KANSAS ATTORNEY GENERAL

Derek Schmidt

Abuse, Neglect and Exploitation Unit (ANE)

Annual Report

July 1, 2013 – June 30, 2014

120 SW 10th Ave., 2nd Floor • Topeka, KS 66612-1597 • (785) 368-8131

www.ag.ks.gov

STATE OF KANSAS
OFFICE OF THE ATTORNEY GENERAL

DEREK SCHMIDT
ATTORNEY GENERAL

MEMORIAL HALL
120 SW 10TH AVE., 2ND FLOOR
TOPEKA, KS 66612-1597
(785) 296-2215 • FAX (785) 296-6296
WWW.AG.KS.GOV

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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 Unit received 1,863 substantiated reports of abuse, neglect or exploitation, an increase from the 1,843 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 nine years ago.

Sincerely,

Derek

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, 2013 to June 30, 2014, the Unit received more than 1,800 reports. These reports were in the form of substantiated findings by state agencies and were also generated by constituent concerns. The Unit is staffed full-time by a Director and a Secretary III. 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.

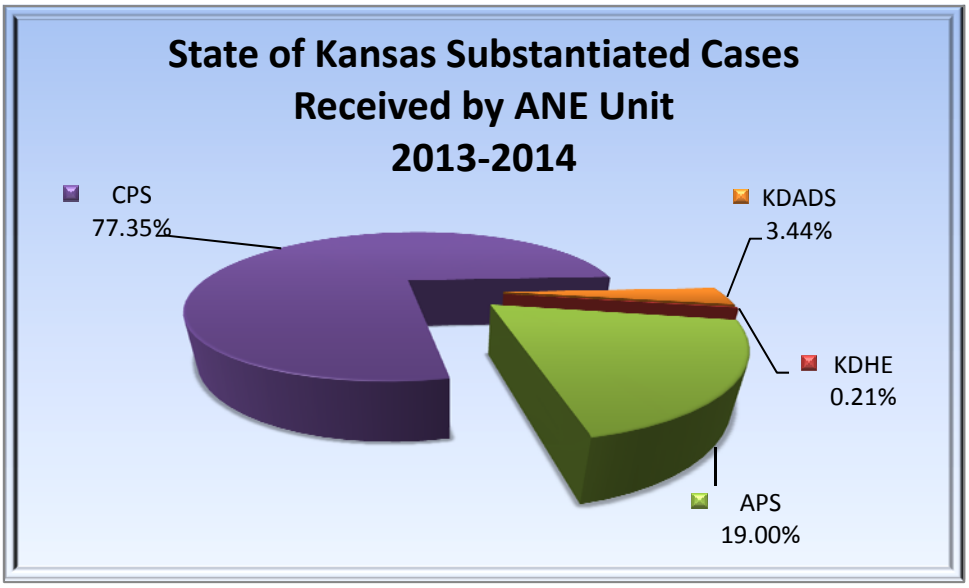
(f) No state funds appropriated to support the provisions of the abuse, neglect or exploitation of persons unit and expended to contract with any third party shall be used by a third party to file any civil action against the state of Kansas or any agency of the state of Kansas. Nothing in this section 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, 2013 to June 30, 2014, the ANE Unit received 1,863 reports of substantiated abuse, neglect or exploitation from the Kansas Department for Children and Families (DCF), Kansas Department on Aging and Disability Services (KDADS) and Kansas Department of Health and Environment (KDHE). The reports consisted of 1,441 from DCF Child Protective Services (CPS), 354 from DCF (APS), 64 from KDADS and 4 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 (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. 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, 2013, to June 30, 2014, the ANE Unit received 30 "other" reports. Of the 30 "other" reports, 14 were child abuse related and 16 were adult abuse related. Reports of substantiated abuse combined with "other" reports reviewed accounted for a total of 1,455 reports of child abuse and 438 reports of adult abuse for a total of 1,893 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 more than 5600 contacts with other individuals or agencies in the form of calls, faxes, emails or other correspondence in an effort to carry out its mission.

