KANSAS ATTORNEY GENERAL

Derek Schmidt

Abuse, Neglect and Exploitation Unit (ANE)

Annual Report

July 1, 2012 – June 30, 2013

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January 2014

Dear Fellow Kansans:

The purpose of the Abuse, Neglect and Exploitation (ANE) Unit in the Office of the Attorney General is to help coordinate the work of numerous state and local agencies that are assigned the critical task of protecting Kansas kids and vulnerable adults from abuse, neglect or exploitation. Since its creation by the Legislature in 2006, the ANE Unit has focused intently on this purpose.

This past fiscal year, the ANE United received 1,843 substantiated reports of abuse, neglect or exploitation, an increase from the 1,695 substantiated reports received the previous year. All were reviewed. Because of funding limitations, the ANE Unit is operated by a dedicated staff of only two people. The disconnect between expectations and capacity is obvious.

Nevertheless, the ANE Unit provides an important, if limited, "check" on the Kansas system of protecting vulnerable Kansans. It offers one additional level of review to help prevent cases from "falling through the cracks" of a large and inherently bureaucratic system.

The ANE Unit also is in a position to see recurring shortcomings in the system. To that end, this year's report – like past reports – includes several recommendations to strengthen the system that is in place to protect vulnerable Kansans.

This year's report outlines work of the ANE Unit in the past year. I look forward to continuing to work with the Legislature and other state leaders to build the capacity for the ANE Unit so it can fully perform the important role that was envisioned when it was created eight years ago.

Sincerely,

Derek Schmidt
Kansas Attorney General

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Acknowledgements

In an effort to improve 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, 2012 to June 30, 2013, the Unit received over 1800 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. We would like to acknowledge the assistance of the Kansas Department on Aging and Disability Services, Kansas Department of Health and Environment and the Kansas Department for Children and Families, as well as the district and county attorneys, their support staff, and local law enforcement agencies throughout the state of Kansas. In light of the volume of cases received, the Unit is especially thankful to those offices and agencies 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 department of social and rehabilitation services, department on aging 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.

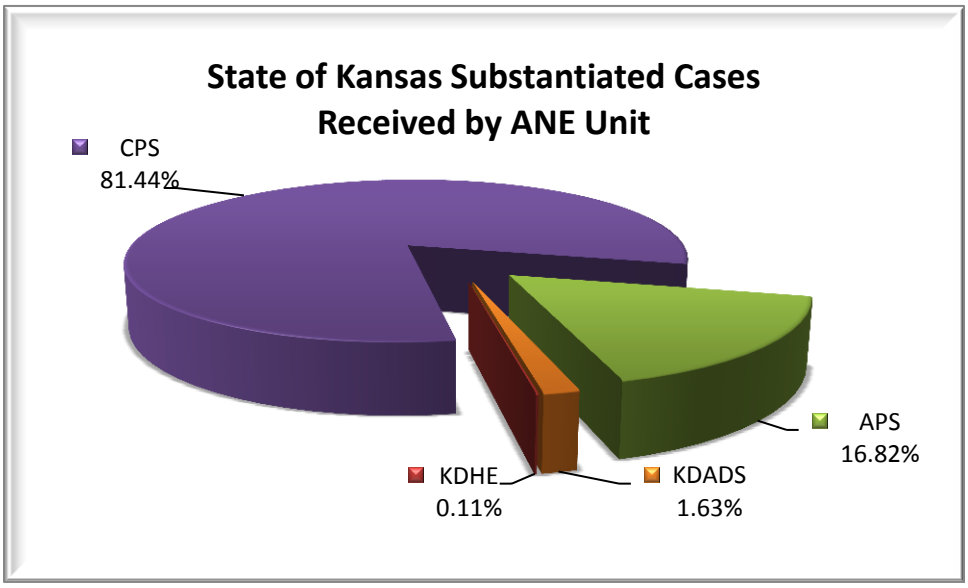
(f) No state funds appropriated to support the provisions of the abuse, neglect or exploitation of persons unit and expended to contract with any third party shall be used by a third party to file any civil action against the state of Kansas or any agency of the state of Kansas. Nothing in this section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

Activities, Investigations and Findings

For the period July 1, 2012 to June 30, 2013, the ANE Unit received 1843 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 1501 from DCF Child Protective Services (CPS), 310 from DCF Adult Protective Services (APS), 30 from KDADS and 2 from KDHE.



DCF Child Protective Services (CPS) - Social workers 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 the Department for Children and Families, and to adults residing in adult care homes and other facilities licensed by the Kansas Department on Aging and Disability Services, 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 www.ksadrc.org

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. http://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, 2012 to June 30, 2013, the ANE Unit received 51 "other" reports. Of the 51 "other" reports, 28 were child abuse related and 23 were adult abuse related. Reports of substantiated abuse combined with "other" reports reviewed accounted for a total of 1529 reports of child abuse and 365 reports of adult abuse for a total of 1894 cases. 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 over 6200 contacts with other individuals or agencies in the form of calls, faxes, emails or other correspondence in an effort to carry out its mission.

Over 95% of the reports received by the ANE Unit originated either with DCF Child Protective Services (CPS) or Adult Protective Services (APS). Almost 3% came from various "other" sources, less than 2% came from KDADS and less than 1% of the reports were from KDHE. (Figure A)

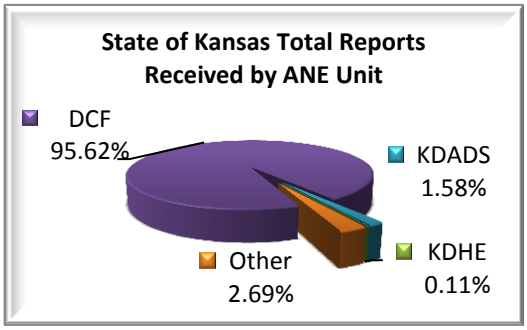


Figure A

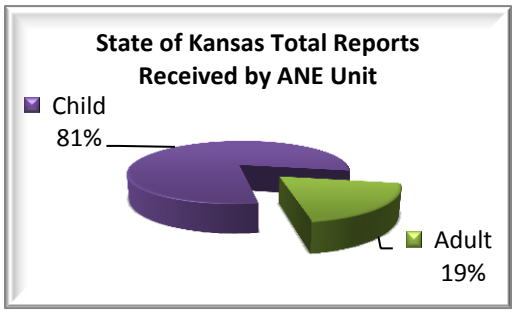


Figure B

Child ANE comprised just over 80% of all reports received. This continues its rise over the previous year. The remaining reports were on vulnerable adults over age 18. (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 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. 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.

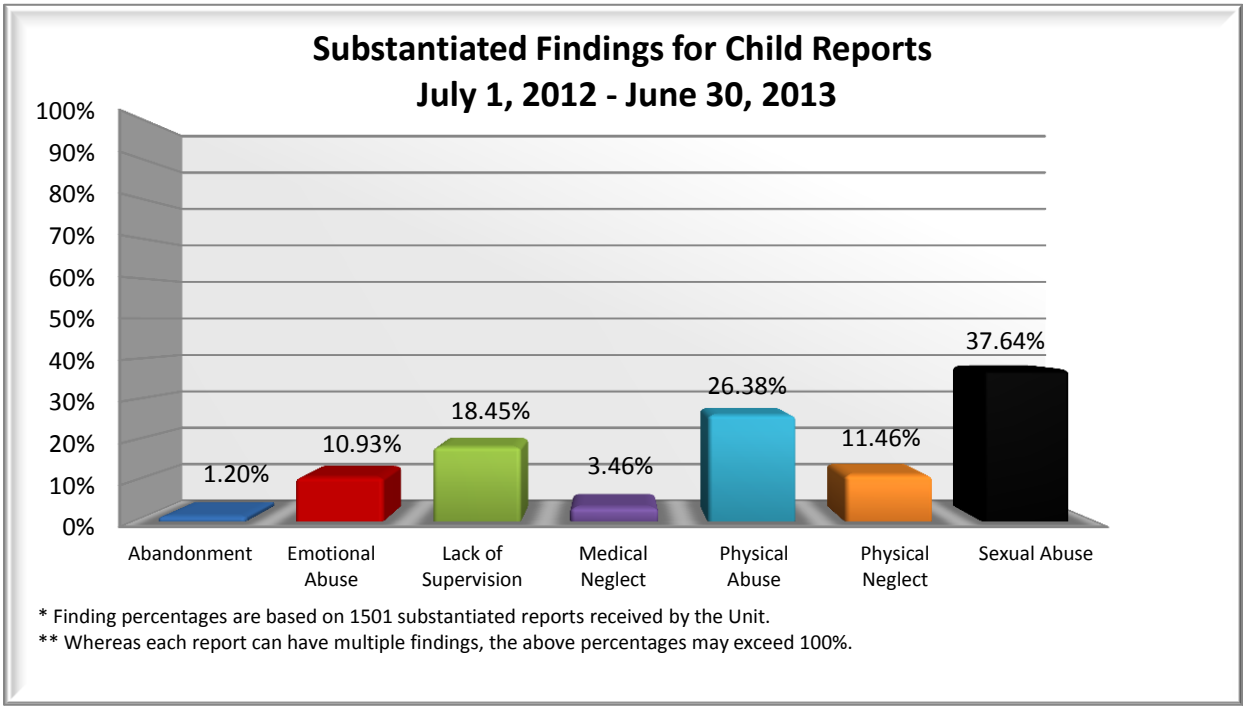
Ongoing discussions are held with state agency representatives to review policies, practices and procedures and to discuss system improvement and staff performance.

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. We strive to cultivate positive working relationships with community agencies and 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 continued collaboration that we can all focus on keeping Kansas families safe.

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

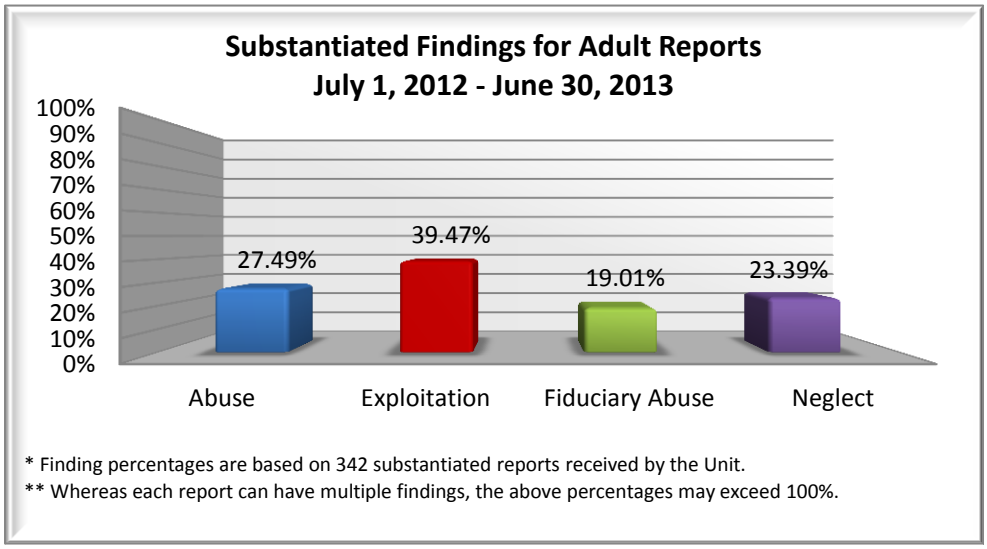
Findings recorded for the 1501 substantiated reports of child abuse include: abandonment, emotional abuse, lack of supervision, medical neglect, physical abuse, physical neglect and sexual abuse. Some reports contained substantiations of more than one type of abuse or may have involved multiple victims or perpetrators. Sexual abuse was the most frequently substantiated form of abuse.



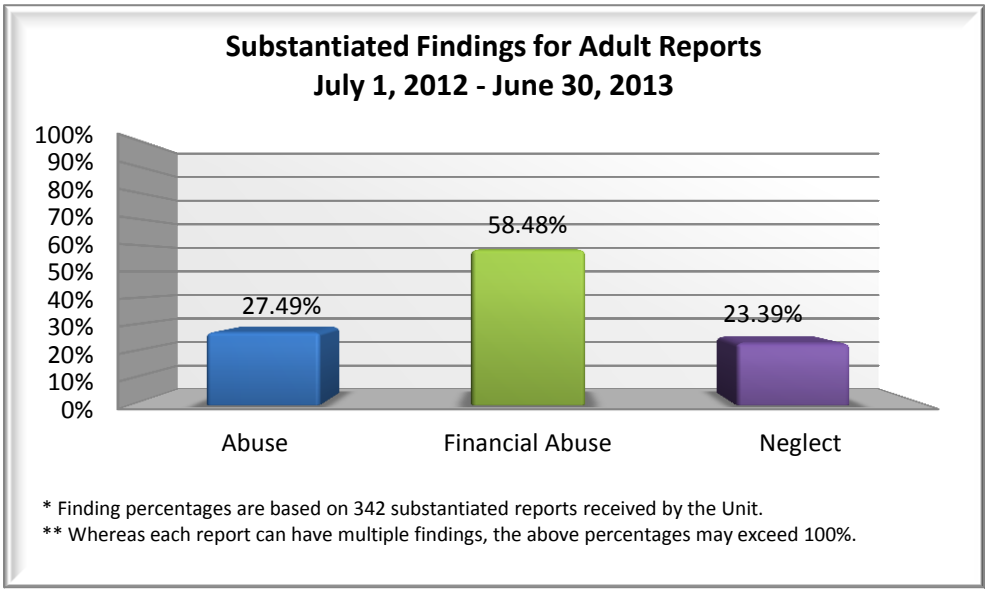
Compared to last year's findings, when 1374 substantiated reports were received, the following variances are noted:

Abandonment	increased 0.47%
Emotional Abuse	increased 2.05%
Lack of Supervision	increased 1.29%
Medical Neglect	increased 1.64%
Physical Abuse	increased 1.56%
Physical Neglect	increased 1.63%
Sexual Abuse	decreased 6.10%

Findings recorded for the 342 substantiated reports of adult abuse include 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. Abuse findings increased 0.70% over last year, while exploitation increased 5.51% and fiduciary abuse decreased 0.62%. Neglect findings decreased 3.71%. During the 2011-2012 fiscal year, the Unit received 321 substantiated reports of adult abuse.



