. DCF and the Unit could reduce communications based on these factors alone if workers become consistent in using current forms and completing them thoroughly and accurately.

The Unit has continued to see occasions where requests for information are not resolved at the quarterly meetings despite detailed agendas being provided in advance. It is not unusual for these requests to be repeatedly carried over from one meeting to the next, for a year or longer. Such resistance by DCF Central Office to attend these meetings prepared to discuss the cases which have been identified on the agenda, as well as provide the information requested results in a significant waste of already thin Unit resources and is hardly in the spirit of compliance with a statutory mandate to provide information. There has been no significant improvement in the daily communications on a case-by-case basis such as those which have been discussed in this report. The Unit hopes improvement in communication and cooperation by Central Office will progress and will also result in improved cooperation and collaboration on an agency-wide basis.

In support:

- In Johnson County, a woman was substantiated for the medical neglect and physical abuse of her 2-year-old child after it was alleged the child suffered burns and bruises to his body which were left untreated. Upon review, the Unit learned DCF had issued a previous finding for this child, which had never been received by the Unit. Though it was subsequently received upon request, the Unit inquired as to whether DCF records indicated it had been previously sent in compliance with statute and if so, when and in what manner. This request to the region in February 2015 went unanswered and therefore, the Unit placed the item on the agenda for the April 2015 quarterly meeting and requested Central Office staff to provide this information. None was forthcoming at the meeting. A third inquiry was sent in June 2015 before the region confirmed the worker had departed the agency and their file did not contain any documentation to support the finding had been previously submitted to the Unit timely. For that reason, this case was previously cited in the report on page 46.

- In Crawford County, a child was substantiated for medical neglect by a foster parent after it was alleged the foster parent ignored the medical advice of the nurse providing in-home care for the child. The DCF report indicated the nurse made her supervisor and KVC staff aware of her concerns regarding the foster parent, but these seemingly went unaddressed. This finding was discussed in last year's report in greater detail due to this concern and further addressed in another portion of that same report due to difficulty acquiring information from DCF. The Unit had requested to review the complete DCF file for this investigation in April 2014. Upon receipt and review in May 2014, multiple questions were sent to DCF to clarify the facts in this case. It was also raised with Central Office at quarterly meetings in June 2014 and October 2014, while answers to those questions failed to be provided.

  On September 9, 2014, the Unit received a subsequent finding on this child for medical neglect by yet another foster parent in Shawnee County. Prior to that investigation, initiated May 9, the child died. This information had not been previously shared with the Unit by DCF during our attempts to review the earlier finding.

  The Unit requested to review the DCF file for this latest finding and requested DCF provide such at the quarterly meeting in October 2014. A file was sent electronically on October 3, but it was the wrong file. Despite being made aware of this, the correct file was not provided at the meeting on October 7, nor were the answers to the previously-directed questions of May 28. These requests were reiterated at the January 2015 quarterly meeting, via email requests throughout February and March 2015, and again at the April 2015 quarterly meeting. DCF continued to fail to provide the requested information. On April 14, prior to the meeting on that date, DCF Central Office staff forwarded a file via email, but it was for an event other than that which was requested. Central Office was advised this was the incorrect file and asked to review the request contained in the agenda. Immediately before the meeting, another file was sent, but that file was also incorrect, as it pertained to a different child. Extensive discussion was had with Central Office staff during that meeting to once again explain what information the Unit awaited.

Nonetheless, DCF continued to fail to provide this information through the June 2015 quarterly meeting and up until it was once again placed on the agenda for a September 2015 quarterly meeting. The requested file was ultimately received on September 30, a full year after the request was initiated.

- In Crawford County, a grandmother was substantiated for lack of supervision of her 5-year-old grandchild after it was reported the child was playing and riding her bike in a heavily-trafficked street alone. It was reported the grandmother had not checked on the child for 45 minutes to an hour. A review of the narrative basis for this finding indicated the child was in DCF custody at the time of the incident and suggested an unknown level of involvement by a contracting agency, KVC. This case was previously discussed on page 35 regarding a concern involving the child placing agency.

  Upon initial review of this finding, the Unit had questions surrounding the family history and the level of services being provided by KVC. Inquiry was made to DCF in August 2014. Though a prompt reply to the inquiry was received, not all questions were fully addressed and requested notes from KVC were not provided. These questions were redirected to DCF in September and the department was asked to provide the DCF file for this event, if KVC log notes were not available. The request was placed on the agenda for the October 7, 2014, and January 27, 2015, quarterly meetings. On neither of those dates did Central Office staff provide the requested information. Likewise, no information was received in response to additional inquiries in the intervening months before the April 2015 quarterly meeting. DCF failed to provide the requested information on that date and ultimately did not deliver any file until June 2015.

  On that date, the Unit appeared to receive the KVC file, which included the log notes originally requested almost a full year earlier. On June 22, 2015 the Unit advised Central Office staff of gaps in the KVC recorded visits and that examination of the records suggested the children were residing in a location which had not been approved by KVC. DCF was asked to review and confirm these facts at the June 30 quarterly meeting, and the matter remained on the agenda for that date. In the interim, region staff submitted a reply and referenced Significant Incident Reports supposedly contained in the file. However, no such reports were included in the copy of the file DCF had submitted to the Unit. DCF was advised of this and also asked to provide the DCF intake for this event. At the June 30 meeting, Central Office staff again came unprepared and indicated they did not have the requested information. During the meeting, staff attempted to gather this, but ultimately provided an intake for the wrong event.

  This incorrect event was discovered to be a sexual abuse report for the same family from the week before, which caused further examination by the Unit in regard to the DCF response to the earlier report, given the indication neither agency knew of the family's whereabouts until a week later. Sexual abuse reports where the alleged perpetrator is in the home require a same day response time, per PPM 1521. In September 2015, the Unit requested the DCF log notes and the narrative basis for finding regarding the sexual abuse report. The Unit was provided a narrative

basis, but advised by DCF that the worker did not complete any log notes regarding the investigation. It should be noted this narrative basis did not identify dates for activities like interviews and exams or otherwise document a timeline of response or any contact with KVC. The Unit highlighted this for Central Office staff at the quarterly meeting in September 2015, during which supervisory staff expressed surprise that there were not log notes for the investigation. The Unit requested the worker's response to the sexual abuse report be reviewed. The Unit also requested DCF provide any information which might document the timeline of the worker's response and explain why KVC was not made aware of the child's whereabouts until a week later, after another report was made by a neighbor.

DCF responded in October 2015 by submitting additional KVC documents which were not contained in the original submission, but nothing explained why KVC was not notified immediately upon receipt of the sexual abuse report. In addition, some of the documents provided appear to be log notes now covering the time period in question, but the majority of which are redacted. At the writing of this report, the Unit has again expressed concern to Central Office staff regarding the failure to provide complete and un-redacted records upon request. No further response has been received.

- In Barton County, a mother was substantiated for the physical abuse of two of her children after it was reported "their mother hit (one child) and threw her up against a cabinet, and that they were going back to the old ways of discipline of mom drowning the kids in the bathtub." DCF went on to state, "the report indicates the mother would stick the children's heads in a tub filled with water as punishment…the report further alleges mother tells the children she didn't want them and has threatened to slit their throats if they tell." This report was originally assigned by DCF in September 2014 and unsubstantiated in November 2014, despite disclosures to family and multiple school staff. This case was cited earlier in the report on page 35.

  Upon receipt of the amended finding in February 2015, in effort to understand how such a significant lapse in communication occurred, the Unit requested to review this DCF file on February 25. On February 27, the region responded the file had been forwarded to Central Office for review and further submission to the Unit. When the file was not received a month later, the Unit submitted a second request on March 30. A third file request was made on April 8 when the matter was placed on the agenda for a quarterly meeting to be held on April 14. DCF subsequently forwarded a file on April 8. This file was reviewed by the Unit and remained staffed at the April 14 quarterly meeting requesting clarification regarding the discrepancy between the SFCS record and the DCF record of the case plan meeting where the mother disclosed her actions. Though Central Office staff agreed to review and respond further, no such information was provided. Nor was this information provided at subsequent quarterly meetings on June 30 or September 30. DCF finally responded on October 10, though no further explanation in the breakdown of communication could be offered other than to advise that the DCF social worker did not attend the full meeting — a fact not stated in the worker's notes regarding the meeting.