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

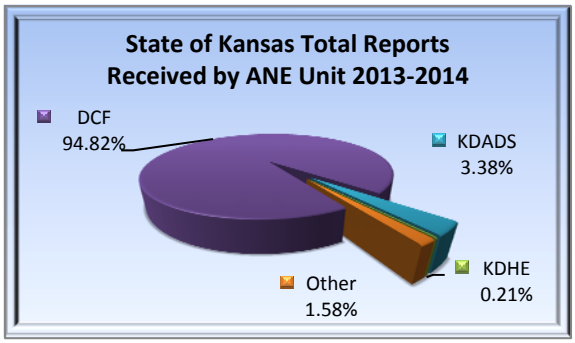


Figure A

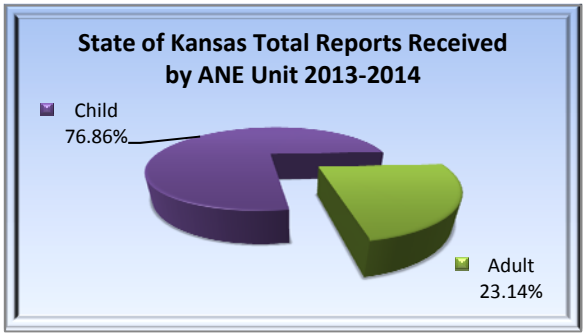


Figure B

Child ANE comprised more than 75% of all reports received. The remaining reports were on vulnerable adults over age 18. The Unit saw a 4% increase over last year in total reports received of abuse toward vulnerable adults. (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.

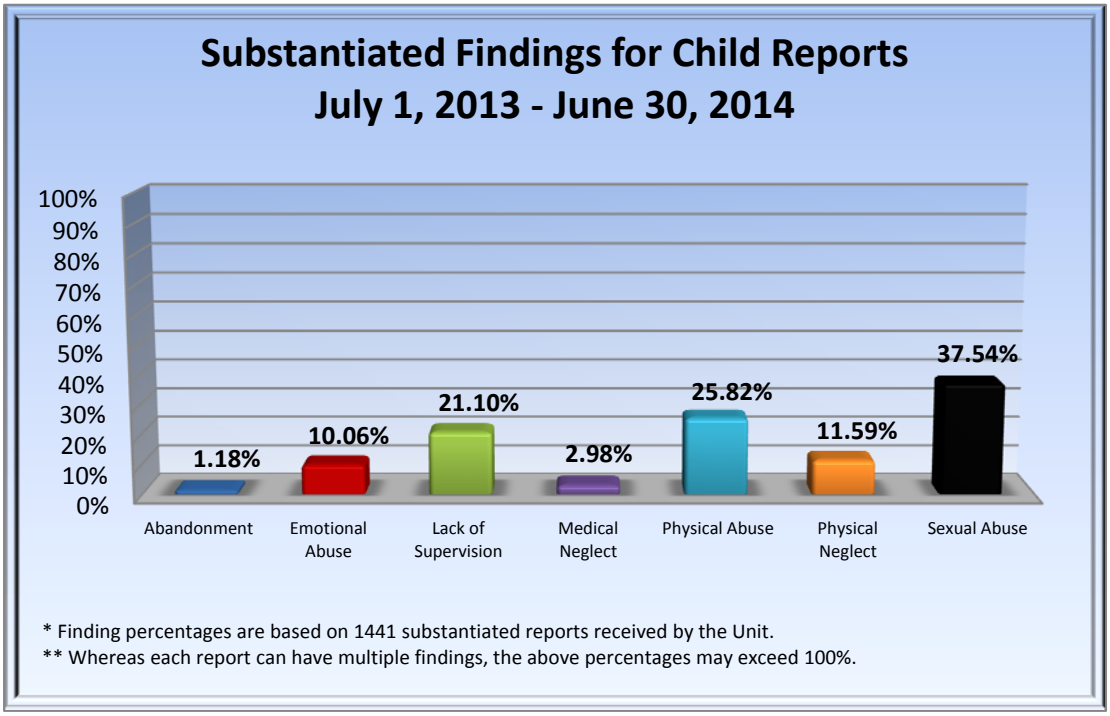
Ongoing discussions are held with state agency representatives to review policies, practices and procedures and to discuss system improvement and staff performance.