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

Failure of Facilities or State Agencies to Report to Law Enforcement

Abuse reports to state agencies where a crime had occurred or appeared to have occurred were not originally forwarded to law enforcement to determine whether criminal investigation was warranted. ANE Unit involvement ultimately resulted in further criminal investigation and charges in some cases.

In support:

- In Leavenworth County, a CNA was substantiated by KDADS for abuse of a resident in the nursing home where the CNA was employed. It was alleged that on two occasions, the CNA restrained the resident in a chair and did not assist the resident as she became distressed and attempted to get up. This occurred in May 2012 and the Unit received the finding in December 2012. Upon review, the Unit discovered that despite requirements in Federal law, the incident was not reported to law enforcement for investigation. The Unit contacted KDADS in January 2013 and the matter was subsequently referred to law enforcement. As of the writing of this report, the Unit continues to research law enforcement action in the matter.

- In Lyon County, a CNA/CMA was substantiated by KDADS for abuse and neglect of four residents of the nursing home where she was employed. It was alleged that because the aide wanted to go home early, she intentionally failed to administer blood sugar tests to the insulin-dependent residents and falsified their medical records to indicate the tests had been performed. Within two hours, one of the residents suffered a hypoglycemic event that required transport to the emergency room. Upon receipt of this finding, the Unit noted there was no indication the incident was reported to law enforcement. After the lack of a report was confirmed with KDADS, the Unit referred the matter to the Attorney General's Medicaid Fraud and Abuse Division. The report was investigated by that division and successfully referred to the Lyon County Attorney's Office who has since charged the aide with four counts of Mistreatment of a Dependent Adult.

- In Ford County, a mother was substantiated for physical abuse of her child after it was alleged she struck the child. DCF staff observed the child to have bruising around his eye, forehead and cheek, which was photographed. The mother admitted to DCF staff that she struck the child one time with an open hand. Despite this admission and the visible physical injury to the child, law enforcement was not contacted during the investigation, nor forwarded the finding at the time the report was substantiated in June 2012. Upon receiving the finding in June, the Unit began inquiry and confirmed with DCF that the matter was not reported to law enforcement for investigation, rather only sent to the County Attorney's office. In further follow up with the County Attorney's

office, they confirmed an ongoing CINC action due to drug concerns in the home. It was only then that the attorney discovered an amended affidavit in his file alleging physical abuse. The file did not contain a copy of the substantiation and he indicated he had been unaware of such. At Unit request, DCF confirmed resending the substantiation to the County Attorney's office on November 14, 2012. Upon requesting and reviewing the police report, the Unit learned that DCF did subsequently send the finding to law enforcement also on November 16, 2012. This generated a police report and subsequent criminal investigation that resulted in the perpetrator being charged with one count of Child Abuse. This was reduced to three counts of Child Endangerment in a plea agreement.

Lack of Agency Communication

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 support:

- In Seward County, DCF issued findings in two separate events. In one, an adoptive parent was substantiated for sexual abuse of a child in the home. In the other event investigated during the same timeframe, the adoptive mother of the victim in the first event was substantiated for lack of supervision of her while an adult sibling was substantiated for the sexual abuse of her brother. The findings were issued eight months after the investigations began. Upon receipt, the Unit requested confirmation as to whether these children remained in the home with all of the perpetrators and if so, whether a Child In Need of Care (CINC) action had been requested or any safety plans implemented. DCF responded initially that they were reviewing the file to determine whether a referral for CINC was necessary and later confirmed that such had since been requested and that the father was out of the home.

- In Cherokee County, a father was substantiated as a perpetrator of physical abuse toward his child. In the course of follow up, the Unit contacted the County Attorney's Office to verify whether they received a case for charging and what charging decision had been made. Support staff confirmed the police report was entered into their system, but could not provide any charging information. The Unit was assured the matter would be reviewed by an Assistant County Attorney (ACA). A month later, the Unit inquired again of the County Attorney's Office. The ACA indicated she had not reviewed the report, but would submit it to the County Attorney for a charging decision. After another month, the Unit contacted the same ACA. She again verified the report was in their system, but indicated that she was unfamiliar with it. She informed the Unit she would pursue obtaining another copy of the report. The following month, the Unit followed up. The same ACA confirmed the report was in their system, but she could not

locate the file. The Unit offered to contact law enforcement and have a new copy of the report sent to her attention. On the same date, at the Unit's request, law enforcement hand delivered a copy of the report to the ACA, who confirmed receipt and indicated a complaint was prepared and awaiting a charging decision by the County Attorney. Less than a month later, the ACA confirmed a count of Child Abuse had been filed against the alleged perpetrator.

Failure to Issue Findings

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

In support:

- In Linn County, DCF issued a finding of medical neglect of a child by her babysitter after it was alleged the sitter failed to seek medical care for the child. Upon receipt of this finding, it was reviewed by the Unit. In the narrative basis for finding, DCF indicated the one-year-old child was found to have injuries including a subdural hemorrhage, retinal hemorrhages, evidence of trauma to the scalp and bruising that were inconsistent with the history provided and consistent with abusive head trauma. The narrative also noted that the babysitter was charged in criminal court and entered a guilty plea to Abuse of a Child. As such, the Unit inquired of DCF as to why there was not a finding issued for physical abuse of this child by the perpetrator, in addition to the medical neglect finding. The following month, DCF indicated they would reassess the case and the Unit subsequently received an amended finding adding physical abuse.

- In Barton County, DCF issued a finding for sexual abuse of a child by his grandfather. In this narrative basis for finding, it is noted that this child reported to DCF that his grandfather also sexually abused the child's brother. The narrative basis cites an interview by law enforcement with that brother where he disclosed sexual abuse by his grandfather. Though DCF is allowed in policy (PPM 2550) to enter findings based on information contained in police reports, when the Unit inquired as to why DCF did not issue a finding pertaining to the sibling, DCF indicated this was because the report was investigated by law enforcement, it came to their attention in the course of their original investigation and it was not part of the original report received by the agency. It should be noted that policy also allows for the addition of new allegations to an event when they are discovered in the course of an investigation. PPM 1450 reads as follows:

<u>Additional Children in the Family Identified in an Ongoing Investigation</u>
If during the course of an investigation/assessment, there is reason to believe other children under the same care are possible victims of the same allegations in the assigned

investigation/assessment, the additional children shall be added to the current investigation and does not require a new report.

Nevertheless, 10 months later, DCF would open an investigation into the abuse of the sibling by his grandfather and an unrelated individual after the sibling continued to disclose his abuse. It was subsequently substantiated by DCF and sent to the Unit 9 months after being assigned and some 19 months after DCF informed the Unit they were not opening an investigation.

Furthermore, upon Unit review of this second finding, its narrative basis described disclosure by yet another sibling of sexual abuse by the same perpetrator as well as his own father. Yet this third sibling was not added as a victim to this second event. Upon Unit inquiry, DCF indicated that after further review, the third child mistakenly failed to be added to the finding. An amended finding including additional information about this child's disclosure and adding him as a substantiated victim of sexual abuse was subsequently received by the Unit.

- In Osage County, DCF issued a finding substantiating a father for emotional abuse of his child due to her suicidal ideations as a result of abuse going on in the home. The original report also alleged physical abuse, but this allegation was unsubstantiated. In the narrative basis for finding, it described disclosures by the child to DCF and to law enforcement detailing the nature of the physical abuse. It also indicated that the responding law enforcement officer noted a visible bump to the child's head. The Unit discovered that the accused perpetrator was charged in criminal court with Battery more than two months prior to DCF issuing the finding and inquired as to why the physical abuse allegation was unsubstantiated. In response, DCF indicated that "in reviewing the finding…the decision has been made to substantiate the allegation of physical abuse….We anticipate that the finding will be amended this week…" In the amended narrative basis, DCF indicated that the finding was being amended "based on newly required pictures of child's injuries that were not seen previously."

- In Sedgwick County, DCF issued a finding substantiating a child's step-father for her sexual abuse. The narrative basis for that finding cited an earlier event from 2011 with the same alleged perpetrator but a different victim. The narrative indicated that this second victim was re-interviewed in 2013 as part of this new investigation and that her statements were consistent with those she made in 2011. The Unit inquired of DCF as to the outcome of the 2011 investigation and DCF indicated "initially, it was unsubstantiated. The DA is considering charges." The Unit further inquired as to whether DCF would be reconsidering their finding, in light of possible criminal charges. DCF responded that after staffing the case, it was decided that the earlier unsubstantiated finding would be substantiated. That finding was received by the Unit two weeks later.

- In Sumner County, DCF issued a substantiated finding for the sexual abuse of a child by a step-sibling. The Unit received this finding in 2012. In the course of monitoring the status of any criminal charges, the Unit contacted the County Attorney's Office who reported there was no

record of the office receiving a report from law enforcement. When the Unit subsequently contacted law enforcement regarding the status of the investigation, it was indicated that the assigned detective was no longer with the department and had left the case open to await further information from the child's therapist. Law enforcement further reviewed the case materials left by the detective and forwarded the case to the County Attorney's office for review. As of the writing of this report, the County Attorney's office had requested additional investigation by law enforcement. The two agencies continue to work this case as new interviews are conducted.

In addition, it is not uncommon for the Unit to catch errors on Notices of Finding issued to parties at the conclusion of investigations. Usually, these are in the form of typos or contradictory language on the nature of the finding. Other times, the errors could be considered more significant.

In support:

- In Kearny County, a child was substantiated as a victim of physical abuse by his mother's boyfriend. Though the Form 2011 narrative of case finding completed by DCF identified the mother as an unsubstantiated perpetrator, the Form 2012 Notice of Department Findings sent to the parties at the conclusion of the investigation identified her as a substantiated perpetrator. The Unit brought this to the attention of DCF and the department sent corrected notices.

- In Barton County, two children were substantiated as victims of physical neglect by their parents. Upon review of the Form 2012's sent to the Unit by DCF, which had been mailed to the perpetrators in this case, the Unit noted that the "document recommendations" section of the form listed first and last names of a family other than that involved in this finding. The Unit brought this to the attention of DCF who corrected the notices. In response to the confidentiality breach, the department indicated personnel action was taken regarding the employee.

Failure by DCF to Forward Findings to the County Attorney in Child Abuse Cases

DCF's Policy and Procedure Manual (PPM 2547) requires social workers, upon substantiating a finding in a child abuse case, to forward notice to the District or County Attorney "for consideration of a child in need of care petition." In some cases received by the Unit from DCF, this did not occur. The Unit followed up with DCF and this process was subsequently completed.

In support:

- In Johnson County, a child was substantiated as the victim of physical abuse by an unknown perpetrator in a home daycare setting. The child suffered a skull fracture, two fractures to one leg and a wrist fracture. In information supplied to the Unit, DCF indicated the finding was not

forwarded to the District Attorney. Upon Unit inquiry, DCF confirmed this requirement had been overlooked and since remedied.

- In Johnson County, DCF substantiated emotional abuse of two children by their grandmother after it was reported the grandmother threatened the children's father in their presence while holding everyone in the room at knifepoint. Despite policy, DCF indicated to the Unit that the finding was not forwarded to the District Attorney. When the Unit inquired, DCF indicated that the finding had not been sent because the DA had already criminally charged the perpetrator. The Unit inquired further of DCF Legal regarding any exception in policy to forwarding substantiated child abuse reports to the district or county attorney's office. DCF Legal confirmed there is no exception in policy and indicated that reminders were being sent to all DCF regions in this regard.

- In Linn County, DCF substantiated sexual abuse of a child by her father. Despite policy, DCF indicated to the Unit that the finding was not forwarded to the County Attorney. Subsequent to Unit inquiry, DCF confirmed they had now sent the finding to the County Attorney.

- In Allen County, DCF substantiated sexual abuse of a child by her sibling. Despite policy, DCF indicated to the Unit that the finding was not forwarded to the County Attorney. Subsequent to Unit inquiry, DCF confirmed that they had now sent the finding to the County Attorney.

Though in some cases, failure by DCF to send notice may not hinder court intervention, in others where the district or county attorney's office may be previously unaware of an incident of abuse or where a DCF investigation may contain additional facts not known to them, this has the potential to impede further intervention. The safety of Kansas children can be improved by the consistent reporting of findings by DCF to district or county attorneys, without fail and without exception.

Referral to Other AG Divisions for Investigation/Prosecution

While receiving and reviewing findings, ANE Unit involvement resulted in identification of certain cases that were not being actively investigated or prosecuted. When such cases met the requisite criteria for the Attorney General's Office to become involved in criminal investigation or prosecution, the Unit was able to refer these matters to the appropriate division within the Office of the Attorney General.

In support:

- As previously discussed on page 9, in Lyon County, a CNA/CMA was substantiated by KDADS for abuse and neglect of four residents of the nursing home where she was employed. It was alleged that because the aide wanted to go home early, she intentionally failed to administer blood sugar tests to the insulin-dependent residents and falsified their medical records to indicate the

tests had been performed. Within two hours, one of the residents suffered a hypoglycemic event that required transport to the emergency room. Upon receipt of this finding, the Unit noted there was no indication the incident was reported to law enforcement. After the lack of a report was confirmed with KDADS, the Unit referred the matter to the Attorney General's Medicaid Fraud and Abuse Division. The matter was investigated by that division and successfully referred to the Lyon County Attorney's Office who has since charged the aide with four counts of Mistreatment of a Dependent Adult.