- In Sedgwick County, adoptive parents were substantiated for the physical abuse and physical neglect of a child. On June 25, 2014, the Unit requested to review the DCF files pertaining to this family. The region immediately responded and indicated their files were at Central Office. Despite Central Office legal staff being copied on the request and response from the region, the request was redirected to legal staff the following day. Legal staff responded the same day and indicated arrangements would be made to forward a copy of the file to the Unit. On July 10, 2014, legal staff again contacted the Unit and indicated she would confirm "no later than" the following day as to when the department would provide the files. No further response was received from DCF.

  In December 2014, the Unit was forwarded an email concern from a constituent that pertained to this investigation. The Unit again contacted DCF to advise these files had never been received. Central Office legal staff advised she would be out of the office for another six days and would respond further after her return to the office. Again, Central Office staff failed to respond or to produce the requested files. On July 17, 2015, the Unit sent an additional request. DCF Central Office legal staff responded the same day and advised the files were contained in her office. Due to the volume of records, the Unit requested a hard copy of the file, rather than an electronic copy. DCF advised the files were a mix of original copies and photocopies and such could not be delivered to the Unit until July 20 in order to photocopy the original documents. The Unit responded that this time frame was sufficient as we absolutely would not want to receive original DCF documents. The Unit did not receive the files until July 23 after inquiring as to their whereabouts on July 20.

  Upon examination, the Unit found the box contained more than 2,000 pages of documents, most of which appeared to be in no particular order. More concerning was that despite previous communication, many of these documents appeared to be originals. The Unit contacted DCF Central Office legal staff immediately, who responded "there maybe [sic] some original documents" and "while I understand that you don't like to have the originals at this time we do not have staff here to copy the files." DCF advised they did have the files scanned, however, and therefore retained copies "currently available on our computer." It required more than a week for the Unit to inventory the documents.

  The Unit is concerned that once again, DCF took more than a year to comply with a file request and in doing so, released original documents to another agency.

- In Shawnee County, parents and a grandparent were substantiated in July 2013 for lack of supervision and physical neglect of a child. The child was removed from the home by law enforcement after a parent and the grandparent were found to be intoxicated and the home conditions described as "disgusting and in total disarray." The Unit received a second finding pertaining to this child during this reporting year, in July 2014. Again, the same perpetrators were substantiated for physical neglect after law enforcement was called to the home in reference to a fight. These findings were discussed earlier in this report on page 28.

Due to concerns regarding the level of services and monitoring in the home, the Unit requested and reviewed KVC logs in the DCF file. The last log made available for review documented a visit to the home 17 days before the child was placed in police protective custody, though the log indicated the therapist would continue to meet with the family once a week until August. As there were no other logs provided to document any visits between June 4 and when the child was placed in police protective custody on June 21, the Unit sent a follow up inquiry to DCF on September 30, 2014 in order to determine whether any additional logs existed and if so, to obtain them. Such was requested multiple times via email, in addition to being raised at repeated quarterly meetings in October 2014 and January 2015.

Additional logs were ultimately received on April 1, 2015, from one member of DCF Central Office who indicated she had previously forwarded them to a member of DCF's legal team (to send on to the Unit) back on October 8, 2014. This same Central Office staff person was present at the quarterly meeting the following January and both she and the aforementioned staff attorney were the recipients of multiple emails inquiring as to the status of the Unit's request for these records throughout October, November, January, February and March. At no time was it acknowledged the records had been compiled nor was an explanation given as to why they were not made available at an earlier date. In the end, the additional logs received did not address the gap in service. Many of the logs were duplicates of those already provided as a result of the initial request. Though eight logs were provided which had not been provided before, they addressed contacts with the family on earlier dates and did not address the gap in contacts after June 4. No records were provided to document KVC contacts between June 4 and June 21.

At the conclusion of this reporting period, DCF Central Office staff did implement a new communications procedure, as it pertains to child abuse cases only. The department has designated a liaison: one person to whom the Unit is to send all inquiries for all investigations across the state. As of the writing of this report, there is continued concern this process further dilutes the accuracy of the information being provided by filtering it through yet another party who was not directly involved in the investigation. The Unit has been explicitly directed by this liaison on more than one occasion not to communicate with the regions directly and there have continued to be occasions where incorrect or incomplete information has been provided in response to requests. The Unit has expressed concern about this process to Central Office and will address this fully in the next year's annual report.

Of even more significant concern is the denial of access to records by DCF Central Office. In response to a constituent concern, the Unit requested to review records in May 2015 which pertained to an allegation of child abuse. DCF Central Office first refused this request on the basis that the report was the subject of an open investigation and contended that the Unit's statutory authority did not extend to such records, despite the Unit's receipt of pending investigation records in past cases. Upon passage of the allowable timeframe, the Unit again submitted the request. On this occasion, DCF Central Office refused the request on the basis that the investigation was unsubstantiated – also records the Unit has requested and reviewed in past investigations.

The full text of K.S.A 75-723 is available for review on page 3 of this report. However, it provides, in part:

> *Upon request of the unit, the unit shall have access to all records of reports, investigation documents and written reports of findings related to confirmed cases of abuse, neglect or exploitation of persons* ***or cases in which there is reasonable suspicion to believe abuse, neglect or exploitation of persons has occurred*** *which are received or generated by the Kansas department for children and families… (emphasis added)*

The Unit contends that to deny access to records of a DCF investigation violates the plain language of the statute, as well as the spirit of the statute. PPM 1300 in the Prevention and Protection Services Manual of DCF states, in part:

> *The Initial Assessment is to determine when there are* ***reasonable grounds to believe*** *abuse or neglect exists and immediate steps are needed to protect the health and welfare of the abused or neglected child. (emphasis added)*

PPM 1301, Initial Assessment by the Protection Report Center, goes on to direct that a Protection Report Center worker shall assess "to determine if there are reasonable grounds to believe abuse, neglect or non-abuse/neglect issues exist, and whether the report should be assigned for further assessment, not assigned for further assessment, or placed on preliminary inquiry."

The Unit interprets this regulation to mean that once a report is assigned for investigation, DCF staff have determined there are "reasonable grounds to believe" abuse, neglect exists and therefore entitles the Unit to review any investigation records per statutory language allowing for review of records where there is "reasonable suspicion." More so, the purpose of the Unit's creation was to act as a measure of oversight to the systemic response to reports in order to ensure concerns are fully and completely investigated to their fullest extent. To deny access to any report received by DCF circumvents the Unit's authority to examine the systemic response to allegations of abuse, neglect and exploitation and allows the very thing the Legislature aimed to prevent in 2006: for the most vulnerable citizens of Kansas to get lost, for their voices to fail to be heard and for them to fall through the proverbial cracks.

As of the writing of this report, DCF continues to fail to produce the requested file for the Unit's inspection.

Recommendations: The Unit recommends that DCF staff increase efficiency, accuracy and timeliness of response to all Unit inquiries and improve the transparency required by K.S.A. 75-723. Prompt, clear and complete response reduces the risk of children and adults remaining in dangerous and vulnerable positions.

In the Coming Year…

DCF has reported a plan to implement significant changes at the conclusion of the 2016 fiscal year. As it pertains to child abuse investigations, the department plans to lower their burden of proof in an investigation from "clear and convincing" to "a preponderance of the evidence". This is a lower standard and should result in an increase of substantiated findings. In addition, they have reported to this Unit they plan to switch to a three-tier finding system where they will no longer only "substantiate" or "unsubstantiate" a report, but any investigation meeting the "preponderance" burden will either be "affirmed" or "substantiated". Only substantiated perpetrators will be placed on the Child Abuse Registry prohibiting perpetrators from working, residing or volunteering in a facility licensed by KDHE. It will be DCF's discretion to determine whether to place a perpetrator on the registry. Finally, they plan to alter the definition of "unsubstantiated". Currently, per PPM 2502 (A), the definition reads as follows:

> *The facts or circumstances do not provide clear and convincing evidence to meet the K.S.A and K.A.R definition of abuse or neglect*

This means that while it may be believed abuse occurred, there is not sufficient evidence to meet the standard of proof – much like finding someone "not guilty" in a criminal court proceeding.