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

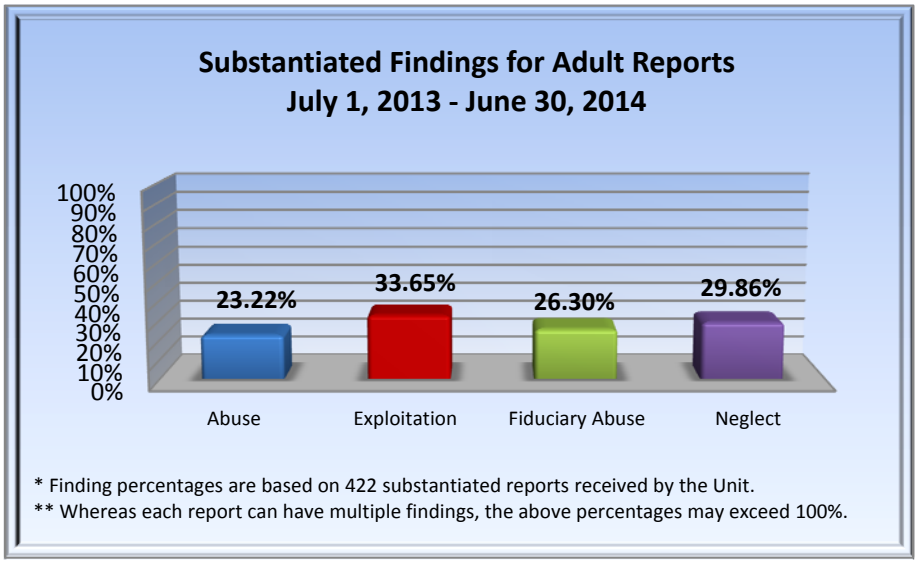
Findings recorded for the 1,441 substantiated reports of child abuse include: abandonment, emotional abuse, lack of supervision, medical neglect, physical abuse, physical neglect and sexual abuse. Some reports contained substantiations of more than one type of abuse or may have involved multiple victims or perpetrators. Sexual abuse was the most frequently substantiated form of abuse.



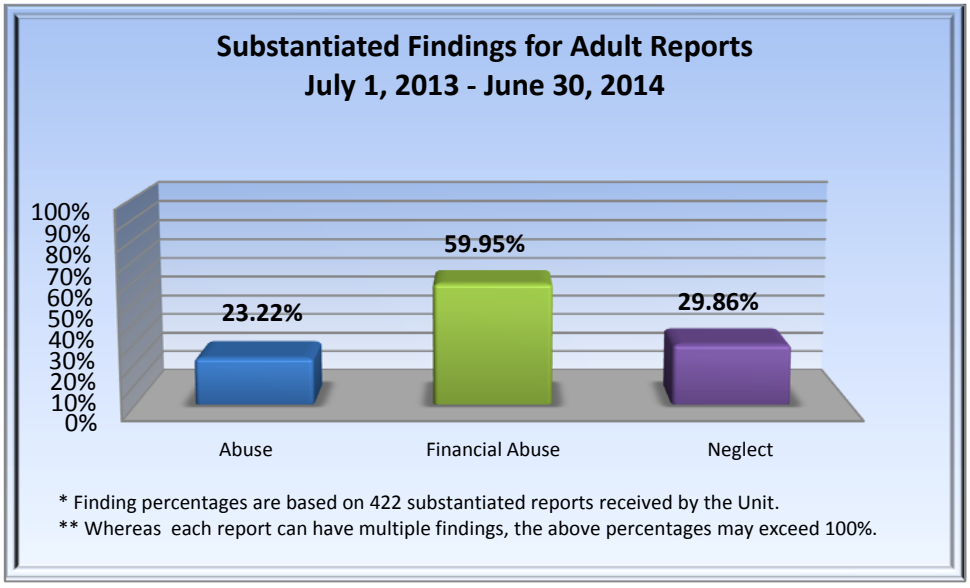
Compared to last year's findings, when 1,501 substantiated reports were received, the following variances are noted:

Abandonment	decreased 0.02%
Emotional Abuse	decreased 0.87%
Lack of Supervision	increased 2.65%
Medical Neglect	decreased 0.48%
Physical Abuse	decreased 0.56%
Physical Neglect	increased 0.13%
Sexual Abuse	decreased 0.10%

Findings recorded for the 422 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 decreased 4.27% over last year, while exploitation decreased 5.82% and fiduciary abuse increased 7.29%. Neglect findings increased 6.47%. During the 2012-2013 fiscal year, the Unit received 342 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 Jefferson County, a Certified Nurse's Aide (CNA) was substantiated by KDADS for abuse and neglect of a facility resident. The resident was identified as suffering from dementia, Parkinson's disease and depression, in addition to multiple other physical ailments. The finding alleges that while the CNA was transferring the resident to a wheelchair, the resident struck the CNA in the face. The CNA then reportedly grabbed the resident's arms, restrained her, screamed and cursed at her. After other staff physically separated the parties, the CNA reportedly returned to the resident, poked her in the face and hit her in the face with a urine-soaked pad. Despite this possible crime, neither the facility, nor KDADS reported the matter to law enforcement as both are required to do by federal mandate.