- In Saline County, APS substantiated a son for exploitation of his father after it was alleged the son, who was also power of attorney, was taking money from his father's bank account while failing to pay his father's expenses. Allegations included that a vehicle owned by the father was unaccounted for, as well as the entirety of funds collected for the sale of a home and income earned from an oil well. In addition to a significant extension in the timeframe for the investigation, APS did not send notice to law enforcement until the completion of their investigation – 11 months after it was initiated. Furthermore, in following up with law enforcement, the local police department reported conflicting information as to whether the referral was received from APS, but were clear that the department had no report on file and was not conducting an investigation. A second law enforcement agency in another county indicated they had not responded to the referral from APS as they were unsure of jurisdiction.

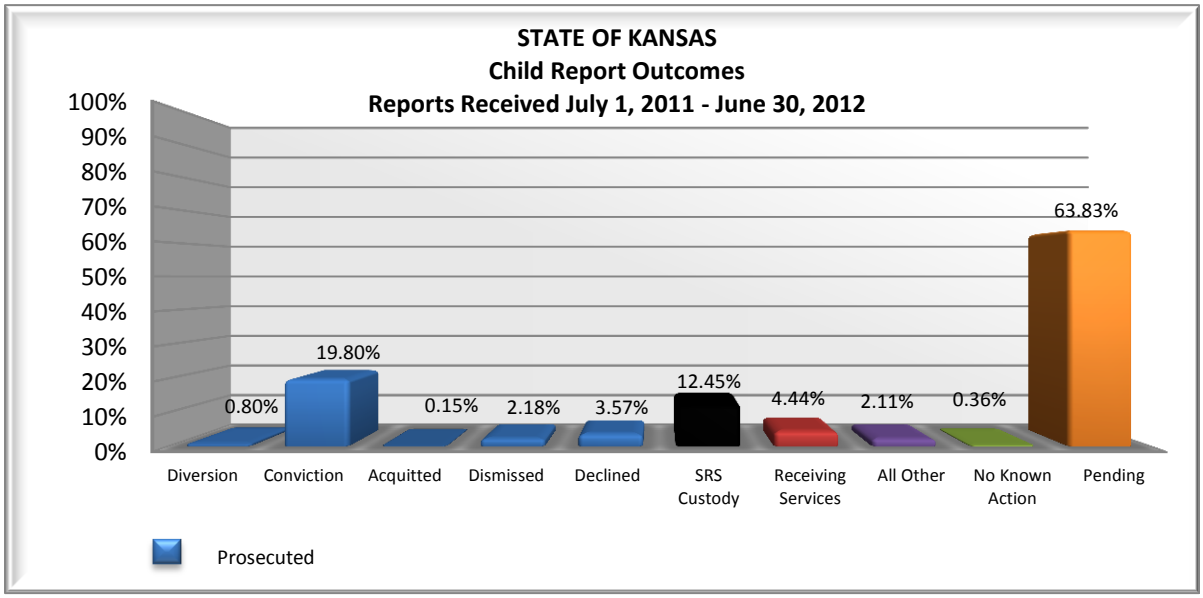
  The Unit referred the case to another division within the Office of the Attorney General where the matter was further reviewed for criminal filing. As primary jurisdiction for such filing rests with the district or county attorney's office where alleged offenses occur rather than with the Office of the Attorney General, records were forwarded to the local police department by the Office of the Attorney General with the request that they be reviewed for investigation if warranted. Though the police department initially confirmed the records were received and assigned to an investigator, who indicated the case was forwarded to the County Attorney for review, when the Unit followed up with that office, staff could not locate any record of the matter being received. The Unit has subsequently learned that law enforcement did not complete a criminal investigation but forwarded APS records directly to the County Attorney. As of the writing of this report, the Unit continues to track this matter and determine whether the case has received the necessary review.

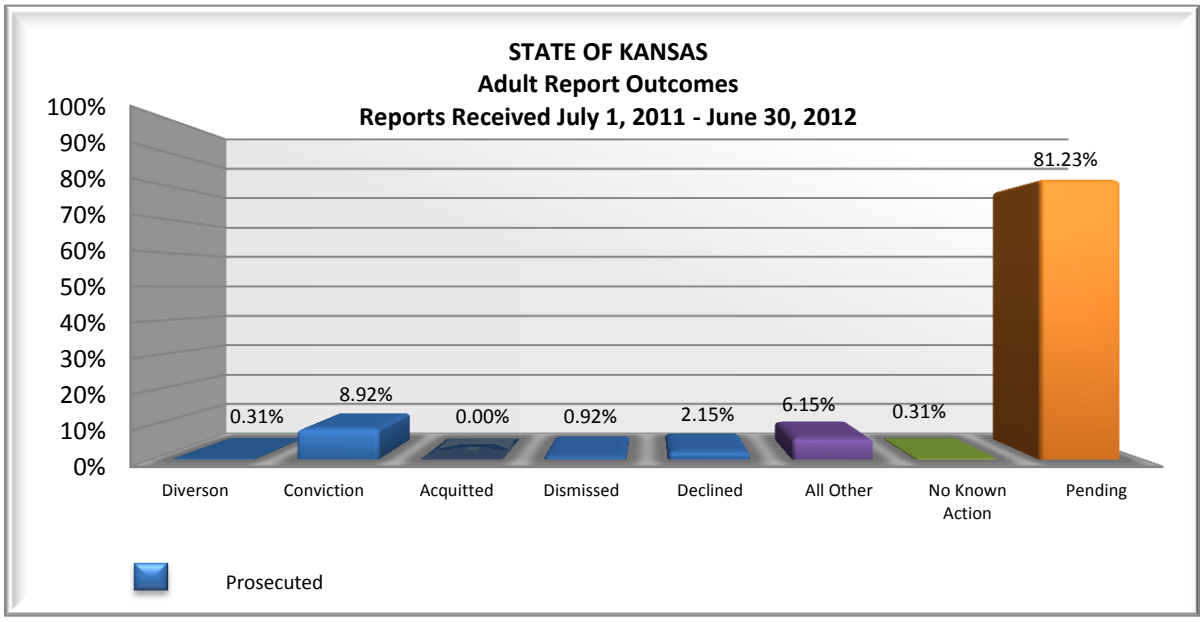
- In Crawford County, APS substantiated a son for the fiduciary abuse of his mother after it was alleged the son, who was also his mother's conservator, failed to meet her needs by using her funds to pay expenses other than her care. When the Unit followed up with local law enforcement, the Chief of Police indicated he did not believe that a crime was committed. The Unit referred the matter to the Medicaid Fraud and Abuse Division, who opened an investigation. As a result, that division determined jurisdiction for criminal prosecution rested in another state and subsequently referred the matter to the proper authorities in that jurisdiction.

- In Butler County, APS substantiated on an unknown perpetrator after an involved adult was victimized in a scam where she lost approximately $11,000. While the local enforcement investigation had stalled due to a lack of leads, the US Postal Service and the FBI were already involved in the investigation. The Unit referred the matter to the Consumer Protection division of the Attorney General's Office, which resulted in an additional referral by that division to the Federal Trade Commission.

- In Riley County, APS substantiated a woman's son and daughter for neglect and fiduciary abuse after the pair, who also held Durable Power of Attorney (DPOA) for their mother, failed to use her funds to pay for her nursing home care and to pay her pharmacy bill. APS determined funds directly deposited into her account were transferred into her daughter's account or were withdrawn to pay her son's personal expenses. In follow up with law enforcement, it was indicated that further investigation would be difficult for the local agency due, in part, to bank accounts in multiple jurisdictions. The Unit referred the matter to the Medicaid Fraud and Abuse Division, where an investigation was opened and remains active.

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. 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. 26.49% of child cases are known to have been reviewed for prosecution at this time, while 12.31% of adult cases are known to have been reviewed for prosecution at this time.





Concerns and Recommendations

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

In the last four consecutive reporting years, 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 that 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, that "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 that not all of these cases would result in prosecution and for some, it may not even be the best course of action, but when facilities and state agencies choose to 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 Coffey County, a mother was substantiated by DCF for physical abuse when she dropped her child causing injury. The mother and father were previously substantiated as perpetrators of physical abuse and medical neglect in an earlier investigation involving another child. In that earlier investigation, the father was convicted of child abuse. Despite the family history, law enforcement was not involved in the investigation nor forwarded the finding.

- In Wyandotte County, an adult sibling was substantiated by DCF as a perpetrator of physical abuse of a mentally disabled child. The finding indicated the child was twice beaten with a belt and/or fists after acting out. The second incident occurred after the first was assigned, opened for investigation by DCF and the family had already been referred for DCCCA services. A CINC was not recommended. The social worker observed physical injury to the child on both occasions in the form of multiple bruises and scrapes but did not report the incidents to law enforcement for criminal investigation.

- In Bourbon County, a child was substantiated by DCF as a victim of physical abuse by her mother's roommate. The child was struck with a belt leaving strap marks and fingernail marks in separate incidents. The child's mother had previously been substantiated as a perpetrator of physical abuse of the child's sibling and this perpetrator's own child attempted suicide during this investigation. The perpetrator showed a belt that had the buckle cut off to DCF and told the worker that she had been told by law enforcement that she could spank the children with a belt, but not with the buckle. She also asked DCF what to do if the victim hit or pushed her and DCF directed her to call the police. However, despite this recommendation, the history in the home and the visible physical injury to this child, DCF did not notify the police of this incident.

- In Riley County, a child was substantiated by DCF as a victim of physical abuse by her mother's boyfriend. The social worker observed and photographed an "open wound" to the child's shoulder. All of the children in the home reported it was not unusual for the perpetrator to hit them with a spoon. The mother acknowledged that things were "always happening" to her children when they were in his care. Services were offered and refused, though it was indicated the mother made the perpetrator leave the home. DCF confirmed law enforcement was not involved in this investigation nor forwarded the finding.

- In Shawnee County, a child was substantiated by DCF as a victim of physical abuse by his foster father. The child was observed at school to have a red mark on his face that appeared to be a handprint. DCF cited an inconsistency in the explanation of injury, his statement, another foster child's statement, and what they described as a "significant" mark on his face in issuing the finding. The incident was not reported to police, nor were they forwarded the finding.

- In Ellis County, a substantiation was issued by DCF for physical abuse of a child by a staff person at the KVC facility where the child resided. It was corroborated by witnesses that the staff person struck the child in the jaw with a closed fist and then pushed him to the ground. Though the facility was cited by KDADS for being noncompliant regarding the standard of discipline, the incident was not reported to law enforcement by DCF or by KDADS and there is no indication the facility did so either. KDADS accepted the facility's termination of the perpetrator and there was no further corrective action.

- In Shawnee County, a step parent was substantiated by DCF for physical abuse of a child. The child was observed by the social worker with bruises and marks on the back estimated to be six to seven inches long, what appeared to be a red mark in the shape of a handprint, petechial bruising and a skin tear that was scabbed over. The worker reported smelling an odor of marijuana in the home and indicated the parents admitted use of the drug. Services were already in the home at the time the incident occurred and it was not reported to law enforcement.

- In Shawnee County, a mother was substantiated by DCF for physical abuse of her child. The child was observed and photographed with a bruise that was described as an inch wide and three

to four inches long. In the narrative basis for finding, reference was made to possible earlier involvement with the family by DCF. Upon Unit inquiry, it was learned that the social worker had contact with the perpetrator a week prior to the assignment of this event after an earlier report of physical abuse was received. The worker scheduled an appointment to meet with the perpetrator for an interview and prior to that appointment, the perpetrator sent the child out of town. This second event that resulted in substantiation was opened when the family that received the child made a separate report to DCF. This matter was not reported to law enforcement.

- In Marshall County, a mother was substantiated by DCF for physical abuse of her child. At the time the abuse occurred, the children were receiving aftercare services from TFI. The mother pushed the child off of her lap, which caused the child to hit her head on the floor and resulted in bruising to her forehead. The children were placed in respite care with the grandparents during the investigation and subsequently were returned to DCF custody after a new filing of CINC.

  DCF previously substantiated on these parents for lack of supervision and physical neglect in 2011. The children had been placed in DCF custody as a result of CINC for that event with no law enforcement involvement. In addition, the family had previous history with DCF in 2007, 2008 and 2010. They had received services in 2007 and again in 2008. Despite this extensive history, law enforcement was not notified of the new incident of physical abuse.

- In Shawnee County, a father was substantiated for physical abuse of his child. Upon initial interview of the child at her school, DCF photographed injury to the child's face reportedly caused by being struck by her father. DCF reported attempting to contact the parents multiple times. However, these attempts went unanswered by the parents. The child reported feeling safe with her mother; however, her mother was present and unable to prevent the incident from occurring. DCF did not report this incident to law enforcement and the child was sent home with no further indication that it was verified safe for her to do so. There was no indication of recommendation for CINC or any intervention to protect this child. Though DCF would later report a CINC was filed, there is no indication they recommended such or that anyone had verified the safety and wellbeing of this child since the inception of the investigation. Staff at the District Attorney's Office indicated the matter would not be reviewed for criminal filing without receipt of a police report.

- In Wyandotte County, a mother was substantiated for physical abuse of her child. Witnesses reported the baby was hit in the head by the mother, who has a previous history with DCF. Witnesses also reported the mother allowed grease to splatter on the infant while she was cooking. Medical professionals confirmed the child had slight swelling to the head and a torn upper frenulum in the process of healing. The doctor indicated the latter was caused by blunt force trauma. DCF reports law enforcement was not involved in the investigation, nor forwarded the finding. There is no indication any report was made to law enforcement.