However, DCF proposes to change the definition to read as follows:

> *A reasonable person weighing the facts or circumstances would conclude it is more likely than not (preponderance of the evidence) abuse and/or neglect per applicable Kansas Statutes Annotated (K.S.A) and Kansas Administrative Regulations (K.A.R) definition* ***did not occur****.* (emphasis added)

The Unit finds this highly concerning; that a social worker would conclude the abuse did not occur, rather than find there is not enough evidence available to say it did occur. What message will children receive if their disclosures are essentially branded as lies? How likely are law enforcement authorities to complete their own criminal investigations if DCF first informs them "it didn't happen"? As the saying goes, "You don't know what you don't know." The Unit finds this application of the term to be dangerous with far-reaching and potentially unforeseen consequences.

Central Office has also advised the Unit they intend to submit both "affirmed" and "substantiated" findings to the Unit for review, so along with the application of a lower standard of evidence, they project this will easily double the number of child abuse findings the Unit will receive.

Given that child abuse findings from DCF account for, on average, 80% of what the Unit receives for review, and that the Unit is dangerously under-staffed at current report levels, it will be impossible to fully review every report the Unit will receive in order to ensure all are properly investigated.

In Conclusion…

The Unit recognizes each agency within the system serves a different function and yet a common goal: the protection and safety of children and vulnerable adults. In a time of reduced manpower and increased caseloads, this is often difficult to accomplish to its fullest extent.

The Unit has identified multiple areas of concern, which include:

- Lack of effective monitoring by the Department of Children and Families' (DCF) contractors to ensure care and safety of children
- Failure to report findings concerning possible criminal acts to a law enforcement agency
- Lack of agency communication
- Ineffective referral process for findings that are referred to law enforcement in adult cases
- Findings not sent to the district or county attorney in the jurisdiction where the crime occurred
- Sexual relations between caregivers and vulnerable populations
- Ineffective use of abuse registries to protect vulnerable children and adults
- Failure of agencies to submit findings to the Unit in compliance with statutory requirement
- DCF's lack of compliance with timely findings
- Failure to report by mandated reporters
- Failure to provide access to records and information within DCF

The one factor that is a common thread through all areas of concern is the need for clear and consistent communication. This includes not only providing information to other agencies, but following up to assure that information is received by the person or agency which is best suited to effectively address the abuse, neglect or exploitation. Social workers, service providers, law enforcement officers and district or county attorney staff may give their best individual efforts in many cases. But it is imperative to understand no single agency is the best means or the only means to keep children and vulnerable adults safe. Only by working together in these agencies' individual capacities, can the system as a whole offer the best protection. A clear message must be sent that abuse to our most innocent and vulnerable will not be tolerated and effective action will be taken.

While this Unit works diligently to bring gaps in the systemic response to abuse to light, it is important to note in its statutory capacity, the Unit has no direct authority over any of the involved agencies. In addition, while there are appropriate and necessary rules of confidentiality, these same protections for victims and perpetrators involved in these investigations create a lack of transparency in agency response. Therefore, the public does not recognize the impact of certain policies: specifically that some policies remain counterproductive to the efforts to protect children and vulnerable adults. Unless these agencies remain committed to joint collaborative efforts which focus on victim safety and perpetrator accountability, with a willingness to engage in creating policy change where necessary, deficiencies will remain.

CHILD REPORTS RECEIVED JULY 1, 2014 - JUNE 30, 2015
KC METRO REGION

SOURCE				DCF REGION		FINDINGS							
DCF - CPS	Other (not substantiated)	Total Reports Received	Percent by Population	County	2014 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
21	-	21	0.13%	Atchison	16,513	-	1	2	1	4	3	10	-
35	-	35	0.03%	Douglas	116,585	-	4	12	1	8	3	12	-
175	1	176	0.03%	Johnson	574,272	-	40	38	8	41	11	52	1
36	-	36	0.05%	Leavenworth	78,797	3	8	7	-	15	2	7	-
106	-	106	0.07%	Wyandotte	161,636	2	16	22	6	25	5	37	-
373	1	374	0.04%	KC METRO	947,803	5	69	81	16	93	24	118	1

"Other" may include reports from legislators, the community at large, other agencies, or any non-standard source.

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division

Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

* Numbers reported include ALL reports received by the ANE Unit, not only those that are substantiated.

CHILD REPORTS RECEIVED JULY 1, 2014 - JUNE 30, 2015
EAST REGION

SOURCE				DCF REGION		FINDINGS							
DCF - CPS	Other (not substantiated)	Total Reports Received	Percent by Population	County	2014 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
8	-	8	0.06%	Allen	12,909	1	-	3	-	3	1	2	-
3	-	3	0.04%	Anderson	7,883	-	1	-	-	-	-	2	-
13	1	14	0.09%	Bourbon	14,772	-	3	3	2	4	1	4	1
13	-	13	0.13%	Brown	9,815	-	1	3	-	5	-	5	-
1	1	2	0.06%	Chautauqua	3,481	-	-	-	-	1	-	-	1
10	-	10	0.05%	Cherokee	20,787	-	-	5	-	2	-	3	-
5	-	5	0.06%	Coffey	8,433	-	1	1	1	1	1	1	-
42	1	43	0.11%	Crawford	39,290	-	8	12	1	10	2	16	1
4	-	4	0.05%	Doniphan	7,874	-	-	2	-	1	1	1	-
18	-	18	0.07%	Franklin	25,611	-	4	1	-	5	8	6	-
15	-	15	0.11%	Jackson	13,539	-	-	4	-	8	2	2	-
7	-	7	0.04%	Jefferson	18,855	-	1	-	1	3	-	3	-
15	-	15	0.07%	Labette	20,960	-	1	6	1	3	4	1	-
7	-	7	0.07%	Linn	9,502	-	2	2	-	4	1	1	-
5	-	5	0.05%	Marshall	10,006	-	-	1	-	2	1	1	-
31	-	31	0.09%	Miami	32,822	-	8	6	-	6	9	8	-
28	-	28	0.08%	Montgomery	34,065	-	1	11	-	6	7	4	-
10	-	10	0.10%	Nemaha	10,148	-	-	1	1	2	3	3	-
15	-	15	0.09%	Neosho	16,416	-	2	8	-	1	1	5	-
12	-	12	0.08%	Osage	15,936	-	2	4	1	3	1	3	-
10	-	10	0.04%	Pottawatomie	22,897	1	1	2	-	4	1	2	-
135	2	137	0.08%	Shawnee	178,406	1	14	26	8	48	9	48	2
3	-	3	0.04%	Wabaunsee	7,022	-	-	-	-	2	-	1	-
2	-	2	0.02%	Wilson	9,028	-	-	1	-	-	-	1	-
1	-	1	0.03%	Woodson	3,157	-	-	1	-	-	-	-	-
413	5	418	0.08%	EAST	553,614	3	50	103	16	124	53	123	5

"Other" may include reports from legislators, the community at large, other agencies, or any non-standard source.

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division

Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

* Numbers reported include ALL reports received by the ANE Unit, not only those that are substantiated.