  Upon inquiry by the Unit, KDADS immediately forwarded a referral to local law enforcement. When the Unit followed up two months later, law enforcement acknowledged receipt of the referral, but indicated no action had been taken in response. The Unit facilitated the production of KDADS' investigative file and forwarded those documents to law enforcement who agreed to staff the matter with the County Attorney to determine whether there should be further action or investigation. As of the writing of this report, law enforcement confirms forwarding the matter to the County Attorney's Office, but the Unit has been unable to verify whether the case has been reviewed for a charging decision. This case is also cited on page 23 of this report.

Lack of Internal/External Agency Communication and Safeguards

In numerous cases the ANE Unit obtained and facilitated delivery of information that was needed by DCF, KDADS, KDHE, local law enforcement, or county or district attorneys to assure that the case received full consideration. In some cases, it was evident a breakdown occurred while information transferred from one agency to another, while in other cases, reports were found to be stalled within an individual agency. Unit inquiry brought these cases back to the attention of persons who were able to take additional action which furthered investigation or prosecution.

In support:

- In Johnson County, DCF substantiated a father for physical abuse of one child, sexual abuse of another child and emotional abuse of both children. In Unit follow up with the District Attorney's Office regarding charging status of this alleged perpetrator, it was reported by a charging attorney that the matter was declined in June 2013. The Unit spoke further with a law enforcement officer who indicated their records showed charges were declined in the sexual abuse case. However, the detective reported that the physical abuse allegation was referred back to law enforcement from the District Attorney's Office with a request for additional investigation. The detective reported completing that investigation and resubmitting the case in August 2013. The Unit followed up further with the District Attorney's Office and after first indicating they were awaiting the additional investigation, an Assistant District Attorney (ADA) confirmed in March 2014 that the additional investigation was received but that "the system" never produced notification. The ADA indicated the case would be reviewed for charging since the additional investigation was brought to the office's attention. As of October 2014, the District Attorney's Office reports the matter is still awaiting review for a charging decision and it was suggested the Unit follow up again after the first of the year. The Unit will continue to monitor outcomes in this case.

- In Shawnee County, parents were substantiated for the lack of supervision and physical abuse of a child. The DCF and law enforcement investigations into this matter were initiated in 2013. Upon receiving the DCF finding in June 2014, the Unit contacted the involved law enforcement agency to inquire as to the status of their investigation. A detective reported that the case was never forwarded to the District Attorney's Office and indicated that he would speak to his sergeant and make sure it was sent over. When the Unit followed up with the District Attorney's Office in July, support staff indicated their office still had no record of receiving the report. However, staff was able to access the report through an interoffice database and took initiative to print the report and provide it to an attorney for review. In August 2014, two cases were filed alleging a felony charge against each perpetrator.

- In Shawnee County, a woman was substantiated by APS of fiduciary abuse of her mother after it was alleged she used her mother's funds for her own benefit while failing to pay for her mother's care in a nursing facility. Though APS reported sending notice of finding to law enforcement for investigation, when the Unit contacted law enforcement, no such documents could be found. The Unit facilitated the forwarding of new documents to law enforcement, who subsequently assigned the matter to a detective for further investigation. Ultimately, the investigation was closed without forwarding for charges as the victim's money had been repaid in the intervening months.

- In Sedgwick County, an unknown perpetrator was substantiated for the physical abuse of a 4-month-old child who was in foster care. The DCF investigation established that during the possible time of injury the child was in the care of foster parents, the parents of the foster

parents, and a licensed daycare provider. DCF's Policy and Procedure Manual (PPM) 2540, Notice of Department Finding, section A(6) requires KDHE to receive notice of finding "if abuse occurred in a facility or a foster home." Upon review of this finding, the Unit inquired if such notice was sent and was advised by a DCF supervisor that notice was not sent to KDHE as the substantiated perpetrator was identified as unknown. The Unit inquired further as to whether notice was required to be sent, especially in light of all of the possible perpetrators being licensed (or required to be approved caregivers) by KDHE. Only after further discussion did DCF acknowledge the error in not sending notice and indicated the department would complete this policy requirement. Subsequent follow up with both involved departments within KDHE revealed they found no record of receiving notice of finding. The Unit continues to facilitate this exchange of information as of the writing of this report. This case is also cited on page 31 of this report.