- In Ford County, an employee of a PRTF facility was substantiated for physical abuse of a child in residence. DCF observed the child to have "still prominent" bruising around one eye and indicated their investigation was extended beyond the timeframe allowed in policy due to "not being able to get full cooperation" from the facility. Though DCF reported sending notice of finding to law enforcement at the conclusion of their investigation, this notice occurred two months after the DCF investigation was initiated. There is no indication law enforcement was contacted at the outset of the investigation into this possible crime or that they were notified when DCF found the facility unwilling to cooperate in the investigation. Upon inquiry by the Unit, law enforcement acknowledged receipt of the finding but indicated that since DCF already initiated and completed an investigation, law enforcement did not pursue the matter. The detective noted that the DCF finding was sent to the County Attorney's office and that the office could review that as a basis for charging.

- In Shawnee County, a father was substantiated for physical abuse of his child after it was alleged he shot her in the leg with a pellet gun. The child reported her father was shooting at the dog with the gun. She reported she made a comment that she wouldn't want to be shot with it and then her father shot her in the leg. The child was observed by the social worker to have a mark on her leg consistent with being shot by a pellet. Though the father admitted firing what he said was an unloaded weapon at the dog, he denied firing it at his child. The child resides with her father and the family was already receiving aftercare services from a DCF contractor at the time this incident was reported. The matter was not reported to law enforcement, and the child remained in the father's home while he agreed not to have the gun around children. A new Child in Need of Care action was not filed.

These cases have continued to be staffed with DCF. The Department believes they are fulfilling their statutory requirement to report to law enforcement by notifying the "chief law enforcement officer" in their jurisdiction: the district/county attorney.

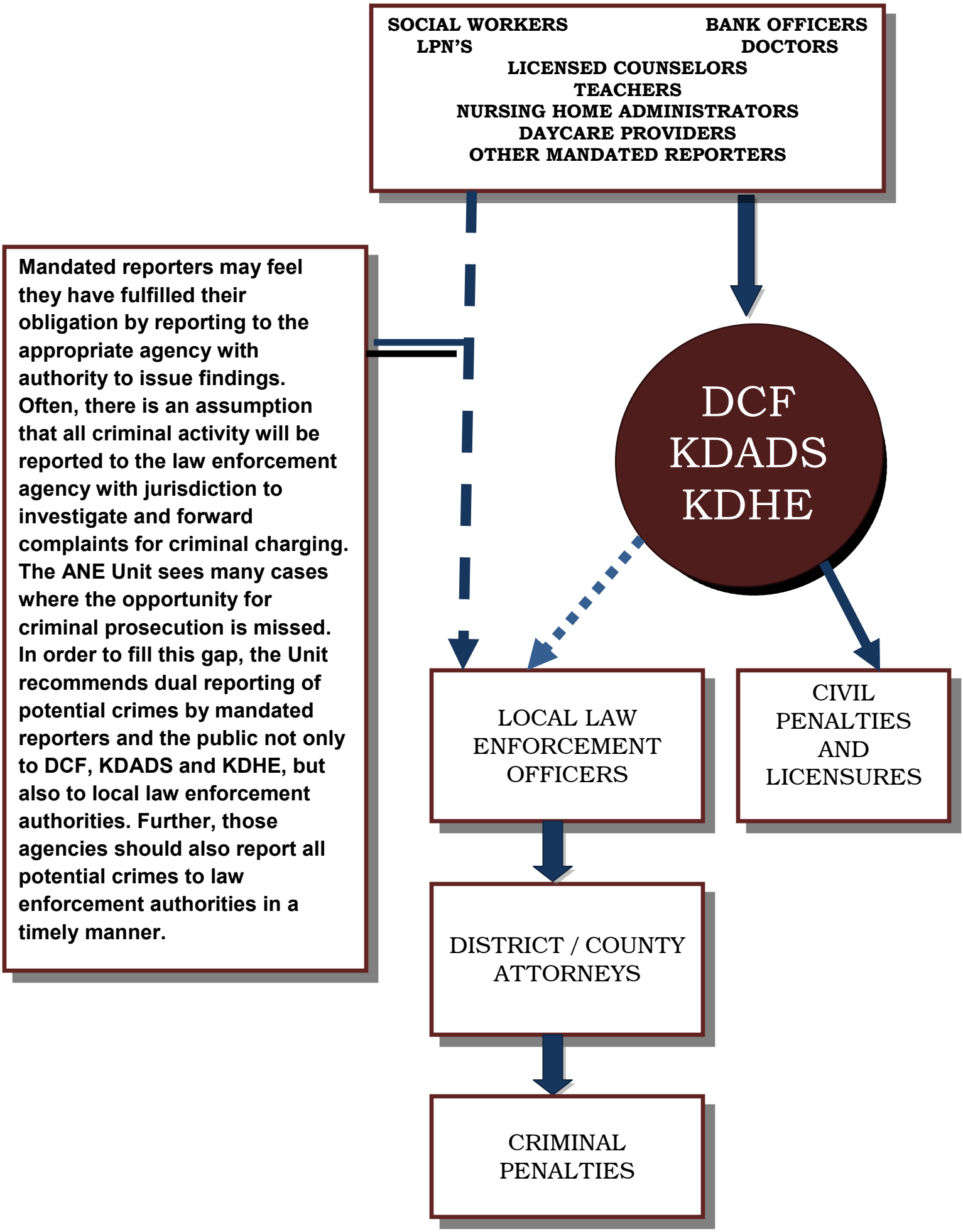
It remains a concern that while some child cases may be forwarded to the juvenile Child in Need of Care divisions within the district/county attorney's office, if these cases have not been reported to a law enforcement agency for criminal investigation, they may not be screened for criminal charges. 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/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 county attorney.

This being noted, the Unit does see many cases of physical abuse where evidence of injury is present and law enforcement only completes Child In Need Care reports as opposed to offense reports that 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 by constituents and by all mandated reporters both to 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 police department and/or sheriff's office. If legislative action is required to create a statutory obligation, this should be reviewed and considered.


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

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.

Adult Protective Services 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 may be 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 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 further 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 that the referral process between APS and law enforcement, and APS's clear reluctance to follow up those referrals (or advance policy beyond what they believe is

minimally required by statute) creates a significant opportunity for cases alleging abuse against adults to get lost in the system and to have no action taken.

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.

In support:

- In Butler County, a paid caregiver was substantiated for exploitation of two adults. The situation occurred when the caregiver borrowed money from the two adults, identified as boyfriend and girlfriend. The female victim loaned the perpetrator money from her own account and then also loaned the perpetrator money from her boyfriend's account without his knowledge or authorization. DCF did not notify law enforcement of this investigation until its conclusion upon entering a finding. A week later, the Unit learned DCF reversed their finding and would not submit the perpetrator to the Central Registry as the perpetrator had agreed to (and subsequently completed) a Corrective Action Plan (CAP) to repay the money to the victims.

  The Unit followed up with the Chief of Police in the jurisdiction. He indicated no record could be found of receiving the notice that APS reported sending by fax. The Unit requested APS resend the case information directly to the Chief's attention. Upon his review, he expressed concern about the challenge of attempting to complete a criminal investigation when APS does not notify them at the outset of their investigation. He indicated that he has asked social workers to contact the department by phone and not fax, due to the opportunity for notices to become lost when they are not sent to the attention of a particular individual. He also noted frustration with the CAP process and the possibility that perpetrators enter into the agreements believing nothing will happen to them criminally when the money is paid back.

- In Butler County, a son was substantiated by APS for the fiduciary abuse of his father. The APS investigation determined the son was using his father's debit card to withdraw a significant sum from his father's account to be used for his own needs, rather than those of his father. The victim was interviewed by the social worker and reported that his son was using his money in ways he did not approve and that he wanted the matter prosecuted. A month after the interview, the victim passed away. Two weeks later, the matter was referred to law enforcement, which declined to prosecute due to the victim's death. The Unit referred records to the Medicaid Fraud and Abuse Division for review, which elected not to open an investigation, in part due to the lack of a strong and thorough victim interview sufficient to meet the higher standards of a criminal prosecution. The case was cited as an example of why it is beneficial to involve law enforcement earlier in the investigation.

The ANE Unit does not believe that 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 that 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 recognizes 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/county attorney in the jurisdiction where the abuse 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 that DCF develop policy to consistently require workers to send notice of finding to the appropriate district/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 that 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 in order ensure the crimes against children are reported to law enforcement, fully investigated, and considered for prosecution.

Sexual Relations Between Caregivers and Their Patients

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.

Recommendation: The ANE Unit continues to encourage legislation that would legally prohibit caregivers from engaging in sexual relations with their patients/clients, regardless of that person's ability to give consent.

DCF Reversal of Substantiated Findings

According to PPM 2502, a substantiated finding is defined as: The facts or circumstances provide clear and convincing evidence to conclude the alleged perpetrator's actions or inactions meet the K.S.A and K.A.R definition of abuse or neglect and, therefore, (the) alleged perpetrator should not be permitted to reside, work or regularly volunteer in a child care facility regulated by KDHE.

Furthermore, PPM 2570 notes that persons substantiated as a perpetrator of abuse or neglect may appeal the DCF finding decision. Appeals are heard by the Office of Administrative Hearings (OAH) and perpetrators may be represented by counsel. Perpetrators who are unsatisfied with the decision rendered by the OAH may seek further relief by requesting a review of that decision by the State Appeals Committee. This may then be appealed to the district court. There has also been an internal practice within DCF where legal staff, upon review of a substantiated finding, may choose to reverse findings after appeals have been filed but prior to hearings being held.

However, the Unit reviewed a matter where DCF staff chose to reverse a finding that had already been upheld on appeal.

In support:

- In Finney County, a mother was substantiated for lack of supervision of her 15-year-old daughter when her child was sexually abused by two unrelated adults living in the home. The mother appealed and the finding was upheld. The OAH ruled that she failed to provide adequate supervision when she allowed the other parties access to her child and that she failed "to remove that child from situations requiring judgment or actions beyond the child's level of maturity or

mental abilities. The appellant, as an adult, cannot waive responsibility by arguing that 15-year-old children engage in sexual activity."

It came to the Unit's attention that a month after this finding was upheld by the OAH, the social worker, supervisor and region staff attorney conferred and reversed the finding. The explanation was that this occurred so that the perpetrator would not lose her job working with a vulnerable population. When the Unit questioned this reversal, DCF reported that neither the region program administrator, nor Central Office legal staff were part of the decision to reverse the finding.

There is a clearly defined appeals process that gives perpetrators the opportunity to challenge findings that they believe may not meet the evidentiary burden. When that appeals process is exhausted, or a 30-day timeframe has passed without the filing of an appeal, the perpetrator is listed on the Central Registry. For some individuals in certain professional positions working with children or vulnerable adults, there may be restrictions on continuing that employment when they become substantiated perpetrators who have been entered on the Central Registry. Such safeguards exist for obvious reasons.

In this particular case, the perpetrator had not yet exhausted the appeals process, yet DCF staff determined of their own accord, to reverse a finding that had already been upheld by the OAH. The Unit is concerned when there is an appearance that a substantiated perpetrator is relieved of the consequences of his or her actions or inactions for no other reason than to prevent from them losing employment. Restrictions on perpetrators working with vulnerable populations are in place to protect those individuals who otherwise may not be able to protect themselves. DCF should not reverse a finding that has met its burden of proof, especially when it has been upheld on appeal, without offering documented support as to why such reversal is in the in the best interest of children or vulnerable adults.

Recommendation: DCF should develop structured policy for reversal of substantiated findings when they have either not been formally appealed or when they have been upheld upon appeal by the appropriate authority designated to hear argument. The reason for such reversal should be clearly supported in documentation.

Abuse Registries

In the previous reporting year, 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 when they are identified as perpetrators.

While nursing facilities are required to check the Kansas Nurse Aid Registry regarding the licensure status for certified nurse aides (CNA's), certified medication aides (CMA's) 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, as these findings were not acted upon or responded to with regard to existing or prospective employees, APS stopped sending them. In follow up with KDADS, it was reported that "few" referrals were nurse aides and that 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 has continued to see a small number of cases where perpetrators are substantiated by DCF for abuse, neglect or exploitation of children or vulnerable adults, who 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.

In support:

- In Pawnee County, an LPN was substantiated for abuse of a former patient at Larned State Hospital. The investigation also concluded that he inappropriately accessed the patient's medical record without valid medical necessity. Despite being terminated and placed on the DCF Central Registry, this individual would go on to obtain employment at a KDADS nursing facility, where they are only required to check the KNAR and criminal records. Subsequently, the alleged perpetrator would again be substantiated by APS for exploitation of his own mother, who resided at the facility where he obtained employment. DCF later reversed the second finding after he completed a Corrective Action Plan to pay back funds that were wrongly used. Nonetheless, this individual has been a known perpetrator to vulnerable adults and until he obtains a criminal conviction, or is substantiated as a result of a KDADS investigation, he will be eligible to continue employment in facilities where he has access to additional vulnerable adults.

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.

Failure to Send Notice of Finding to KDHE

In reports from past years, the Unit has identified concerns where DCF (then SRS) failed to routinely notify KDHE of abuse occurring in facilities licensed by the agency.

The Unit has also noticed improvement in recent years with notification occurring on a more consistent basis. However, a particular case was reviewed by the Unit during this reporting year that caused some level of concern.

- In Cowley County, substantiation was issued for the sexual abuse of a child by a foster child residing in the home. When the Unit inquired as to whether KDHE was notified, DCF indicated that KDHE was not notified, that they did not consider this to be a facility report and cited PPM 2522, which reads as follows:

  Case Findings When the Perpetrator Works, Resides or Volunteers in a Location Licensed by KDHE

  A finding pertaining to a perpetrator is made regarding a person, not the facility. If abuse or neglect occurs in a facility and there are management or procedural actions or inactions which allowed it to occur, a referral must be made to KDHE for an investigation regarding any violations to the license or registration and to DCF child care of investigation regarding the provider agreement.