CHILD REPORTS RECEIVED JULY 1, 2014 - JUNE 30, 2015
WEST REGION

SOURCE				DCF REGION		FINDINGS							
DCF - CPS	Other (not substantiated)	Total Reports Received	Percent by Population	County	2014 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
28	-	28	0.10%	Barton	27,385	-	-	3	2	8	3	12	-
-	-	0	0.00%	Chase	2,692	-	-	-	-	-	-	-	-
3	-	3	0.11%	Cheyenne	2,693	-	-	-	-	1	1	1	-
1	-	1	0.05%	Clark	2,144	-	-	1	-	-	-	-	-
6	-	6	0.07%	Clay	8,317	-	1	2	-	3	-	1	-
12	-	12	0.13%	Cloud	9,385	-	-	5	-	5	-	2	-
3	-	3	0.15%	Comanche	1,954	-	-	-	1	1	-	1	-
1	-	1	0.03%	Decatur	2,908	-	-	-	-	-	-	1	-
10	1	11	0.06%	Dickinson	19,394	-	1	3	1	1	-	4	1
-	-	0	0.00%	Edwards	3,030	-	-	-	-	-	-	-	-
7	-	7	0.02%	Ellis	29,013	-	2	-	-	2	1	3	-
7	-	7	0.11%	Ellsworth	6,392	-	-	1	-	1	-	5	-
64	-	64	0.17%	Finney	37,184	3	3	15	3	13	11	25	-
26	-	26	0.07%	Ford	34,795	-	-	1	-	3	1	22	-
12	-	12	0.03%	Geary	36,713	-	-	5	-	3	1	5	-
-	-	0	0.00%	Gove	2,727	-	-	-	-	-	-	-	-
4	-	4	0.16%	Graham	2,566	-	-	1	-	1	-	2	-
6	-	6	0.08%	Grant	7,816	-	-	1	-	1	2	3	-
7	-	7	0.12%	Gray	6,082	-	-	2	-	-	-	5	-
2	-	2	0.15%	Greeley	1,301	-	-	-	-	-	1	1	-
3	-	3	0.12%	Hamilton	2,603	-	-	2	-	-	-	1	-
17	-	17	0.05%	Harvey	34,820	-	1	7	-	3	1	9	-
5	-	5	0.12%	Haskell	4,106	-	2	2	-	-	-	2	-
-	-	0	0.00%	Hodgeman	1,916	-	-	-	-	-	-	-	-
1	-	1	0.03%	Jewell	3,043	-	-	-	-	-	-	1	-
9	-	9	0.23%	Kearny	3,915	-	-	3	-	1	-	5	-
-	-	0	0.00%	Kiowa	2,513	-	-	-	-	-	-	-	-
2	-	2	0.12%	Lane	1,687	-	1	-	-	1	-	-	-
2	-	2	0.06%	Lincoln	3,167	-	-	1	-	1	-	-	-
1	-	1	0.04%	Logan	2,794	-	-	-	-	1	-	-	-
22	-	22	0.07%	Lyon	33,212	-	4	6	-	4	7	4	-
3	-	3	0.02%	Marion	12,208	-	-	-	-	-	-	3	-

6	-	6	0.02%	McPherson	29,241	-	1	1	-	1	-	3	-
1	-	1	0.02%	Meade	4,357	-	-	1	-	-	-	-	-
4	-	4	0.06%	Mitchell	6,284	-	-	-	-	1	-	3	-
4	-	4	0.07%	Morris	5,698	-	-	2	-	-	1	1	-
-	-	0	0.00%	Morton	3,110	-	-	-	-	-	-	-	-
-	-	0	0.00%	Ness	3,105	-	-	-	-	-	-	-	-
1	-	1	0.02%	Norton	5,560	-	-	-	-	1	-	-	-
3	-	3	0.08%	Osborne	3,756	-	-	1	-	-	-	2	-
3	-	3	0.05%	Ottawa	6,065	-	-	-	-	2	-	1	-
7	-	7	0.10%	Pawnee	6,916	-	1	1	2	1	1	1	-
2	-	2	0.04%	Phillips	5,533	-	-	1	-	1	-	-	-
-	-	0	0.00%	Rawlins	2,584	-	-	-	-	-	-	-	-
61	1	62	0.10%	Reno	63,794	1	10	9	8	14	11	13	1
6	-	6	0.12%	Republic	4,803	-	1	1	2	3	1	-	-
14	-	14	0.14%	Rice	10,015	-	2	2	-	2	3	5	-
17	-	17	0.02%	Riley	75,194	-	-	3	2	7	-	6	-
3	-	3	0.06%	Rooks	5,155	-	1	-	-	2	-	-	-
5	-	5	0.16%	Rush	3,197	-	1	-	1	4	-	-	-
11	-	11	0.16%	Russell	6,956	-	4	-	-	1	-	8	-
32	1	33	0.06%	Saline	55,755	-	3	10	-	8	2	14	1
6	-	6	0.12%	Scott	5,080	-	-	3	-	2	2	1	-
8	-	8	0.03%	Seward	23,465	-	1	3	-	3	-	3	-
-	-	0	0.00%	Sheridan	2,539	-	-	-	-	-	-	-	-
9	-	9	0.15%	Sherman	6,110	-	-	1	1	2	3	3	-
-	-	0	0.00%	Smith	3,769	-	-	-	-	-	-	-	-
2	-	2	0.05%	Stafford	4,297	-	1	-	-	-	1	-	-
1	-	1	0.05%	Stanton	2,111	-	-	-	-	-	-	1	-
6	-	6	0.10%	Stevens	5,801	-	-	1	-	-	1	4	-
8	-	8	0.10%	Thomas	7,891	-	1	2	-	1	5	2	-
-	-	0	0.00%	Trego	2,902	-	-	-	-	-	-	-	-
-	-	0	0.00%	Wallace	1,506	-	-	-	-	-	-	-	-
-	-	0	0.00%	Washington	5,598	-	-	-	-	-	-	-	-
1	-	1	0.05%	Wichita	2,176	-	-	-	-	1	-	-	-
485	3	488	0.07%	WEST	730,798	4	42	103	23	111	60	189	3

"Other" may include reports from legislators, the community at large, other agencies, or any non-standard source.

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division
Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

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CHILD REPORTS RECEIVED JULY 1, 2014 - JUNE 30, 2015
WICHITA REGION

SOURCE				DCF REGION		FINDINGS							
DCF - CPS	Other (not substantiated)	Total Reports Received	Percent by Population	County	2014 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
-	-	0	0.00%	Barber	4,897	-	-	-	-	-	-	-	-
17	-	17	0.03%	Butler	66,227	-	1	5	-	6	4	2	-
8	-	8	0.02%	Cowley	35,963	-	-	2	1	4	1	2	-
2	-	2	0.07%	Elk	2,694	-	-	1	-	-	-	1	-
2	-	2	0.03%	Greenwood	6,328	-	-	-	-	-	2	-	-
1	-	1	0.02%	Harper	5,818	-	-	-	-	1	-	-	-
3	-	3	0.04%	Kingman	7,698	-	-	-	-	1	-	2	-
3	-	3	0.03%	Pratt	9,850	-	-	1	-	-	2	1	-
162	-	162	0.03%	Sedgwick	508,803	-	9	16	2	45	10	85	-
2	-	2	0.01%	Sumner	23,528	-	-	-	-	-	1	1	-
200	0	200	0.03%	WICHITA	671,806	0	10	25	3	57	20	94	0

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Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division

Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

* Numbers reported include ALL reports received by the ANE Unit, not only those that are substantiated.

CHILD REPORTS RECEIVED JULY 1, 2014 - JUNE 30, 2015
STATEWIDE

SOURCE				DCF REGION		FINDINGS							
DCF - CPS	Other (not substantiated)	Total Reports Received	Percent by Population	County	2014 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
373	1	374	0.04%	KC Metro	947,803	5	69	81	16	93	24	118	1
413	5	418	0.08%	East	553,614	3	50	103	16	124	53	123	5
485	3	488	0.07%	West	730,798	4	42	103	23	111	60	189	3
200	-	200	0.03%	Wichita	671,806	-	10	25	3	57	20	94	-
1471	9	1480	0.05%	STATEWIDE	2,904,021	12	171	312	58	385	157	524	9

"Other" may include reports from legislators, the community at large, other agencies, or any non-standard source.

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division

Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

* Numbers reported include ALL reports received by the ANE Unit, not only those that are substantiated.

ADULT REPORTS RECEIVED JULY 1, 2014 - JUNE 30, 2015
KC METRO REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other - (not substantiated)	KDHE - CP (Corrective Action - not substantiated)	Total Reports Received	Percent by Population	County	2014 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
3	-	-	-	-	3	0.02%	Atchison	16,513	-	-	3	-	-
4	1	-	-	-	5	0.00%	Douglas	116,585	-	3	1	1	-
24	3	1	1	-	29	0.01%	Johnson	574,272	8	3	4	15	1
6	-	-	-	-	6	0.01%	Leavenworth	78,797	3	1	2	1	-
11	1	-	1	-	13	0.01%	Wyandotte	161,636	3	5	1	3	1
48	5	1	2	0	56	0.01%	KC METRO	947,803	14	12	11	20	2

"Other" may include reports from legislators, the community at large, other agencies, or any non-standard source.