- In Jefferson County, a father was substantiated for physical abuse of his child after it was alleged he was driving under the influence of alcohol and/or drugs with his child in the vehicle. The father struck a sign while driving, causing injury to his child due to broken glass. In follow up, the Unit contacted the County Attorney's office, which initially reported the child's father had been charged criminally. However, after further research, the office reported the matter had been left open as the County Attorney who was previously in office had been awaiting lab results. During transition, it was not realized those results had since been received. As a result of Unit inquiry, this case was brought to the attention of the new County Attorney, who subsequently charged the father, resulting in a second-offense DUI conviction.

- In Ellis County, a grandparent was substantiated for the sexual abuse of his grandchild. Upon Unit inquiry to the County Attorney's office a few months after the finding was received, the office verified receipt of the report from law enforcement, but could not confirm it was assigned to an attorney for review. The office reported they would research the matter. Upon follow up, it was confirmed the report had subsequently been located, assigned and reviewed accordingly for charging.

- In Shawnee County, a man was substantiated for physical abuse of his minor girlfriend. Upon Unit follow up with law enforcement in March 2014, regarding the status of any criminal investigation, a supervisory officer discovered the responding officer had never completed his narrative and therefore, the matter was not fully investigated. Unit inquiry resulted in the completion of the narrative and the matter being assigned to a detective for further investigation. When the Unit followed up again in November 2014, the District Attorney's office denied receiving the case, though the detective reported forwarding such in March. The detective agreed to have the report resent. As of the writing of this narrative, District Attorney's Office staff denies the report has been received and indicated intent to contact the detective directly. The Unit will continue to monitor and confirm outcome.

- In Jackson County, parents were substantiated in 2011 for physical neglect of their children due to drug use and conditions in the home. Though criminal charges had been filed against both parents, the Unit followed up with the County Attorney's Office when it appeared a summons had failed to be served on one parent for a lengthy period of time and there was no indication of arraignment having been completed. Upon Unit inquiry, the County Attorney's Office confirmed a warrant had never followed up the original summons and immediately issued such. The case remains pending and the Unit will continue to monitor for disposition.

- In Ellsworth County, a father was substantiated for the sexual abuse of his child. The substantiated finding was not issued for more than a year and DCF explained the delay in finding as being allowable in policy due to an inability to locate and interview the alleged perpetrator. The Unit requested to review DCF log notes in November 2013 and these were not received until March 2014. Review of those log notes (in the form of case activity notes reported in DCF assessment forms) finds no evidence of any effort to locate the alleged perpetrator in the intervening months. In fact, all case activity is documented in September 2012 and in September 2013 only. Other correspondence received with these documents reflects communication between a DCF supervisor and a child welfare agency out of state, where the supervisor reported in September 2013 that the assigned DCF worker had left the agency while awaiting police reports in the case. The Unit received this finding in October 2013 and contacted the County Attorney's Office in November to inquire as to the status of a criminal case. As a result, the County Attorney forwarded a copy of the police report, which reflected no law enforcement interviews of the victim or the perpetrator. At that time, the County Attorney also sent a written request to the Chief of Police to follow up on the investigation. As of the writing of this report, the outcome of this case is unknown and the Unit continues to monitor. This case is discussed further on page 36 of this report.

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, a man was substantiated for the physical abuse and lack of supervision of his partner's children after it was alleged he struck them with a belt and drugs were found in the home within access of the children. Upon review of the finding, the Unit learned that the children's mother was criminally charged with drug offenses similar to those of the substantiated perpetrator. The Unit inquired of DCF regarding the lack of a substantiated finding against the mother for lack of supervision, at which time, DCF amended their finding

and added the mother as a substantiated perpetrator. Furthermore, the Unit noted the DCF finding referenced the mother's occupation as a licensed nurse. DCF did not report this finding to the Board of Nursing until the day after the Unit inquired as to whether that had been completed, almost three months after the finding was issued.