  This section does not apply to a person, under the age of 18 and in state custody, residing in the home.

  If the abuse or neglect took place in a facility subject to regulation by the Kansas Department of Health and Environment, the PPS2016, page 2, Complaint Report Facility Subject to Regulation by KDHE, is completed and sent to KDHE upon the completion of the investigation. Section IV shall contain any specific recommendations to be addressed in a Corrective Action Plan completed by KDHE.

  The Unit responded further to DCF, citing PPM 2540, Notice of Department Finding, where section A(6) requires KDHE to receive notice "if abuse occurred in a facility or a foster home." Though the assigned social worker, the worker's supervisor, the region Program Administrator and Central Office legal staff were copied on all communication, the Unit did not receive a subsequent response, nor did any staff intervene to make any corrections. The Unit staffed this concern at the next quarterly meeting, after which it was then confirmed notice had since been sent to KDHE in compliance with policy. DCF reported it was not sent earlier due to a supervisor error. While it is understandable that some misinterpretation of policy may occasionally occur within the agency, the Unit has some concern that multiple supervisory staff would receive and review a response, misapply policy, and fail to intervene with any correction until the Unit presses the question repeatedly.

Recommendation: The Unit encourages continued training among staff and diligent monitoring of those cases where notice is required to be sent.

DCF Compliance with Timely Findings

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 that 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 not noted any significant improvement this year over last year with regard to the timely submission of findings.

In some cases, it was apparent that workers mistakenly waited for the perpetrator's appeal period to pass before sending the finding to the Unit. In some cases where APS entered into Corrective Action Plans (CAP) with perpetrators, social workers substantiated the finding, but then waited until the perpetrators completed (or failed to complete) the CAP before sending the finding to the Unit and/or law enforcement. In other cases, the Unit failed to receive findings at all unless that information became known in the course of other investigations and was subsequently requested from DCF.

DCF Central Office staff is provided with a list of cases every quarter that 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 that requirements are clear.

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

DCF policy with regard to child findings (PPM 2511) directed that a case finding shall be made within 30 working days from the date the report was accepted for assessment. (The timeframe was extended during this reporting year from the previous requirement of 25 working days.) 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 2531 further states that for any finding issued outside of the established timeframe, an explanation will be given in the basis for the decision.

Despite these requirements, the Unit continues to receive findings issued outside of the timeframe established in policy for which no explanation is provided in the narrative. The Unit requests this information from DCF in many of these cases, as the workload allows. Regardless, DCF is provided a list of cases received every quarter where this policy requirement does not appear to be met.

In addition, the Unit has also received cases where the stated reason for the delay in finding appears to contradict other information obtained.

In support:

- In Johnson County, an unrelated male was substantiated for the sexual abuse of a child. The investigation was assigned within DCF at the beginning of February 2012 and the finding was not issued until the end of October 2012. In the narrative basis, DCF indicated only that the "case findings (are) late per policy." The Unit inquired as to which allowable reason was cause for delay and DCF indicated the agency was waiting on police reports that had not been received. The Unit inquired further as to when such reports had been requested from law enforcement and when they had been received. The dates provided by DCF indicated that the police reports had not been requested by DCF until more than six months after their report had been assigned for investigation; by which time, DCF had already exceeded the allowable timeframe. The Unit inquired further as to whether there were additional reasons for the delay that were not previously cited. DCF subsequently indicated earlier attempts by the worker to request and obtain the police report. However, the earliest of these was still outside the timeframe. DCF reported at that time, in early April 2012, the report was not ready due to the failure to complete a forensic interview with the child. The Unit was not provided with a reason why the child was not interviewed within the allowable timeframe to complete the investigation and issue a finding.

- In Douglas County, a juvenile step-sibling was substantiated for sexual abuse of a child. The report was assigned for investigation with DCF in November 2011 but the finding was not completed until January 2013. The narrative basis for finding described no actions at all in this investigation between late 2011 and 2013 and indicated the delay was due to the social worker waiting for police reports. The finding noted that once the reports were received, they were in the form of a DVD that would not work on the social worker's computer and "then had no time to listen to hours of interviews to type a finding." The narrative basis indicated that the social worker used interns to type logs from the interviews before being able to have time to finish the finding. Further inquiry by the Unit indicated the DVD was received by DCF "shortly" after it

was requested in March 2012, but it would take approximately another ten months for the social worker to complete the finding.

- In Dickinson County, a juvenile uncle was substantiated for sexual abuse of a child. The report was assigned for investigation in June 2012 and the finding was not issued until the end of October 2012. The narrative basis for finding indicated that the finding was late for an allowable reason in policy – a law enforcement request that DCF not interview the perpetrator. However, records suggest DCF received a probable cause affidavit from law enforcement on or about August 9, 2012, just two days outside of timeframe. Yet it would be another two to three months before the finding was issued. Upon further inquiry, DCF then indicated that there was not an allowable policy reason for the extensive delay in issuing the finding.

- In Geary County, a mother was substantiated for physical abuse of her child. The report was assigned for investigation in February 2012 but the finding was not issued until September 2012. The only explanation for the delay in the narrative basis read "finding delayed due to ACA". Unit research into online records indicated criminal charges were filed in the matter in February 2012 and the perpetrator was sentenced after conviction in March 2012.

  At the quarterly meeting with DCF staff scheduled for January 2013, the Unit requested additional information on the specific nature of the delay. DCF was not prepared to provide this information but Central Office staff indicated they would inquire further. When the information was not received, the matter was placed back on the agenda for the April 2013 meeting. Additional information was not provided on this date. In May 2013, DCF Central Office staff reported the delay was originally due to a request by the county attorney's office to hold the finding, then due to awaiting additional documentation from the county attorney's office and law enforcement. DCF reported the paperwork was not date-stamped when it was received and therefore, it was unknown how long after it was received before the finding was completed. As a result, DCF staff report an agreement between the department and the county attorney's office to document when information is requested and received as a means of corrective action.

- In Sedgwick County, a father was substantiated for physical abuse of his child. The report was assigned for investigation in October 2011, but the finding was not issued for more than a year – in December 2012. The narrative basis for finding indicated the delay in finding was due to a request made by law enforcement. The Unit discovered the perpetrator was convicted for an offense related to this finding in June 2012 and sentenced in July 2012. It would take another five months before DCF would issue the finding. The Unit is unaware of any additional reasons for the continued delay in finding after the conclusion of the criminal case.

- In Mitchell County, a step-parent was substantiated for the sexual abuse of a child. The report was assigned for investigation in May 2012 and the finding was not issued until October 2012. The narrative basis indicated the finding was initially held open at the request of law enforcement, who wanted to complete a polygraph with the alleged perpetrator, and was then held

open further due to "a policy exception approved by the program administrator." The Unit requested clarification on which allowable policy exception was being cited. Again, DCF cited only the policy number, PPM 2511, without citing the specific allowable reason for delay. Subsequent to an additional request, DCF indicated the delay was due to a pending revision of applicable statutes. The Unit has confirmed with DCF several times that a temporary revision went into effect in June 2012 and the permanent revision was sent for publication August 2012. This revision was responsible for a significant decline in substantiated findings being issued for May 2012, which were then completed and forwarded in June. DCF reported possible confusion on the part of social workers as to why findings were continuing to be held for this reason. This topic was specifically addressed at quarterly meeting in September 2012 and April 2013.

- In Ford County, a babysitter was substantiated for physical abuse of a child. The report was assigned for investigation in November 2012 but a finding was not issued until March 2013. The narrative basis contained no explanation for the delay in finding as is required by policy. When the Unit inquired, DCF reported the delay was due to an ongoing law enforcement investigation. However, when the Unit pointed out that a criminal case was filed in January 2013, implying a completed law enforcement investigation, DCF then indicated the delay was due to a "non-policy reason."

- In Geary County, a mother was substantiated for physical abuse and medical neglect of her child. The report was assigned for investigation in September 2011 and the finding was not issued until November 2012. The narrative basis contained no explanation for the delay in finding as is required by policy. When the Unit inquired, DCF reported only that the case was "under an LE (law enforcement) delay". Available records indicated a criminal case was filed in September 2011, the same day the DCF report was assigned for investigation. Furthermore, the perpetrator was convicted in May 2012 and sentenced August 2012. The Unit has no information on the cause of any additional delay in issuing the DCF finding.

While some of these delays were ultimately still for reasons allowable in policy, others were not. In many cases, where workers did not follow policy in stating the reasons for delay, the Unit had to request this information. In those listed above and others like them, where reasons for the delay are stated in compliance with policy, the listed reasons have turned out to be inaccurate or incorrect. Examples such as these 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 that occurs, it is imperative that DCF clearly and correctly indicate the reason for delay.

With policy revisions that went into effect in July 2013, at the end of this reporting year, 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.

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, it should be clearly stated. Supervisors should ensure compliance upon review and approval of findings.

Communications with DCF

Exchange of information with DCF continues to provide many of the same challenges discussed in previous FY reports. Internal practices at DCF continued to instruct workers NOT to respond directly to Unit inquiries. They are directed to provide information to supervisors and/or program administrators in the regions. Central Office staff reports they believe this keeps supervisors "in the loop" and allows them to review the response for accuracy in order to provide the best information. However, this has not prevented the Unit from receiving multiple responses with contradictory information, or responses that fail to answer all of the questions posed. In addition, the time it takes for responses to be funneled through multiple staff significantly increases the time it takes for information to be shared with the Unit. In some cases, 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 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. In addition, this lack of timely response could leave children and adults in a compromised position vulnerable to further abuse.

Additional 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 confirms this, the social worker will indicate otherwise.
- Narratives establishing a basis for finding may reference additional incidents with no action, status, or outcome of those incidents 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 middle of a 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 a

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 SRS to discuss ongoing concerns. A positive outcome has been the further modification of the cover sheet by DCF to include custody and placement information regarding children, as well as the aforementioned prompt regarding the reasons for delay in issuing finding. This change went into effect at the conclusion of this reporting period. When workers become consistent in using current forms and completing them thoroughly and accurately, the Unit hopes to see continued improvement in the sharing of this information. While the Unit has continued to see occasions where requests for information are not resolved at the meetings despite detailed agendas being provided in advance, some other long-standing requests for information have been resolved. Though there has been no significant difference in the daily communications on a case-by-case basis such as those that have been discussed in this report, the Unit hopes improvement in communication and cooperation in this regard will continue and will also create improvement on an agency-wide basis.

Recommendations: The Unit recommends that SRS staff increase efficiency, accuracy and timeliness of response to all Unit inquiries.

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 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 that 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 that 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 that 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 that 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, 2012 TO JUNE 30, 2013
KANSAS CITY METRO REGION

SOURCE				DCF REGION		FINDING							
DCF - CPS	Other (not confirmed)	Total Reports Received	Percent by Population	County	2012 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
18	-	18	0.11%	Atchison	16,813	-	4	4	2	3	4	1	-
54	-	54	0.05%	Douglas	112,864	1	11	11	2	17	8	9	-
205	2	207	0.04%	Johnson	559,913	3	37	25	6	55	15	81	2
43	-	43	0.06%	Leavenworth	77,739	-	10	5	1	4	4	20	-
122	1	123	0.08%	Wyandotte	159,129	3	13	26	1	35	12	44	1
442	**3**	**445**	**0.05%**	**KC Metro**	**926,458**	**7**	**75**	**71**	**12**	**114**	**43**	**155**	**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, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

CHILD REPORTS RECEIVED JULY 1, 2012 TO JUNE 30, 2013
EAST REGION

SOURCE				DCF REGION		FINDING							
DCF - CPS	Other (not confirmed)	Total Reports Received	Percent by Population	County	2012 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
6	1	7	0.05%	Allen	13,319	-	-	3	-	2	-	2	1
3	-	3	0.04%	Anderson	7,917	-	-	-	-	-	1	2	-
5	-	5	0.03%	Bourbon	14,897	-	-	1	1	1	-	2	-
17	-	17	0.17%	Brown	9,881	-	2	4	1	6	-	7	-
6	-	6	0.17%	Chautauqua	3,571	-	1	1	-	3	-	1	-
29	-	29	0.14%	Cherokee	21,226	-	1	16	1	3	5	7	-
3	-	3	0.04%	Coffey	8,502	-	-	-	-	2	-	1	-
37	-	37	0.09%	Crawford	39,361	2	2	9	2	12	4	11	-
11	-	11	0.14%	Doniphan	7,864	-	2	3	1	1	-	5	-
12	-	12	0.05%	Franklin	25,906	-	-	5	-	2	4	1	-
11	-	11	0.08%	Jackson	13,449	-	2	6	-	2	-	2	-
6	1	7	0.04%	Jefferson	18,945	-	1	2	1	4	-	-	1
15	1	16	0.08%	Labette	21,284	-	2	7	2	3	2	2	1
6	-	6	0.06%	Linn	9,441	1	-	-	1	2	-	3	-
4	-	4	0.04%	Marshall	10,022	-	-	-	-	2	1	1	-
23	1	24	0.07%	Miami	32,612	-	5	4	-	8	1	7	1
30	-	30	0.09%	Montgomery	34,459	-	-	5	2	7	8	9	-
4	1	5	0.05%	Nemaha	10,132	-	-	1	-	1	-	2	1
13	1	14	0.09%	Neosho	16,406	-	-	5	-	3	3	2	1
17	-	17	0.11%	Osage	16,142	-	2	5	1	5	1	6	-
9	-	9	0.04%	Pottawatomie	22,302	-	1	-	1	5	2	1	-
189	1	190	0.11%	Shawnee	178,991	6	26	45	7	48	17	64	1
-	-	0	0.00%	Wabaunsee	7,039	-	-	-	-	-	-	-	-
14	1	15	0.16%	Wilson	9,105	-	-	4	-	7	2	2	1
6	-	6	0.18%	Woodson	3,278	-	-	1	-	2	1	2	-
476	**8**	**484**	**0.09%**	**East**	**556,051**	**9**	**47**	**127**	**21**	**131**	**52**	**142**	**8**