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division
Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

* Numbers reported include ALL reports received by the ANE Unit, not only those that are substantiated.

ADULT REPORTS RECEIVED JULY 1, 2014 - JUNE 30, 2015
EAST REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other - (not substantiated)	KDHE - CP (Corrective Action - not substantiated)	Total Reports Received	Percent by Population	County	2014 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
2	1	-	-	-	3	0.02%	Allen	12,909	-	1	1	1	-
-	-	-	-	-	0	0.00%	Anderson	7,883	-	-	-	-	-
-	-	-	-	-	0	0.00%	Bourbon	14,772	-	-	-	-	-
2	1	-	-	-	3	0.03%	Brown	9,815	-	-	2	1	-
-	-	-	-	-	0	0.00%	Chautauqua	3,481	-	-	-	-	-
-	1	-	1	-	2	0.01%	Cherokee	20,787	-	1	-	-	1
3	-	-	1	-	4	0.05%	Coffey	8,433	1	1	1	-	1
4	-	-	-	-	4	0.01%	Crawford	39,290	1	-	2	1	-
-	-	-	-	-	0	0.00%	Doniphan	7,874	-	-	-	-	-
1	-	-	-	-	1	0.00%	Franklin	25,611	-	-	1	-	-
-	-	-	-	-	0	0.00%	Jackson	13,539	-	-	-	-	-
3	-	-	-	-	3	0.02%	Jefferson	18,855	1	2	-	1	-
2	-	-	-	-	2	0.01%	Labette	20,960	1	-	-	1	-
1	-	-	-	-	1	0.01%	Linn	9,502	-	-	-	1	-
1	1	-	-	-	2	0.02%	Marshall	10,006	1	1	-	-	-
1	1	-	-	-	2	0.01%	Miami	32,822	1	-	-	2	-
1	-	-	1	-	2	0.01%	Montgomery	34,065	-	-	1	-	1
1	1	-	-	-	2	0.02%	Nemaha	10,148	-	2	-	-	-
3	-	-	1	-	4	0.02%	Neosho	16,416	-	1	2	-	1
2	-	-	1	-	3	0.02%	Osage	15,936	1	-	1	-	1
-	-	-	-	-	0	0.00%	Pottawatomie	22,897	-	-	-	-	-
48	2	-	2	-	52	0.03%	Shawnee	178,406	15	8	8	21	2
-	-	-	-	-	0	0.00%	Wabaunsee	7,022	-	-	-	-	-
-	-	-	-	-	0	0.00%	Wilson	9,028	-	-	-	-	-
-	-	-	-	-	0	0.00%	Woodson	3,157	-	-	-	-	-
75	8	0	7	0	90	0.02%	EAST	553,614	22	17	19	29	7

"Other" may include reports from legislators, the community at large, other agencies, or any non-standard source.

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division

Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

* Numbers reported include ALL reports received by the ANE Unit, not only those that are substantiated.

ADULT REPORTS RECEIVED JULY 1, 2014 - JUNE 30, 2015
WEST REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other - (not substantiated)	KDHE - CP (Corrective Action - not substantiated)	Total Reports Received	Percent by Population	County	2014 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
-	-	-	-	-	0	0.00%	Barton	27,385	-	-	-	-	-
-	-	-	-	-	0	0.00%	Chase	2,692	-	-	-	-	-
-	-	-	-	-	0	0.00%	Cheyenne	2,693	-	-	-	-	-
-	-	-	-	-	0	0.00%	Clark	2,144	-	-	-	-	-
-	1	-	-	-	1	0.01%	Clay	8,317	1	-	-	1	-
2	-	-	-	-	2	0.02%	Cloud	9,385	1	-	1	-	-
1	-	-	-	-	1	0.05%	Comanche	1,954	-	-	1	-	-
-	-	-	-	-	0	0.00%	Decatur	2,908	-	-	-	-	-
1	-	-	-	-	1	0.01%	Dickinson	19,394	1	-	-	-	-
-	-	-	-	-	0	0.00%	Edwards	3,030	-	-	-	-	-
2	-	-	-	-	2	0.01%	Ellis	29,013	-	1	1	-	-
1	-	-	-	-	1	0.02%	Ellsworth	6,392	-	-	-	1	-
1	1	-	-	-	2	0.01%	Finney	37,184	1	1	-	1	-
-	-	-	-	-	0	0.00%	Ford	34,795	-	-	-	-	-
1	-	-	-	-	1	0.00%	Geary	36,713	-	1	-	-	-
-	-	-	-	-	0	0.00%	Gove	2,727	-	-	-	-	-
1	-	-	-	-	1	0.04%	Graham	2,566	-	-	-	1	-
-	-	-	-	-	0	0.00%	Grant	7,816	-	-	-	-	-
-	-	-	-	-	0	0.00%	Gray	6,082	-	-	-	-	-
-	-	-	-	-	0	0.00%	Greeley	1,301	-	-	-	-	-
-	-	-	-	-	0	0.00%	Hamilton	2,603	-	-	-	-	-
4	-	-	-	-	4	0.01%	Harvey	34,820	-	2	-	2	-
-	-	-	-	-	0	0.00%	Haskell	4,106	-	-	-	-	-
-	-	-	-	-	0	0.00%	Hodgeman	1,916	-	-	-	-	-
-	-	-	-	-	0	0.00%	Jewell	3,043	-	-	-	-	-
-	-	-	-	-	0	0.00%	Kearny	3,915	-	-	-	-	-
-	-	-	-	-	0	0.00%	Kiowa	2,513	-	-	-	-	-
-	-	-	-	-	0	0.00%	Lane	1,687	-	-	-	-	-
-	-	-	-	-	0	0.00%	Lincoln	3,167	-	-	-	-	-
-	-	-	-	-	0	0.00%	Logan	2,794	-	-	-	-	-
2	-	-	1	-	3	0.01%	Lyon	33,212	-	1	1	-	1
-	1	-	-	-	1	0.01%	Marion	12,208	1	-	-	1	-

3	2	-	-	-	5	0.02%	McPherson	29,241	3	1	1	1	-
-	-	-	-	-	0	0.00%	Meade	4,357	-	-	-	-	-
-	-	-	-	-	0	0.00%	Mitchell	6,284	-	-	-	-	-
-	-	-	-	-	0	0.00%	Morris	5,698	-	-	-	-	-
-	1	-	-	-	1	0.03%	Morton	3,110	1	-	-	1	-
-	-	-	-	-	0	0.00%	Ness	3,105	-	-	-	-	-
-	1	-	-	-	1	0.02%	Norton	5,560	-	1	-	-	-
-	-	-	-	-	0	0.00%	Osborne	3,756	-	-	-	-	-
1	-	-	-	-	1	0.02%	Ottawa	6,065	-	-	1	-	-
-	-	-	-	-	0	0.00%	Pawnee	6,916	-	-	-	-	-
-	-	-	-	-	0	0.00%	Phillips	5,533	-	-	-	-	-
-	-	-	-	-	0	0.00%	Rawlins	2,584	-	-	-	-	-
9	1	-	-	-	10	0.02%	Reno	63,794	5	6	1	-	-
2	-	-	-	-	2	0.04%	Republic	4,803	-	2	-	-	-
3	-	-	-	-	3	0.03%	Rice	10,015	-	-	3	-	-
3	-	-	-	-	3	0.00%	Riley	75,194	1	1	1	-	-
-	1	-	-	-	1	0.02%	Rooks	5,155	1	-	-	1	-
1	-	-	-	-	1	0.03%	Rush	3,197	-	-	1	-	-
-	-	-	-	-	0	0.00%	Russell	6,956	-	-	-	-	-
7	-	-	-	-	7	0.01%	Saline	55,755	3	2	2	-	-
-	-	-	-	-	0	0.00%	Scott	5,080	-	-	-	-	-
-	-	-	-	-	0	0.00%	Seward	23,465	-	-	-	-	-
-	-	-	-	-	0	0.00%	Sheridan	2,539	-	-	-	-	-
-	-	-	-	-	0	0.00%	Sherman	6,110	-	-	-	-	-
2	-	-	-	-	2	0.05%	Smith	3,769	-	-	1	1	-
-	-	-	1	-	1	0.02%	Stafford	4,297	-	-	-	-	1
-	-	-	-	-	0	0.00%	Stanton	2,111	-	-	-	-	-
-	-	-	-	-	0	0.00%	Stevens	5,801	-	-	-	-	-
-	-	-	-	-	0	0.00%	Thomas	7,891	-	-	-	-	-
-	-	-	-	-	0	0.00%	Trego	2,902	-	-	-	-	-
-	-	-	-	-	0	0.00%	Wallace	1,506	-	-	-	-	-
3	2	-	-	-	5	0.09%	Washington	5,598	1	3	1	-	-
-	-	-	-	-	0	0.00%	Wichita	2,176	-	-	-	-	-
50	11	0	2	0	63	0.01%	WEST	730,798	20	22	16	11	2

"Other" may include reports from legislators, the community at large, other agencies, or any non-standard source.