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

DCF 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 Harvey County, a father was substantiated for medical neglect of his child after it was alleged he failed to follow medical advice in treating his daughter's condition. Her treating physician's notes indicated the father's actions could have triggered congestive heart failure or heart attack and increased the risk of fainting due to a secondary condition. Upon Unit inquiry, it was found that the social worker failed to forward this finding to the County Attorney's office in accordance with policy. Further, the social worker disregarded a prompt to do so. This prompt is located on the cover sheet sent to the Unit with the finding. As a result of the Unit's inquiry, the finding was subsequently sent to the County Attorney. Because the child resided with the non-offending parent, it is unlikely a Child in Need of Care would be filed.

- In Cherokee County, a father was substantiated for medical neglect of his child after it was alleged the father failed to treat what was later diagnosed as an abscess on the child's body. Despite a policy requirement to do so, DCF reported notice of the finding was not sent to the County Attorney and failed to do so until inquiry by the Unit.

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 failure to send notice has the potential to impede further intervention. The safety of Kansas children can be improved by the consistent reporting of findings in accordance with policy by DCF to district or county attorneys.

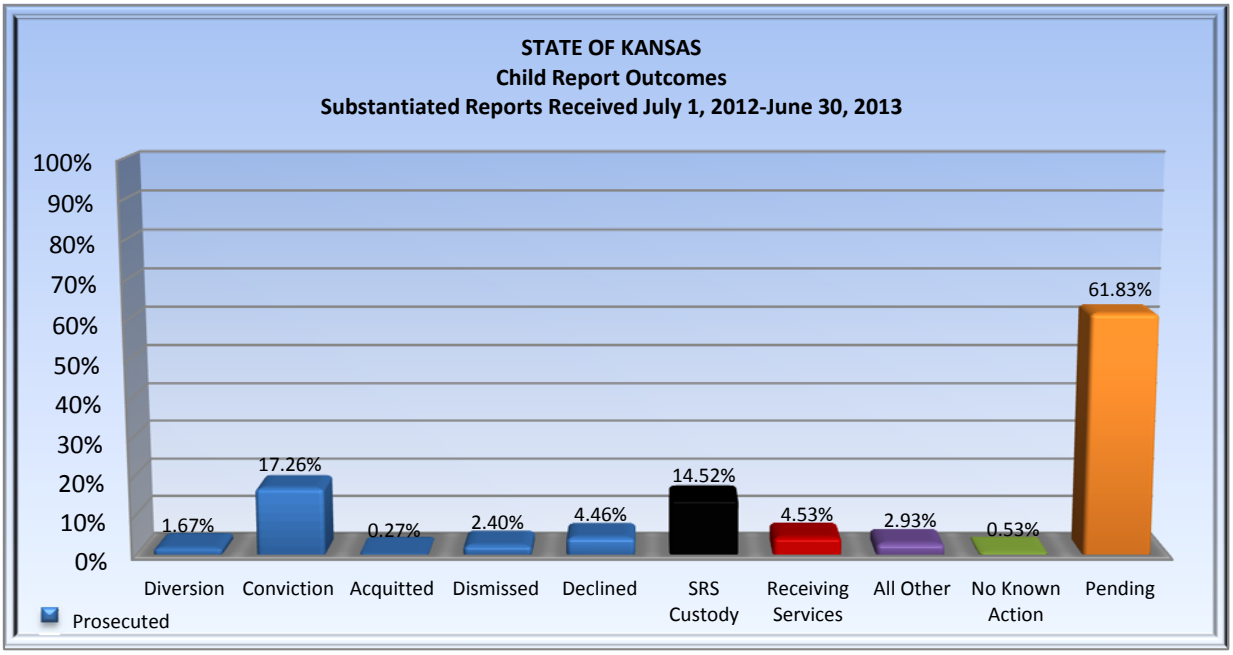
Collaboration with Other AG Divisions for Investigation/Prosecution