"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, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

CHILD REPORTS RECEIVED JULY 1, 2012 TO JUNE 30, 2013
WEST REGION

SOURCE				DCF REGION		FINDING							
DCF - CPS	Other (not confirmed)	Total Reports Received	Percent by Population	County	2012 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
28	1	29	0.11%	Barton	27,557	-	2	8	2	6	4	9	1
3	-	3	0.11%	Chase	2,757	-	-	-	-	1	1	1	-
-	-	0	0.00%	Cheyenne	2,678	-	-	-	-	-	-	-	-
-	-	0	0.00%	Clark	2,181	-	-	-	-	-	-	-	-
3	-	3	0.04%	Clay	8,531	-	-	-	-	-	-	3	-
13	1	14	0.15%	Cloud	9,397	-	1	1	1	3	2	5	1
2	-	2	0.10%	Comanche	1,913	-	-	2	-	-	-	-	-
1	-	1	0.03%	Decatur	2,871	-	-	1	-	-	-	-	-
15	-	15	0.08%	Dickinson	19,762	-	2	-	-	4	5	6	-
1	-	1	0.03%	Edwards	2,979	-	-	1	-	-	-	-	-
6	-	6	0.02%	Ellis	29,053	-	-	-	-	4	-	2	-
5	1	6	0.09%	Ellsworth	6,494	-	-	-	-	1	-	4	1
29	-	29	0.08%	Finney	37,200	-	8	5	6	4	10	3	-
27	1	28	0.08%	Ford	34,752	-	1	3	-	5	1	18	1
34	-	34	0.09%	Geary	38,013	-	2	3	3	17	12	3	-
-	-	0	0.00%	Gove	2,729	-	-	-	-	-	-	-	-
-	-	0	0.00%	Graham	2,578	-	-	-	-	-	-	-	-
3	-	3	0.04%	Grant	7,923	-	-	1	-	1	-	1	-
2	-	2	0.03%	Gray	6,030	-	-	1	-	1	-	-	-
2	-	2	0.15%	Greeley	1,298	-	-	-	-	1	1	-	-
3	-	3	0.11%	Hamilton	2,639	-	1	1	-	1	1	1	-
12	-	12	0.03%	Harvey	34,852	-	-	2	-	1	2	9	-
1	-	1	0.02%	Haskell	4,256	-	-	-	-	-	-	1	-
3	-	3	0.15%	Hodgeman	1,963	-	-	-	-	-	-	3	-
1	-	1	0.03%	Jewell	3,046	-	1	-	-	1	-	-	-
5	-	5	0.13%	Kearny	3,968	-	-	1	-	2	1	2	-
-	-	0	0.00%	Kiowa	2,496	-	-	-	-	-	-	-	-
-	-	0	0.00%	Lane	1,704	-	-	-	-	-	-	-	-
1	-	1	0.03%	Lincoln	3,174	-	-	-	-	-	-	1	-
1	-	1	0.04%	Logan	2,784	-	-	-	-	-	-	1	-
13	-	13	0.04%	Lyon	33,748	-	1	6	-	5	2	4	-
2	-	2	0.02%	Marion	12,347	-	-	-	-	1	-	1	-
3	1	4	0.01%	McPherson	29,356	-	-	-	-	-	-	3	1
1	-	1	0.02%	Meade	4,396	-	-	-	-	1	-	-	-

5	-	5	0.08%	Mitchell	6,355	-	-	-	-	-	1	4	-
2	-	2	0.03%	Morris	5,854	-	-	1	-	-	-	1	-
1	-	1	0.03%	Morton	3,169	-	-	-	-	-	-	1	-
1	-	1	0.03%	Ness	3,068	-	-	-	-	1	-	-	-
2	-	2	0.04%	Norton	5,612	-	1	1	-	-	-	-	-
-	-	0	0.00%	Osborne	3,806	-	-	-	-	-	-	-	-
5	-	5	0.08%	Ottawa	6,072	-	1	1	-	3	1	1	-
6	-	6	0.09%	Pawnee	6,928	-	-	-	-	2	-	4	-
3	-	3	0.05%	Phillips	5,519	-	-	1	-	1	-	1	-
-	-	0	0.00%	Rawlins	2,560	-	-	-	-	-	-	-	-
24	-	24	0.04%	Reno	64,438	-	1	6	1	8	6	3	-
3	-	3	0.06%	Republic	4,858	-	-	1	-	2	1	-	-
7	-	7	0.07%	Rice	9,985	-	-	3	-	-	-	5	-
11	2	13	0.02%	Riley	75,508	-	1	2	-	4	2	3	2
1	-	1	0.02%	Rooks	5,223	-	-	-	-	-	-	1	-
2	-	2	0.06%	Rush	3,220	-	-	-	-	-	-	2	-
5	-	5	0.07%	Russell	6,946	-	-	-	-	1	-	4	-
45	9	54	0.10%	Saline	55,988	1	6	5	-	13	7	19	9
2	-	2	0.04%	Scott	4,937	-	-	-	-	1	-	1	-
3	-	3	0.01%	Seward	23,547	-	-	1	-	-	-	2	-
-	-	0	0.00%	Sheridan	2,538	-	-	-	-	-	-	-	-
1	-	1	0.02%	Sherman	6,113	-	-	-	-	-	-	1	-
-	-	0	0.00%	Smith	3,765	-	-	-	-	-	-	-	-
-	-	0	0.00%	Stafford	4,358	-	-	-	-	-	-	-	-
-	-	0	0.00%	Stanton	2,175	-	-	-	-	-	-	-	-
1	-	1	0.02%	Stevens	5,756	-	-	-	-	-	1	-	-
-	-	0	0.00%	Thomas	7,941	-	-	-	-	-	-	-	-
3	-	3	0.10%	Trego	2,986	-	-	-	-	-	-	3	-
-	-	0	0.00%	Wallace	1,517	-	-	-	-	-	-	-	-
4	-	4	0.07%	Washington	5,758	-	1	-	-	2	-	3	-
-	-	0	0.00%	Wichita	2,256	-	-	-	-	-	-	0	-
357	**16**	**373**	**0.05%**	**West**	**736,181**	**1**	**30**	**58**	**13**	**98**	**61**	**140**	**16**

"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, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

CHILD REPORTS RECEIVED JULY 1, 2012 TO JUNE 30, 2013
WICHITA REGION

SOURCE				DCF REGION		FINDING							
DCF - CPS	Other (not confirmed)	Total Reports Received	Percent by Population	County	2012 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
3	-	3	0.06%	Barber	4,861	-	-	1	-	-	-	2	-
14	-	14	0.02%	Butler	65,827	-	-	-	-	5	7	3	-
16	-	16	0.04%	Cowley	36,288	-	3	4	1	3	2	6	-
1	-	1	0.04%	Elk	2,720	-	-	-	-	-	1	-	-
0	-	0	0.00%	Greenwood	6,454	-	-	-	-	-	-	-	-
1	-	1	0.02%	Harper	5,911	-	-	-	-	1	-	-	-
1	-	1	0.01%	Kingman	7,863	-	-	-	-	-	-	1	-
3	-	3	0.03%	Pratt	9,728	-	-	-	1	1	-	1	-
186	-	186	0.04%	Sedgwick	503,889	1	9	16	4	43	6	114	-
1	-	1	0.00%	Sumner	23,674	-	-	-	-	-	-	1	-
226	**0**	**226**	**0.03%**	**Wichita**	**667,215**	**1**	**12**	**21**	**6**	**53**	**16**	**128**	**0**

"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, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

CHILD REPORTS RECEIVED JULY 1, 2012 TO JUNE 30, 2013
STATEWIDE

SOURCE				DCF REGION		FINDING							
DCF - CPS	Other (not confirmed)	Total Reports Received	Percent by Population	County	2012 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
442	3	445	0.05%	KC Metro	926,458	7	75	71	12	114	43	155	3
476	9	485	0.09%	East	556,051	9	47	127	21	131	52	142	9
357	16	373	0.05%	West	736,181	1	30	58	13	98	61	140	16
226	-	226	0.03%	Wichita	667,215	1	12	21	6	53	16	128	-
1,501	**28**	**1,529**	**0.05%**	**Statewide**	**2,885,905**	**18**	**164**	**277**	**52**	**396**	**172**	**565**	**28**

"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, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

ADULT REPORTS RECEIVED JULY 1, 2012 TO JUNE 30, 2013
KANSAS CITY METRO REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other (not confirmed)	KDHE - CP (Corrective Action - not confirmed)	Total Reports Received	Percent by Population	County	2012 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
3	-	-		-	3	0.02%	Atchison	16,813	2	-	1	-	-
12	-	-	1	-	13	0.01%	Douglas	112,864	10	1	1	-	1
4	9	-	1	-	14	0.00%	Johnson	559,913	6	5	1	5	1
2	1	-	-	-	3	0.00%	Leavenworth	77,739	2	1	-	-	-
8	-	-	-	-	8	0.01%	Wyandotte	159,129	3	4	1	1	-
29	**10**	**0**	**2**	**0**	**41**	**0.00%**	**KC Metro**	**926,458**	**23**	**11**	**4**	**6**	**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, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

ADULT REPORTS RECEIVED JULY 1, 2012 TO JUNE 30, 2013
EAST REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other (not confirmed)	KDHE - CP (Corrective Action - not confirmed)	Total Reports Received	Percent by Population	County	2012 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
1	-	-	-	-	1	0.01%	Allen	13,319	-	-	-	1	-
-	-	-	-	-	0	0.00%	Anderson	7,917	-	-	-	-	-
4	-	-	-	-	4	0.03%	Bourbon	14,897	4	-	-	-	-
-	-	-	-	-	0	0.00%	Brown	9,881	-	-	-	-	-
-	-	-	-	-	0	0.00%	Chautauqua	3,571	-	-	-	-	-
1	-	-	-	-	1	0.00%	Cherokee	21,226	1	-	-	-	-
1	1	-	-	-	2	0.02%	Coffey	8,502	1	1	-	-	-
7	1	-	-	-	8	0.02%	Crawford	39,361	1	1	6	-	-
-	-	-	-	-	0	0.00%	Doniphan	7,864	-	-	-	-	-
3	-	-	-	-	3	0.01%	Franklin	25,906	2	-	1	-	-
1	-	-	-	-	1	0.01%	Jackson	13,449	-	-	1	-	-
-	-	-	-	-	0	0.00%	Jefferson	18,945	-	-	-	-	-
1	1	-	1	-	3	0.01%	Labette	21,284	1	-	1	-	1
-	-	-	-	-	0	0.00%	Linn	9,441	-	-	-	-	-
-	-	-	-	-	0	0.00%	Marshall	10,022	-	-	-	-	-
3	-	-	-	-	3	0.01%	Miami	32,612	-	3	-	-	-
4	1	-	-	-	5	0.01%	Montgomery	34,459	5	-	-	1	-
-	-	-	-	-	0	0.00%	Nemaha	10,132	-	-	-	-	-
4	-	-	-	-	4	0.02%	Neosho	16,406	1	2	1	-	-
-	-	-	2	-	2	0.01%	Osage	16,142	-	-	-	-	2
1	1	-		-	2	0.01%	Pottawatomie	22,302	1	1	-	-	-
23	1	-	5	-	29	0.02%	Shawnee	178,991	5	6	8	10	5
-	-	-	-	-	0	0.00%	Wabaunsee	7,039	-	-	-	-	-
1	-	-	-	-	1	0.01%	Wilson	9,105	1	-	-	-	-
-	-	-	-	-	0	0.00%	Woodson	3,278	-	-	-	-	-
55	**6**	**0**	**8**	**0**	**69**	**0.01%**	**East**	**556,051**	**23**	**14**	**18**	**12**	**8**

"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, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