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division
Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

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ADULT REPORTS RECEIVED JULY 1, 2014 - JUNE 30, 2015
WICHITA REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other - (not substantiated)	KDHE - CP (Corrective Action - not substantiated)	Total Reports Received	Percent by Population	County	2014 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
-	-	-	-	-	0	0.00%	Barber	4,897	-	-	-	-	-
9	3	-	-	-	12	0.02%	Butler	66,227	3	5	3	2	-
6	-	-	-	-	6	0.02%	Cowley	35,963	2	1	1	3	-
-	-	-	-	-	0	0.00%	Elk	2,694	-	-	-	-	-
-	-	-	-	-	0	0.00%	Greenwood	6,328	-	-	-	-	-
3	-	-	-	-	3	0.05%	Harper	5,818	2	1	-	-	-
1	1	-	-	-	2	0.03%	Kingman	7,698	2	-	-	1	-
2	-	-	-	-	2	0.02%	Pratt	9,850	-	1	-	1	-
86	10	3	3	-	102	0.02%	Sedgwick	508,803	21	29	18	37	3
3	1	-	-	-	4	0.02%	Sumner	23,528	-	2	-	2	-
110	15	3	3	0	131	0.02%	WICHITA	671,806	30	39	22	46	3

"Other" may include reports from legislators, the community at large, other agencies, or any non-standard source.

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division

Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

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ADULT REPORTS RECEIVED JULY 1, 2014 - JUNE 30, 2015
STATEWIDE

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other - (not substantiated)	KDHE - CP (Corrective Action - not substantiated)	Total Reports Received	Percent by Population	County	2014 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
48	5	1	2	-	56	0.01%	KC METRO	947,803	14	12	11	20	2
75	8	-	7	-	90	0.02%	EAST	553,614	22	17	19	29	7
50	11	-	2	-	63	0.01%	WEST	730,798	20	22	16	11	2
110	15	3	3	-	131	0.02%	WICHITA	671,806	30	39	22	46	3
283	39	4	14	0	340	0.01%	STATEWIDE	2,904,021	86	90	68	106	14

"Other" may include reports from legislators, the community at large, other agencies, or any non-standard source.

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division
Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

* Numbers reported include ALL reports received by the ANE Unit, not only those that are substantiated.

DISPOSITION OF 2013-2014 CHILD CASES BY COUNTY
KC METRO REGION

	DCF REGION		Outcome as a Percentage of Reports Received									
Total Reports Received	County	2014 Population Estimate	Diversion	Convicted	Acquitted	Dismissed	Declined	DCF Custody	Receiving Services	All Other	No Action Taken	Pending
4	Atchison	16,513	-	25%	-	-	-	50%	-	-	-	50%
36	Douglas	116,585	-	17%	-	-	3%	6%	3%	6%	-	72%
195	Johnson	574,272	2%	12%	1%	1%	2%	7%	2%	2%	1%	76%
41	Leavenworth	78,797	2%	15%		2%	2%	5%	5%	-	-	76%
118	Wyandotte	161,636	1%	16%	1%	1%	1%	8%	3%	1%	1%	75%
394	KC METRO	947,803	2%	14%	1%	1%	2%	8%	2%	2%	1%	75%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division
Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

* Numbers reported include all substantiated reports received by the ANE Unit plus any KDHE Corrective Actions received.

* Percentages are rounded to the nearest whole number. Those reported as 0% are under 0.5%

DISPOSITION OF 2013-2014 CHILD CASES BY COUNTY
EAST REGION

	DCF REGION		Outcome as a Percentage of Reports Received									
Total Reports Received	County	2014 Population Estimate	Diversion	Convicted	Acquitted	Dismissed	Declined	DCF Custody	Receiving Services	All Other	No Action Taken	Pending
4	Allen	12,909	-	100%	-	-	-	50%	-	-	-	-
1	Anderson	7,883	-	100%	-	-	-	-	-	-	-	-
16	Bourbon	14,772	13%	25%	-	-	-	19%	13%	-	-	50%
12	Brown	9,815	-	8%	-	-	-	17%	-	-	-	83%
3	Chautauqua	3,481	-	33%	-	-	-	-	-	-	-	67%
20	Cherokee	20,787	5%	5%	-	-	5%	5%	-	5%	-	80%
4	Coffey	8,433	-	25%	-	-	-	-	-	-	-	75%
45	Crawford	39,290	-	11%	-	-	4%	11%	2%	-	2%	76%
7	Doniphan	7,874	-	14%	-	-	-	-	-	-	-	86%
16	Franklin	25,611	-	13%	-	13%	-	25%	-	-	-	63%
14	Jackson	13,539	-	7%	-	-	-	7%	-	7%	-	86%
10	Jefferson	18,855	-	10%	-	10%	-	20%	-	10%	-	70%
16	Labette	20,960	-	6%	-	-	-	6%	6%	6%	-	81%
7	Linn	9,502	-	29%	-	-	-	14%	-	-	-	71%
3	Marshall	10,006	-	-	-	-	33%	33%	-	-	-	67%
21	Miami	32,822	-	10%	-	-	10%	5%	-	5%	-	71%
41	Montgomery	34,065	-	17%	-	2%	-	5%	7%	-	-	78%
2	Nemaha	10,148	-	50%	-	-	-	-	-	-	-	50%
17	Neosho	16,416	6%	-	-	6%	-	-	-	-	-	88%
7	Osage	15,936	-	14%	-	14%	-	-	-	-	-	71%
11	Pottawatomie	22,897	-	9%	-	9%	9%	27%	-	-	-	64%
162	Shawnee	178,406	-	12%	-	2%	1%	6%	3%	1%	1%	80%
3	Wabaunsee	7,022	-	-	-	-	-	-	-	-	-	100%
14	Wilson	9,028	-	21%	-	-	-	21%	-	-	-	79%
3	Woodson	3,157	-	-	-	-	-	33%	-	-	-	67%
459	EAST	553,614	1%	13%	-	2%	2%	9%	3%	1%	0%	76%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division

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* Numbers reported include all substantiated reports received by the ANE Unit plus any KDHE Corrective Actions received.

* Percentages are rounded to the nearest whole number. Those reported as 0% are under 0.5%