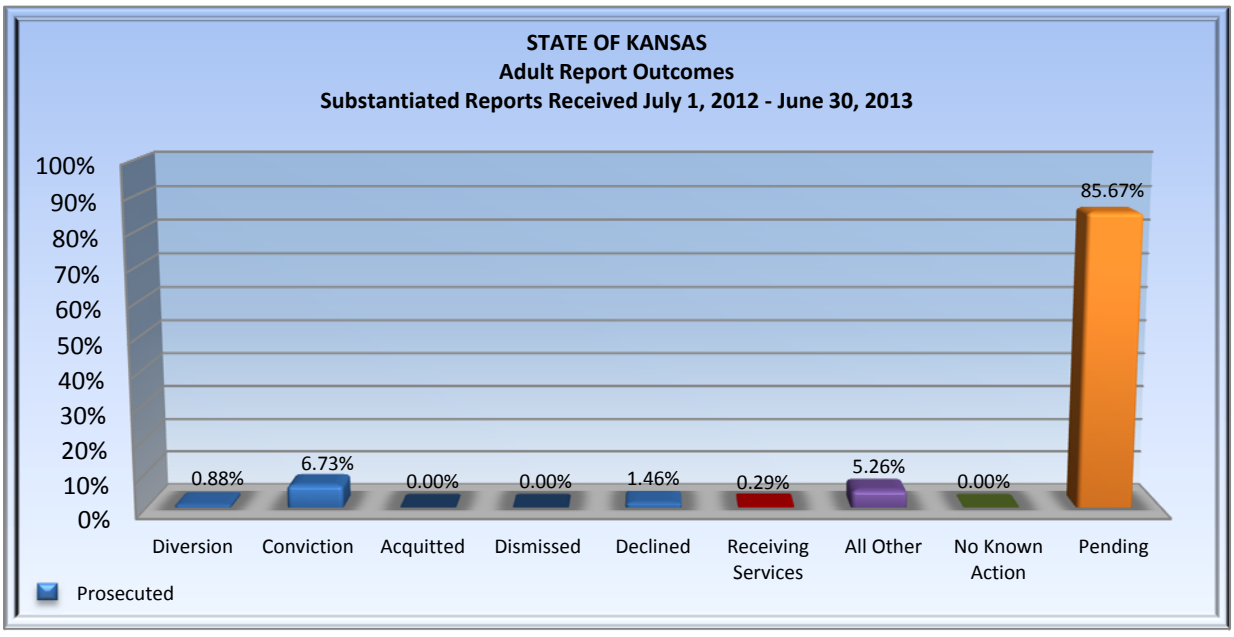
While receiving and reviewing findings, ANE Unit involvement resulted in identification of certain cases that were not being actively investigated or prosecuted. When such cases met the requisite criteria for the Attorney General's Office to become involved, the Unit was able to refer these matters to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

The Unit referred five cases that were received during this reporting period. Three of those were the result of receiving substantiated findings from APS or KDHE. Two were referred as a result of concerns received from constituents. All were reviewed by the Medicaid Fraud and Abuse Division or the Consumer Protection Division. Two of those concerns continue to be evaluated by the Consumer Protection Division. In another, the Unit worked with the Medicaid Fraud and Abuse Division to refer the report to local law enforcement authorities for further investigation and continues to monitor the outcome.

It should also be noted that six of the "other" cases opened by the Unit during this reporting period were received as referrals from other divisions with the Office of the Attorney General, namely the Consumer Protection Division.

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. 26.05% of child cases are known to have been reviewed for prosecution at this time, while 9.06% of adult cases are known to have been reviewed for prosecution at this time.





Concerns and Recommendations

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

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

In support:

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

  The Unit received a second finding on these children in July 2014. In this event, both parents were substantiated for lack of supervision and physical neglect. DCF reported the family had been receiving services "non-stop" since September 2011. After being removed in August 2013 as a result of the previous finding, the children were returned home in October 2013 and remained in DCF custody with KVC services in place. DCF indicated KVC reported that their workers were not allowed in the home unless a visit was scheduled in advance. A review of KVC logs contained in the DCF file reflected that KVC was last in the home the week before this second report was received by DCF. The DCF finding described the home as having living conditions that were "atrocious with multiple safety hazards, including broken glass on the floor and food smeared all over." On the day that law enforcement and DCF were in the home, one of the children had cut himself on this broken glass. DCF documented deplorable conditions that included piles of clothes on the floor and furniture, moldy food on the table and floor, prescription medication on the floor, a hole in the kitchen floor the size of an adult foot, a hole in the wall the size of a fist, dirty dishes stacked on the counter and stove, trash on the floors and overflowing the trash cans, and cupboards and a refrigerator without any food. The bathroom was described as filthy. The children's bedroom was reported to have the floor covered in trash; toys and clothes; dried paint on the walls, curtains and floor; and a used potty chair also on the floor. The Unit reviewed photos taken by both DCF and law enforcement which documented deplorable conditions that did not occur overnight. Yet, the notes from the KVC worker, who

was in the home the previous week, made no mention of the conditions in the home at all, either good or bad. This second report originated because the children were observed to be walking down the street alone and "poorly dressed" and not because of a new report made by the KVC staff responsible for monitoring the home.