ADULT REPORTS RECEIVED JULY 1, 2012 TO JUNE 30, 2013
WEST REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other (not confirmed)	KDHE - CP (Corrective Action - not confirmed)	Total Reports Received	Percent by Population	County	2012 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
4	1	-	-	-	5	0.02%	Barton	27,557	2	2	-	1	-
-	-	-	-	-	0	0.00%	Chase	2,757	-	-	-	-	-
-	-	-	-	-	0	0.00%	Cheyenne	2,678	-	-	-	-	-
-	-	-	-	-	0	0.00%	Clark	2,181	-	-	-	-	-
1	-	-	-	-	1	0.01%	Clay	8,531	-	-	1	-	-
1	-	-	-	-	1	0.01%	Cloud	9,397	-	-	-	1	-
-	-	-	-	-	0	0.00%	Comanche	1,913	-	-	-	-	-
-	-	-	-	-	0	0.00%	Decatur	2,871	-	-	-	-	-
2	-	-	-	-	2	0.01%	Dickinson	19,762	-	2	-	2	-
-	-	-	-	-	0	0.00%	Edwards	2,979	-	-	-	-	-
-	2	-	-	-	2	0.01%	Ellis	29,053	2	-	-	1	-
2	-	-	-	-	2	0.03%	Ellsworth	6,494	2	-	--	-	-
2	-	-	-	-	2	0.01%	Finney	37,200	1	-	-	1	-
5	-	-	-	-	5	0.01%	Ford	34,752	1	2	-	2	-
2	-	-	-	-	2	0.01%	Geary	38,013	-	1	1	2	-
-	-	-	-	-	0	0.00%	Gove	2,729	-	-	-	-	-
-	-	-	-	-	0	0.00%	Graham	2,578	-	-	-	-	-
-	-	-	-	-	0	0.00%	Grant	7,923	-	-	-	-	-
-	-	-	-	-	0	0.00%	Gray	6,030	-	-	-	-	-
-	-	-	-	-	0	0.00%	Greeley	1,298	-	-	-	-	-
-	1	-	-	-	1	0.04%	Hamilton	2,639	1	-	-	1	-
2	1	-	1	-	4	0.01%	Harvey	34,852	1	2	-	1	1
-	-	-	-	-	0	0.00%	Haskell	4,256	-	-	-	-	-
-	-	-	-	-	0	0.00%	Hodgeman	1,963	-	-	-	-	-
-	-	-	-	-	0	0.00%	Jewell	3,046	-	-	-	-	-
-	-	-	-	-	0	0.00%	Kearny	3,968	-	-	-	-	-
-	-	-	-	-	0	0.00%	Kiowa	2,496	-	-	-	-	--
-	-	-	-	-	0	0.00%	Lane	1,704	-	-	-	-	-
-	-	-	-	-	0	0.00%	Lincoln	3,174	-	-	-	-	-
1	1	-	-	-	2	0.07%	Logan	2,784	2	-	-	1	-
4	1	-	-	-	5	0.01%	Lyon	33,748	1	2	2	1	-
-	-	-	-	-	0	0.00%	Marion	12,347	-	-	-	-	-
9	-	-	-	-	9	0.03%	McPherson	29,356	-	5	4	-	-
-	-	-	1	-	1	0.02%	Meade	4,396	-	-	-	-	1

1	-	-	-	-	1	0.02%	Mitchell	6,355	-	-	-	1	-
-	-	-	1	-	1	0.02%	Morris	5,854	-	-	-	-	1
-	-	-	-	-	0	0.00%	Morton	3,169	-	-	-	-	-
-	-	-	-	-	0	0.00%	Ness	3,068	-	-	-	-	-
-	-	-	-	-	0	0.00%	Norton	5,612	-	-	-	-	-
-	-	-	-	-	0	0.00%	Osborne	3,806	-	-	-	-	-
-	-	-	-	-	0	0.00%	Ottawa	6,072	-	-	-	-	-
2	1	-	-	-	3	0.04%	Pawnee	6,928	1	1	1	1	-
-	-	-	-	-	0	0.00%	Phillips	5,519	-	-	-	-	-
-	-	-	1	-	1	0.04%	Rawlins	2,560	-	-	-	-	1
8	-	-	-	-	8	0.01%	Reno	64,438	1	6	-	1	-
-	-	-	-	-	0	0.00%	Republic	4,858	-	-	-	-	-
-	-	-	-	-	0	0.00%	Rice	9,985	-	-	-	-	-
4	-	-	-	-	4	0.01%	Riley	75,508	-	1	3	2	-
-	-	-	-	-	0	0.00%	Rooks	5,223	-	-	-	-	-
-	-	-	-	-	0	0.00%	Rush	3,220	-	-	-	-	-
1	-	-	-	-	1	0.01%	Russell	6,946	-	-	1	-	-
15	-	-	-	-	15	0.03%	Saline	55,988	4	3	6	4	-
-	-	-	-	-	0	0.00%	Scott	4,937	-	-	-	-	-
1	-	-	-	-	1	0.00%	Seward	23,547	-	-	-	1	-
-	-	-	-	-	0	0.00%	Sheridan	2,538	-	-	-	-	-
-	1	-	-	-	1	0.02%	Sherman	6,113	1	-	-	1	-
-	-	-	-	-	0	0.00%	Smith	3,765	-	-	-	-	-
1	-	-	-	-	1	0.02%	Stafford	4,358	-	-	1	-	-
-	-	-	-	-	0	0.00%	Stanton	2,175	-	-	-	-	-
-	-	-	-	-	0	0.00%	Stevens	5,756	-	-	-	-	-
-	1	-	-	-	1	0.01%	Thomas	7,941	1	-	-	1	-
-	1	-	-	-	1	0.03%	Trego	2,986	1	-	-	1	-
-	-	-	-	-	0	0.00%	Wallace	1,517	-	-	-	-	-
1	-	-	-	-	1	0.02%	Washington	5,758	-	-	1	-	-
-	-	-	-	-	0	0.00%	Wichita	2,256	-	-	-	-	-
69	**11**	**0**	**4**	**0**	**84**	**0.01%**	**West**	**736,181**	**22**	**27**	**21**	**27**	**4**

"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, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

ADULT REPORTS RECEIVED JULY 1, 2012 TO JUNE 30, 2013
WICHITA REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other (not confirmed)	KDHE - CP (Corrective Action - not confirmed)	Total Reports Received	Percent by Population	County	2012 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
-	-	-	-	-	0	0.00%	Barber	4,861	-	-	-	-	-
15	1	-	1	-	17	0.03%	Butler	65,827	1	9	5	1	1
7	-	-	-	-	7	0.02%	Cowley	36,288	2	1	-	4	-
-	-	-	1	-	1	0.04%	Elk	2,720	-	-	-	-	1
2	-	-	1	-	3	0.05%	Greenwood	6,454	-	2	-	-	1
2	-	-	-	-	2	0.03%	Harper	5,911	1	-	-	1	-
3	-	-	-	-	3	0.04%	Kingman	7,863	2	-	1	-	-
2	1	-	-	-	3	0.03%	Pratt	9,728	2	-	-	2	-
121	1	2	6	-	130	0.03%	Sedgwick	503,889	18	68	16	25	6
5	-	-	-	-	5	0.02%	Sumner	23,674	-	3	-	2	-
157	**3**	**2**	**9**	**0**	**171**	**0.03%**	**Wichita**	**667,215**	**26**	**83**	**22**	**35**	**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, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

ADULT REPORTS RECEIVED JULY 1, 2012 TO JUNE 30, 2013
STATEWIDE

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other (not confirmed)	KDHE - CP (Corrective Action - not confirmed)	Total Reports Received	Percent by Population	County	2012 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
29	10	-	2	-	41	0.00%	KC Metro	926,458	23	11	4	6	2
55	6	-	8	-	69	0.01%	East	556,051	23	14	18	12	8
69	11	-	4	-	84	0.01%	West	736,181	22	27	21	27	4
157	3	2	9	-	171	0.03%	Wichita	667,215	26	83	22	35	9
310	**30**	**2**	**23**	**0**	**365**	**0.01%**	**Statewide**	**2,885,905**	**94**	**135**	**65**	**80**	**23**

"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, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

DISPOSITION OF 2011-2012 CHILD CASES BY COUNTY
KANSAS CITY METRO REGION

	SRS REGION**		Outcome as Percentage of Reports Received									
Total Reports Received	County	2012 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	SRS Custody	Receiving Services	All Other	No Known Action	Pending
13	Atchison	16,813	-	31%	-	8%	8%	8%	8%	8%	-	38%
44	Douglas	112,864	-	14%	-	2%	-	7%	5%	5%	-	73%
172	Johnson	559,913	1%	16%	-	2%	7%	12%	3%	2%	-	67%
41	Leavenworth	77,739	-	10%	-	2%	10%	15%	7%	5%	-	61%
105	Wyandotte	159,129	-	16%	1%	2%	2%	8%	7%	2%	-	70%
375	**KC Metro**	**926,458**	**0%**	**16%**	**0%**	**2%**	**5%**	**10%**	**5%**	**3%**	**-**	**67%**

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

* 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%.

**During 2011-2012, the Department for Children and Families (DCF) was known as the Department of Social and Rehabilitation Services (SRS).

DISPOSITION OF 2011-2012 CHILD CASES BY COUNTY
EAST REGION

	SRS REGION**		Outcome as Percentage of Reports Received									
Total Reports Received	County	2012 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	SRS Custody	Receiving Services	All Other	No Known Action	Pending
5	Allen	13,319	-	20%	-	-	-	-	-	-	-	80%
3	Anderson	7,917	-	67%	-	-	-	-	-	-	-	33%
8	Bourbon	14,897	-	38%	-	-	-	25%	-	-	-	63%
12	Brown	9,881	-	25%	-	-	-	25%	17%	-	-	50%
2	Chautauqua	3,571	-	100%	-	-	-	-	-	-	-	-
16	Cherokee	21,226	-	-	-	-	-	19%	-	-	6%	75%
3	Coffey	8,502	-	-	-	-	-	67%	-	-	-	33%
36	Crawford	39,361	3%	8%	-	-	-	6%	-	3%	-	81%
2	Doniphan	7,864	-	-	-	-	-	-	50%	-	-	50%
13	Franklin	25,906	8%	23%	-	-	-	-	8%	-	-	69%
21	Jackson	13,449	-	14%	-	-	-	-	5%	10%	-	71%
6	Jefferson	18,945	-	50%	-	-	17%	50%	-	-	-	17%
8	Labette	21,284	-	13%	-	-	-	-	-	-	-	88%
3	Linn	9,441	-	-	-	-	-	-	-	67%	-	33%
5	Marshall	10,022	-	-	-	-	-	20%	-	-	-	80%
22	Miami	32,612	-	9%	-	-	-	14%	5%	-	-	77%
26	Montgomery	34,459	-	19%	-	-	8%	19%	4%	4%	-	62%
5	Nemaha	10,132	-	40%	-	20%	-	-	-	-	-	40%
27	Neosho	16,406	-	22%	-	11%	4%	19%	4%	7%	-	52%
14	Osage	16,142	-	21%	7%	-	-	21%	7%	-	-	64%
8	Pottawatomie	22,302	-	25%	-	-	13%	-	13%	-	-	50%
159	Shawnee	178,991	1%	11%	-	1%	4%	13%	4%	2%	3%	69%
0	Wabaunsee	7,039	-	-	-	-	-	-	-	-	-	-
6	Wilson	9,105	-	33%	-	-	-	17%	-	-	-	67%
4	Woodson	3,278	-	25%	-	-	-	25%	-	-	-	50%
414	**East**	**556,051**	**1%**	**15%**	**0%**	**1%**	**3%**	**13%**	**4%**	**3%**	**1%**	**66%**

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

* 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%.

**During 2011-2012, the Department for Children and Families (DCF) was known as the Department of Social and Rehabilitation Services (SRS).

DISPOSITION OF 2011-2012 CHILD CASES BY COUNTY
WEST REGION

	SRS REGION**		Outcome as Percentage of Reports Received									
Total Reports Received	County	2012 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	SRS Custody	Receiving Services	All Other	No Known Action	Pending
21	Barton	27,557	-	10%	-	10%	5%	10%	-	-	-	76%
0	Chase	2,757	-	-	-	-	-	-	-	-	-	-
2	Cheyenne	2,678	-	50%	-	-	-	-	-	-	-	50%
3	Clark	2,181	-	33%	-	-	-	33%	-	-	-	67%
1	Clay	8,531	-	-	-	-	-	-	-	-	-	100%
6	Cloud	9,397	-	33%	-	-	17%	17%	-	-	-	50%
0	Comanche	1,913	-	-	-	-	-	-	-	-	-	-
2	Decatur	2,871	-	50%	-	-	-	-	-	-	-	50%
2	Dickinson	19,762	-	-	-	50%	-	-	50%	-	-	50%
0	Edwards	2,979	-	-	-	-	-	-	-	-	-	-
12	Ellis	29,053	-	8%	-	-	8%	8%	8%	-	-	83%
2	Ellsworth	6,494	-	50%	-	-	-	-	-	-	-	50%
35	Finney	37,200	-	14%	-	6%	3%	17%	11%	3%	-	63%
42	Ford	34,752	2%	24%	-	5%	2%	10%	5%	2%	-	60%
14	Geary	38,013	7%	29%	-	-	7%	36%	7%	-	-	43%
0	Gove	2,729	-	-	-	-	-	-	-	-	-	-
1	Graham	2,578	-	-	-	-	-	-	100%	-	-	-
3	Grant	7,923	-	-	-	-	33%	-	-	-	-	67%
1	Gray	6,030	100%	-	-	-	-	100%	-	-	-	-
0	Greeley	1,298	-	-	-	-	-	-	-	-	-	-
1	Hamilton	2,639	-	-	-	-	-	-	100%	-	-	-
13	Harvey	34,852	-	15%	-	15%	-	8%	-	15%	-	54%
0	Haskell	4,256	-	-	-	-	-	-	-	-	-	-
0	Hodgeman	1,963	-	-	-	-	-	-	-	-	-	-
1	Jewell	3,046	-	100%	-	-	-	100%	-	-	-	-
4	Kearny	3,968	-	-	-	-	-	-	25%	-	-	75%
0	Kiowa	2,496	-	-	-	-	-	-	-	-	-	-
2	Lane	1,704	-	-	-	-	-	-	-	-	-	100%
0	Lincoln	3,174	-	-	-	-	-	-	-	-	-	-
0	Logan	2,784	-	-	-	-	-	-	-	-	-	-
7	Lyon	33,748	-	43%	-	-	-	14%	-	29%	-	29%
1	Marion	12,347	-	-	-	-	-	100%	-	-	-	-
2	McPherson	29,356	-	50%	-	-	-	-	-	-	-	50%
3	Meade	4,396	-	33%	-	33%	33%	-	-	-	-	-