DISPOSITION OF 2013-2014 CHILD CASES BY COUNTY
WEST REGION

	DCF REGION		Outcome as a Percentage of Reports Received									
Total Reports Received	County	2014 Population Estimate	Diversion	Convicted	Acquitted	Dismissed	Declined	DCF Custody	Receiving Services	All Other	No Action Taken	Pending
30	Barton	27,385	-	17%	-	3%	-	10%	-	-	-	77%
0	Chase	2,692	-	-	-	-	-	-	-	-	-	-
0	Cheyenne	2,693	-	-	-	-	-	-	-	-	-	-
1	Clark	2,144	-	100%	-	-	-	-	-	-	-	-
2	Clay	8,317	-	0%	-	-	-	-	-	-	-	100%
12	Cloud	9,385	-	25%	-	25%	-	-	8%	-	-	42%
0	Comanche	1,954	-	-	-	-	-	-	-	-	-	-
3	Decatur	2,908	-	-	-	-	-	-	-	-	-	100%
16	Dickinson	19,394	6%	19%	-	-	-	13%	-	-	-	69%
0	Edwards	3,030	-	-	-	-	-	-	-	-	-	-
8	Ellis	29,013	13%	25%	-	-	13%	-	-	-	-	63%
1	Ellsworth	6,392	-	-	-	-	-	-	-	-	-	100%
27	Finney	37,184	-	11%	-	4%	-	11%	4%	-	-	81%
24	Ford	34,795	-	25%	-	4%	4%	13%	-	4%	-	63%
10	Geary	36,713	-	30%	-	-	10%	20%	-	10%	-	40%
1	Gove	2,727	-	-	-	-	-	-	-	-	-	100%
1	Graham	2,566	-	-	-	-	-	-	-	-	-	100%
3	Grant	7,816	-	-	-	-	-	-	-	-	-	100%
7	Gray	6,082	-	29%	-	29%	-	57%	-	-	-	29%
3	Greeley	1,301	-	-	-	33%	-	-	-	-	-	67%
2	Hamilton	2,603	50%	50%	-	-	-	50%	-	-	-	-
18	Harvey	34,820	-	28%	-	6%	-	6%	-	6%	-	56%
3	Haskell	4,106	-	-	-	-	-	-	-	33%	-	67%
0	Hodgeman	1,916	-	-	-	-	-	-	-	-	-	-
1	Jewell	3,043	-	-	-	-	-	-	-	-	-	100%
4	Kearny	3,915	-	25%	-	-	-	25%	-	-	-	75%
0	Kiowa	2,513	-	-	-	-	-	-	-	-	-	-
0	Lane	1,687	-	-	-	-	-	-	-	-	-	-
1	Lincoln	3,167	-	-	-	100%	-	-	-	-	-	-
1	Logan	2,794	-	100%	-	-	-	-	-	-	-	-
27	Lyon	33,212	7%	22%	-	4%	-	22%	4%	-	-	67%
3	Marion	12,208	-	33%	-	-	-	-	-	-	-	67%

7	McPherson	29,241	-	29%	-	14%	-	-	-	-	-	57%
3	Meade	4,357	-	-	-	-	-	-	-	-	-	100%
7	Mitchell	6,284	-	14%	-	29%	-	-	-	-	-	57%
5	Morris	5,698	20%	20%	-	-	-	-	-	-	-	80%
1	Morton	3,110	-	-	-	100%	-	-	100%	-	-	-
1	Ness	3,105	-	-	-	-	-	-	-	-	-	100%
2	Norton	5,560	-	50%	-	-	-	-	-	-	-	50%
5	Osborne	3,756	-	40%	-	-	-	-	-	-	-	60%
3	Ottawa	6,065	33%	67%	-	-	-	33%	-	-	-	-
4	Pawnee	6,916	-	-	-	-	-	-	-	-	-	100%
4	Phillips	5,533	-	-	-	-	-	25%	-	-	-	75%
2	Rawlins	2,584	-	50%	-	-	-	50%	-	-	-	50%
17	Reno	63,794	-	-	6%	-	-	6%	-	-	-	88%
2	Republic	4,803	-	-	-	-	-	-	-	-	-	100%
5	Rice	10,015	-	60%	-	-	-	-	-	-	-	40%
17	Riley	75,194	6%	18%	-	6%	6%	18%	6%	-	-	59%
9	Rooks	5,155	-	11%	-	-	-	-	-	-	-	89%
1	Rush	3,197	-	-	-	-	-	-	-	-	-	100%
2	Russell	6,956	-	-	-	-	-	-	-	-	-	100%
38	Saline	55,755	-	32%	-	3%	-	5%	-	-	-	66%
5	Scott	5,080	-	-	-	-	-	-	-	-	-	100%
19	Seward	23,465	-	21%	-	5%	-	16%	5%	-	-	63%
0	Sheridan	2,539	-	-	-	-	-	-	-	-	-	-
4	Sherman	6,110	-	-	-	-	-	-	-	-	-	100%
2	Smith	3,769	-	-	-	-	-	-	-	-	-	100%
0	Stafford	4,297	-	-	-	-	-	-	-	-	-	-
2	Stanton	2,111	-	-	-	-	-	-	-	-	-	100%
3	Stevens	5,801	-	33%	-	-	-	33%	-	-	33%	33%
5	Thomas	7,891	-	20%	-	-	-	-	-	-	-	80%
0	Trego	2,902	-	-	-	-	-	-	-	-	-	-
3	Wallace	1,506	-	33%	-	-	-	-	-	-	-	67%
1	Washington	5,598	-	-	-	-	-	100%	100%	-	-	-
1	Wichita	2,176	-	-	-	-	-	-	-	-	-	100%
389	WEST	730,798	2%	20%	0%	5%	1%	10%	2%	1%	0%	67%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division
Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

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DISPOSITION OF 2013-2014 CHILD CASES BY COUNTY
WICHITA REGION

	DCF REGION		Outcome as a Percentage of Reports Received									
Total Reports Received	County	2014 Population Estimate	Diversion	Convicted	Acquitted	Dismissed	Declined	DCF Custody	Receiving Services	All Other	No Action Taken	Pending
1	Barber	4,897	-	-	-	-	-	-	-	-	-	100%
14	Butler	66,227	-	-	-	-	-	29%	-	-	-	71%
5	Cowley	35,963	-	20%	-	-	-	-	-	-	-	80%
0	Elk	2,694	-	-	-	-	-	-	-	-	-	-
4	Greenwood	6,328	-	25%	-	-	-	25%	-	25%	-	25%
2	Harper	5,818	-	-	50%	50%	-	50%	50%	-	-	-
6	Kingman	7,698	-	17%	-	17%	-	-	-	-	-	67%
0	Pratt	9,850	-	-	-	-	-	-	-	-	-	-
163	Sedgwick	508,803	-	30%	-	-	1%	9%	3%	1%	-	68%
4	Sumner	23,528	-	25%	-	25%	-	-	-	-	-	50%
199	WICHITA	671,806	-	27%	1%	2%	1%	10%	3%	1%	-	67%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division
Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

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DISPOSITION OF 2013-2014 CHILD CASES BY COUNTY
STATEWIDE

	DCF REGION		Outcome as a Percentage of Reports Received									
Total Reports Received	County	2014 Population Estimate	Diversion	Convicted	Acquitted	Dismissed	Declined	DCF Custody	Receiving Services	All Other	No Action Taken	Pending
394	KC Metro	947,803	2%	14%	1%	1%	2%	8%	2%	2%	1%	75%
459	East	553,614	1%	13%	-	2%	2%	9%	3%	1%	0%	76%
389	West	730,798	2%	20%	0%	5%	1%	10%	2%	1%	0%	67%
199	Wichita	671,806	-	27%	1%	2%	1%	10%	3%	1%	-	67%
1441	STATEWIDE	2,904,021	1%	17%	0%	2%	1%	9%	2%	1%	0%	72%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division
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DISPOSITION OF 2013-2014 ADULT CASES BY COUNTY
KC METRO REGION

	DCF REGION		Outcome as Percentage of Reports Received							
Total Reports Received	County	2014 Population Estimate	Diversion	Convicted	Acquitted	Dismissed	Declined	All Other	No Known Action	Pending
1	Atchison	16,513	-	-	-	-	-	-	-	100%
8	Douglas	116,585	-	-	-	-	-	-	-	100%
48	Johnson	574,272	-	8%	-	-	2%	-	-	90%
4	Leavenworth	78,797	50%	-	-	-	-	-	-	50%
17	Wyandotte	161,636	-	6%	-	-	-	6%	-	88%
78	KC METRO	947,803	3%	6%	-	-	1%	1%	-	88%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division
Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2014. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2015. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2015.

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DISPOSITION OF 2013-2014 ADULT CASES BY COUNTY
EAST REGION

	DCF REGION		Outcome as Percentage of Reports Received							
Total Reports Received	County	2014 Population Estimate	Diversion	Convicted	Acquitted	Dismissed	Declined	All Other	No Known Action	Pending
1	Allen	12,909	-	-	-	-	-	-	-	100%
0	Anderson	7,883	-	-	-	-	-	-	-	-
4	Bourbon	14,772	-	-	-	-	-	-	-	100%
3	Brown	9,815	-	-	-	-	-	-	-	100%
0	Chautauqua	3,481	-	-	-	-	-	-	-	-
5	Cherokee	20,787	-	-	-	-	-	20%	-	80%
1	Coffey	8,433	-	-	-	-	-	-	-	100%
7	Crawford	39,290	-	-	-	-	-	-	-	100%
1	Doniphan	7,874	-	-	-	-	-	-	-	100%
6	Franklin	25,611	-	-	-	-	-	17%	-	83%
3	Jackson	13,539	-	33%	-	-	-	-	-	67%
5	Jefferson	18,855	-	-	-	-	-	-	-	100%
6	Labette	20,960	-	17%	-	-	-	-	-	83%
0	Linn	9,502	-	-	-	-	-	-	-	-
0	Marshall	10,006	-	-	-	-	-	-	-	-
2	Miami	32,822	-	-	-	-	-	-	-	100%
2	Montgomery	34,065	-	-	-	-	-	-	-	100%
2	Nemaha	10,148	-	-	-	-	-	-	-	100%
4	Neosho	16,416	-	50%	-	-	-	-	-	50%
7	Osage	15,936	-	-	-	-	-	-	-	100%
0	Pottawatomie	22,897	-	-	-	-	-	-	-	-
49	Shawnee	178,406	-	-	-	-	-	6%	-	94%
0	Wabaunsee	7,022	-	-	-	-	-	-	-	-
0	Wilson	9,028	-	-	-	-	-	-	-	-
1	Woodson	3,157	-	-	-	-	-	-	-	100%
109	EAST	553,614	-	4%	-	-	-	5%	-	92%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2014

Source: U.S. Census Bureau, Population Division

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DISPOSITION OF 2013-2014 ADULT CASES BY COUNTY
WEST REGION

	DCF REGION		Outcome as Percentage of Reports Received							
Total Reports Received	County	2014 Population Estimate	Diversion	Convicted	Acquitted	Dismissed	Declined	All Other	No Known Action	Pending
10	Barton	27,385	-	-	-	-	-	30%	-	70%
0	Chase	2,692	-	-	-	-	-	-	-	-
0	Cheyenne	2,693	-	-	-	-	-	-	-	-
0	Clark	2,144	-	-	-	-	-	-	-	-
0	Clay	8,317	-	-	-	-	-	-	-	-
3	Cloud	9,385	-	-	-	-	-	-	-	100%
0	Comanche	1,954	-	-	-	-	-	-	-	-
0	Decatur	2,908	-	-	-	-	-	-	-	-
5	Dickinson	19,394	-	-	-	-	-	-	-	100%
0	Edwards	3,030	-	-	-	-	-	-	-	-
2	Ellis	29,013	-	-	-	-	-	-	-	100%
0	Ellsworth	6,392	-	-	-	-	-	-	-	-
2	Finney	37,184	-	-	-	-	-	-	-	100%
4	Ford	34,795	-	-	-	-	-	-	-	100%
2	Geary	36,713	-	-	-	-	-	-	-	100%
1	Gove	2,727	-	-	-	-	-	-	-	100%
1	Graham	2,566	-	-	-	-	-	-	-	100%
0	Grant	7,816	-	-	-	-	-	-	-	-
0	Gray	6,082	-	-	-	-	-	-	-	-
0	Greeley	1,301	-	-	-	-	-	-	-	-
0	Hamilton	2,603	-	-	-	-	-	-	-	-
6	Harvey	34,820	-	-	-	-	-	-	-	100%
1	Haskell	4,106	-	-	-	-	-	-	-	100%
0	Hodgeman	1,916	-	-	-	-	-	-	-	-
1	Jewell	3,043	-	-	-	-	-	-	-	100%
0	Kearny	3,915	-	-	-	-	-	-	-	-
2	Kiowa	2,513	-	-	-	-	-	-	-	100%
0	Lane	1,687	-	-	-	-	-	-	-	-
0	Lincoln	3,167	-	-	-	-	-	-	-	-
1	Logan	2,794	-	-	-	-	-	-	-	100%
2	Lyon	33,212	-	-	-	-	-	50%	-	50%
5	Marion	12,208	-	-	-	-	-	-	-	100%

9	McPherson	29,241	-	-	-	-	22%	-	-	78%
1	Meade	4,357	-	-	-	-	-	-	-	100%
1	Mitchell	6,284	-	-	-	-	-	-	-	100%
0	Morris	5,698	-	-	-	-	-	-	-	-
0	Morton	3,110	-	-	-	-	-	-	-	-
1	Ness	3,105	-	-	-	-	-	-	-	100%
0	Norton	5,560	-	-	-	-	-	-	-	-
0	Osborne	3,756	-	-	-	-	-	-	-	-
1	Ottawa	6,065	-	100%	-	-	-	-	-	-
1	Pawnee	6,916	-	-	-	-	-	-	-	100%
0	Phillips	5,533	-	-	-	-	-	-	-	-
0	Rawlins	2,584	-	-	-	-	-	-	-	-
16	Reno	63,794	6%	-	-	-	-	-	-	94%
1	Republic	4,803	-	-	-	-	-	-	-	100%
2	Rice	10,015	-	-	-	-	-	-	-	100%
2	Riley	75,194	-	-	-	-	-	-	-	100%
1	Rooks	5,155	-	-	-	-	-	-	-	100%
0	Rush	3,197	-	-	-	-	-	-	-	-
1	Russell	6,956	-	100%	-	-	-	-	-	-
11	Saline	55,755	-	-	-	-	-	-	-	100%
0	Scott	5,080	-	-	-	-	-	-	-	-
2	Seward	23,465	-	50%	-	-	-	-	-	50%
0	Sheridan	2,539	-	-	-	-	-	-	-	-
0	Sherman	6,110	-	-	-	-	-	-	-	-
0	Smith	3,769	-	-	-	-	-	-	-	-
1	Stafford	4,297	-	-	-	-	-	-	-	100%
0	Stanton	2,111	-	-	-	-	-	-	-	-
0	Stevens	5,801	-	-	-	-	-	-	-	-
0	Thomas	7,891	-	-	-	-	-	-	-	-
0	Trego	2,902	-	-	-	-	-	-	-	-
0	Wallace	1,506	-	-	-	-	-	-	-	-
0	Washington	5,598	-	-	-	-	-	-	-	-
0	Wichita	2,176	-	-	-	-	-	-	-	-
99	WEST	730,798	1%	3%	-	-	2%	4%	-	90%

Population figures taken from:

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DISPOSITION OF 2013-2014 ADULT CASES BY COUNTY
WICHITA REGION

	DCF REGION		Outcome as Percentage of Reports Received							
Total Reports Received	County	2014 Population Estimate	Diversion	Convicted	Acquitted	Dismissed	Declined	All Other	No Known Action	Pending
2	Barber	4,897	-	-	-	-	-	-	-	100%
22	Butler	66,227	-	14%	-	-	-	9%	-	77%
13	Cowley	35,963	-	38%	-	15%	38%	-	-	8%
0	Elk	2,694	-	-	-	-	-	-	-	-
2	Greenwood	6,328	-	-	-	-	-	-	-	100%
1	Harper	5,818	-	-	-	-	-	-	-	100%
3	Kingman	7,698	67%	33%	-	-	-	-	-	-
2	Pratt	9,850	-	-	-	-	-	-	-	100%
87	Sedgwick	508,803	-	2%	-	1%	-	1%	-	95%
4	Sumner	23,528	-	-	-	-	-	-	-	100%
136	WICHITA	671,806	1%	8%	-	2%	4%	2%	-	82%

Population figures taken from:

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DISPOSITION OF 2013-2014 ADULT CASES BY COUNTY
STATEWIDE

	DCF REGION		Outcome as Percentage of Reports Received							
Total Reports Received	County	2014 Population Estimate	Diversion	Convicted	Acquitted	Dismissed	Declined	All Other	No Known Action	Pending
78	KC Metro	947,803	3%	6%	-	-	1%	1%	-	88%
109	East	553,614	-	4%	-	-	-	5%	-	92%
99	West	730,798	1%	3%	-	-	2%	4%	-	90%
136	Wichita	671,806	1%	8%	-	2%	4%	2%	-	82%
422	STATEWIDE	2,904,021	1%	5%	-	1%	2%	3%	-	88%

Population figures taken from:

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