11	Mitchell	6,355	-	45%	-	-	-	9%	-	-	-	45%
1	Morris	5,854	-	100%	-	-	-	100%	-	-	-	-
1	Morton	3,169	-	-	-	-	-	-	-	-	-	100%
0	Ness	3,068	-	-	-	-	-	-	-	-	-	-
3	Norton	5,612	-	-	-	-	-	-	-	-	-	100%
2	Osborne	3,806	-	-	-	-	-	-	-	-	-	100%
0	Ottawa	6,072	-	-	-	-	-	-	-	-	-	-
1	Pawnee	6,928	100%	-	-	-	-	100%	-	-	-	-
6	Phillips	5,519	-	33%	-	-	-	-	-	-	-	67%
0	Rawlins	2,560	-	-	-	-	-	-	-	-	-	-
17	Reno	64,438	-	29%	-	-	-	18%	6%	-	-	65%
1	Republic	4,858	-	-	-	-	-	-	-	-	-	100%
4	Rice	9,985	-	25%	-	-	-	-	-	-	-	75%
23	Riley	75,508	4%	9%	-	-	-	4%	-	-	-	87%
2	Rooks	5,223	-	50%	-	-	-	-	-	-	-	50%
2	Rush	3,220	50%	-	-	-	-	-	-	-	-	50%
2	Russell	6,946	-	-	-	-	-	-	-	-	-	100%
24	Saline	55,988	-	38%	-	4%	-	8%	13%	-	-	58%
7	Scott	4,937	-	29%	-	29%	14%	14%	14%	-	-	14%
21	Seward	23,547	-	38%	-	10%	10%	10%	14%	-	-	29%
0	Sheridan	2,538	-	-	-	-	-	-	-	-	-	-
1	Sherman	6,113	-	-	-	-	-	-	-	-	-	100%
4	Smith	3,765	-	-	-	-	-	-	-	-	-	100%
1	Stafford	4,358	-	-	-	-	-	-	-	-	-	100%
1	Stanton	2,175	-	-	-	-	-	-	-	-	-	100%
2	Stevens	5,756	-	-	-	-	-	-	-	-	-	100%
4	Thomas	7,941	-	50%	-	-	-	50%	-	-	-	25%
0	Trego	2,986	-	-	-	-	-	-	-	-	-	-
0	Wallace	1,517	-	-	-	-	-	-	-	-	-	-
1	Washington	5,758	-	-	-	-	-	-	-	-	-	100%
3	Wichita	2,256	-	-	-	-	-	33%	-	-	-	67%
326	**West**	**736,181**	**2%**	**23%**	**-**	**5%**	**3%**	**12%**	**6%**	**2%**	**-**	**60%**

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

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DISPOSITION OF 2011-2012 CHILD CASES BY COUNTY
WICHITA REGION

	SRS REGION**		Outcome as Percentage of Reports Received									
Total Reports Received	County	2012 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	SRS Custody	Receiving Services	All Other	No Known Action	Pending
2	Barber	4,861	50%	-	-	-	-	-	-	-	-	50%
24	Butler	65,827	-	13%	-	-	-	25%	4%	-	-	63%
5	Cowley	36,288	-	-	-	20%	-	20%	20%	-	-	60%
3	Elk	2,720	-	33%	-	-	-	67%	-	-	-	33%
4	Greenwood	6,454	-	-	-	-	-	-	-	-	-	100%
3	Harper	5,911	-	67%	-	-	-	67%	-	-	-	33%
1	Kingman	7,863	-	100%	-	-	-	-	-	-	-	-
6	Pratt	9,728	-	17%	-	-	-	33%	17%	-	-	67%
204	Sedgwick	503,889	-	32%	-	-	4%	12%	2%	0%	-	61%
7	Sumner	23,674	-	29%	-	-	-	14%	-	-	-	71%
259	**Wichita**	**667,215**	**0%**	**29%**	**-**	**0%**	**3%**	**15%**	**3%**	**0%**	**-**	**61%**

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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

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DISPOSITION OF 2011-2012 CHILD CASES BY COUNTY
STATEWIDE

	SRS REGION**		Outcome as Percentage of Reports Received									
Total Reports Received	County	2012 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	SRS Custody	Receiving Services	All Other	No Known Action	Pending
375	KC Metro	926,458	0%	16%	0%	2%	5%	10%	5%	3%	-	67%
414	East	556,051	1%	15%	0%	1%	3%	13%	4%	3%	1%	66%
326	West	736,181	2%	23%	-	5%	3%	12%	6%	2%	-	60%
259	Wichita	667,215	0%	29%	-	0%	3%	15%	3%	0%	-	61%
1,374	**Statewide**	**2,885,905**	**1%**	**20%**	**0%**	**2%**	**4%**	**12%**	**4%**	**2%**	**0%**	**64%**

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

* 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%.

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DISPOSITION OF 2011-2012 ADULT CASES BY COUNTY
KANSAS CITY METRO REGION

	SRS REGION**		Outcome as Percentage of Reports Received							
Total Reports Received	County	2012 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	All Other	No Known Action	Pending
2	Atchison	16,813	-	50%	-	-	-	-	-	50%
4	Douglas	112,864	-	25%	-	-	-	25%	-	50%
30	Johnson	559,913	-	30%	-	-	-	7%	-	63%
4	Leavenworth	77,739	-	-	-	-	-	-	-	100%
3	Wyandotte	159,129	-	-	-	-	-	-	-	100%
43	**KC Metro**	**926,458**	**-**	**26%**	**-**	**-**	**-**	**7%**	**-**	**67%**

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

* 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%.

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DISPOSITION OF 2011-2012 ADULT CASES BY COUNTY
EAST REGION

	SRS REGION**		Outcome as Percentage of Reports Received							
Total Reports Received	County	2012 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	All Other	No Known Action	Pending
0	Allen	13,319	-	-	-	-	-	-	-	-
0	Anderson	7,917	-	-	-	-	-	-	-	-
0	Bourbon	14,897	-	-	-	-	-	-	-	-
0	Brown	9,881	-	-	-	-	-	-	-	-
0	Chautauqua	3,571	-	-	-	-	-	-	-	-
1	Cherokee	21,226	-	-	-	-	-	-	-	100%
0	Coffey	8,502	-	-	-	-	-	-	-	-
9	Crawford	39,361	-	11%	-	-	-	-	11%	78%
0	Doniphan	7,864	-	-	-	-	-	-	-	-
0	Franklin	25,906	-	-	-	-	-	-	-	-
1	Jackson	13,449	-	-	-	-	-	-	-	100%
1	Jefferson	18,945	-	-	-	-	-	-	-	100%
5	Labette	21,284	-	-	-	-	-	-	-	100%
0	Linn	9,441	-	-	-	-	-	-	-	-
2	Marshall	10,022	-	-	-	-	-	50%	-	50%
1	Miami	32,612	-	-	-	-	-	-	-	100%
2	Montgomery	34,459	-	-	-	-	-	-	-	100%
1	Nemaha	10,132	-	-	-	-	-	-	-	100%
4	Neosho	16,406	-	-	-	-	25%	25%	-	50%
2	Osage	16,142	-	-	-	-	-	-	-	100%
2	Pottawatomie	22,302	-	-	-	-	-	-	-	100%
24	Shawnee	178,991	-	-	-	-	-	8%	-	92%
0	Wabaunsee	7,039	-	-	-	-	-	-	-	-
0	Wilson	9,105	-	-	-	-	-	-	-	-
0	Woodson	3,278	-	-	-	-	-	-	-	-
55	**East**	**556,051**	**-**	**2%**	**-**	**-**	**2%**	**7%**	**2%**	**87%**

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2012
Source: U.S. Census Bureau, Population Division. Release date: March 2013

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DISPOSITION OF 2011-2012 ADULT CASES BY COUNTY
WEST REGION

	SRS REGION**		Outcome as Percentage of Reports Received							
Total Reports Received	County	2012 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	All Other	No Known Action	Pending
4	Barton	27,557	-	-	-	-	-	-	-	100%
0	Chase	2,757	-	-	-	-	-	-	-	-
0	Cheyenne	2,678	-	-	-	-	-	-	-	-
0	Clark	2,181	-	-	-	-	-	-	-	-
4	Clay	8,531	-	50%	-	-	-	25%	-	25%
1	Cloud	9,397	-	-	-	-	-	-	-	100%
0	Comanche	1,913	-	-	-	-	-	-	-	-
0	Decatur	2,871	-	-	-	-	-	-	-	-
0	Dickinson	19,762	-	-	-	-	-	-	-	-
2	Edwards	2,979	-	-	-	-	-	50%	-	50%
3	Ellis	29,053	-	-	-	-	-	-	-	100%
1	Ellsworth	6,494	-	-	-	-	-	-	-	100%
6	Finney	37,200	-	67%	-	17%	-	-	-	17%
0	Ford	34,752	-	-	-	-	-	-	-	-
1	Geary	38,013	-	-	-	-	-	-	-	100%
3	Gove	2,729	-	-	-	-	-	100%	-	-
1	Graham	2,578	-	100%	-	-	-	-	-	-
1	Grant	7,923	-	-	-	-	-	-	-	100%
0	Gray	6,030	-	-	-	-	-	-	-	-
1	Greeley	1,298	-	-	-	-	-	-	-	100%
1	Hamilton	2,639	-	-	-	-	-	100%	-	-
3	Harvey	34,852	-	-	-	-	-	-	-	100%
1	Haskell	4,256	-	-	-	-	-	-	-	100%
0	Hodgeman	1,963	-	-	-	-	-	-	-	-
0	Jewell	3,046	-	-	-	-	-	-	-	-
0	Kearny	3,968	-	-	-	-	-	-	-	-
0	Kiowa	2,496	-	-	-	-	-	-	-	-
0	Lane	1,704	-	-	-	-	-	-	-	-
2	Lincoln	3,174	-	-	-	-	-	-	-	100%
1	Logan	2,784	-	-	-	-	-	-	-	100%
1	Lyon	33,748	-	-	-	-	-	-	-	100%
3	Marion	12,347	-	-	-	33%	-	-	-	67%
3	McPherson	29,356	-	-	-	-	-	-	-	100%
0	Meade	4,396	-	-	-	-	-	-	-	-

1	Mitchell	6,355	-	-	-	-	-	-	-	100%
0	Morris	5,854	-	-	-	-	-	-	-	-
1	Morton	3,169	-	-	-	-	-	-	-	100%
0	Ness	3,068	-	-	-	-	-	-	-	-
0	Norton	5,612	-	-	-	-	-	-	-	-
1	Osborne	3,806	-	-	-	-	-	-	-	100%
2	Ottawa	6,072	-	-	-	-	-	-	-	100%
9	Pawnee	6,928	-	-	-	-	11%	-	-	89%
1	Phillips	5,519	-	100%	-	-	-	-	-	-
0	Rawlins	2,560	-	-	-	-	-	-	-	-
2	Reno	64,438	-	-	-	-	-	-	-	100%
0	Republic	4,858	-	-	-	-	-	-	-	-
0	Rice	9,985	-	-	-	-	-	-	-	-
7	Riley	75,508	-	-	-	-	-	-	-	100%
0	Rooks	5,223	-	-	-	-	-	-	-	-
0	Rush	3,220	-	-	-	-	-	-	-	-
0	Russell	6,946	-	-	-	-	-	-	-	-
8	Saline	55,988	-	-	-	-	-	-	-	100%
1	Scott	4,937	-	-	-	-	-	-	-	100%
0	Seward	23,547	-	-	-	-	-	-	-	-
0	Sheridan	2,538	-	-	-	-	-	-	-	-
1	Sherman	6,113	-	-	-	-	-	-	-	100%
3	Smith	3,765	-	-	-	-	-	-	-	100%
0	Stafford	4,358	-	-	-	-	-	-	-	-
0	Stanton	2,175	-	-	-	-	-	-	-	-
0	Stevens	5,756	-	-	-	-	-	-	-	-
1	Thomas	7,941	-	-	-	-	-	-	-	100%
0	Trego	2,986	-	-	-	-	-	-	-	-
0	Wallace	1,517	-	-	-	-	-	-	-	-
1	Washington	5,758	100%	-	-	-	-	-	-	-
0	Wichita	2,256	-	-	-	-	-	-	-	-
82	**West**	**736,181**	**1%**	**10%**	**-**	**2%**	**1%**	**7%**	**-**	**78%**

Population figures taken from:

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DISPOSITION OF 2011-2012 ADULT CASES BY COUNTY
WICHITA REGION

	SRS REGION**		Outcome as Percentage of Reports Received							
Total Reports Received	County	2012 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	All Other	No Known Action	Pending
1	Barber	4,861	-	-	-	-	-	100%	-	-
7	Butler	65,827	-	-	-	-	-	-	-	100%
9	Cowley	36,288	-	11%	-	-	-	22%	-	67%
0	Elk	2,720	-	-	-	-	-	-	-	-
1	Greenwood	6,454	-	-	-	-	-	100%	-	-
2	Harper	5,911	-	-	-	-	-	-	-	100%
0	Kingman	7,863	-	-	-	-	-	-	-	-
2	Pratt	9,728	-	-	-	-	-	-	-	100%
120	Sedgwick	503,889	-	5%	-	1%	4%	3%	-	88%
3	Sumner	23,674	-	67%	-	-	-	-	-	33%
145	**Wichita**	**667,215**	**-**	**6%**	**-**	**1%**	**3%**	**5%**	**-**	**85%**

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DISPOSITION OF 2011-2012 ADULT CASES BY COUNTY
STATEWIDE

	SRS REGION**		Outcome as Percentage of Reports Received							
Total Reports Received	County	2012 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	All Other	No Known Action	Pending
43	KC Metro	926,458	-	26%	-	-	-	7%	-	67%
55	East	556,051	-	2%	-	-	2%	7%	2%	87%
82	West	736,181	1%	10%	-	2%	1%	7%	-	78%
145	Wichita	667,215	-	6%	-	1%	3%	5%	-	85%
325	**Statewide**	**2,885,905**	**0%**	**9%**	**-**	**1%**	**2%**	**6%**	**0%**	**81%**

Population figures taken from:

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