- In Wyandotte County, a foster parent was substantiated for physical neglect of a child in DCF custody. The basis for finding cited factors such as a lack of hygiene items for the child, a dirty bathroom with a broken faucet knob, a concern for insufficient food, a lack of clean clothing and home conditions that included dirty rooms and safety hazards. In addition, it was noted that during a visit to the home by DCF and KDHE staff, the child's bedroom was extremely hot. It was observed that the bedrooms of the foster parent and her biological children all had window air conditioners, yet the bedroom of the foster child did not. During another DCF interview on August 7, 2013, it was also noted that the child's medication management records had not been updated since late July. One KVC social worker reported last being in the home about a week prior to the report. The DCF finding notes the KVC worker indicated the home "was not spotless" and admitted she did not visit the upstairs of the home during her visit, which included the foster child's bedroom. Another KVC worker was interviewed later and noted there had been ongoing concerns regarding the cleanliness of the foster home. This worker also indicated she did not check the kitchen cabinets or the refrigerator when she was in the home to ensure there was food. She reported past concerns with children in this placement leaving the home with fewer possessions then they had upon entering the home and that some children in the alleged perpetrator's care would go to a new placement and be found to be filthy. Records indicate this home was cited previously by KDHE in February 2012 with regard to the foster children missing belongings. KDHE cited the home for violation of at least eight other regulations in connection with this investigation and the home's license was revoked. As a result of this investigation, KDHE initiated a complaint on KVC. Areas of noncompliance by the agency were found and corrective action was initiated.

- In Sedgwick County, a mother was substantiated for physical neglect of her children after they were removed by law enforcement due to the conditions of the home. The social worker conducting the investigation noted that upon entering the home, there was a smell of urine and dog feces, the living room was without furniture and the floor was covered with dog feces and urine stains. In addition, there were groceries lying on the floor next to the dog feces, along with a bottle of bleach, trash and clothing on the floor. The home was observed to have no running water, a broken furnace and two electric space heaters. One heater had a curtain hanging over it and the other had trash around and underneath it, creating a fire hazard. Due to the absence of running water in the home, the bathroom toilet was full of fecal matter and the bathroom had what the worker described as an excessive amount of used toilet paper in the sink, the bathtub and on the floor. One of the children had no mattress and was sleeping on a board covered with blankets. The worker notes clothes, rotten food and trash on the floors so that it was difficult to walk through rooms without moving things. DCF reported previous concerns for neglect due to five reports received between 2009 and 2013. As a result of a 2010 investigation, the family had

been referred to Family Preservation services to aid in addressing the repeated concerns of cleanliness of the home. In an interview completed the day the investigation was assigned to DCF, a Saint Francis Community Services (SFCS) worker reported being in the home about four weeks prior and directing the mother to clean the home. She reported the home was "not that bad" at the time. The DCF report references a follow up home visit by the SFCS worker in which the home was referred to as "completely disgusting" but when this occurred is not referenced. The Unit has requested additional documents from DCF and has staffed this matter with Central Office at two quarterly meetings. As of the writing of this report, the Unit continues to await those records.

- In Johnson County, parents were substantiated for physical neglect of their child after it was reported the child had a severe rash for which the parents weren't seeking aid. Upon observing the child, the social worker reported that "his rash appeared to be an open wound on both sides of his buttocks and behind his scrotum." Law enforcement had previously responded to calls for welfare checks of the child and twice been denied the opportunity to view his rash by his father. During one of the welfare checks, the father advised officers that DCF came twice weekly to observe the child. However, DCF reported this to be inaccurate – that "the family signed a case plan with DCCCA; however had not had any contact with the family" in two months. As a result of this finding, the child was placed in DCF custody with a relative residential placement.

  Four months later, DCF initiated a second investigation for physical abuse of the child by his father and lack of supervision by the KVC worker assigned to supervise visits. Both parties were substantiated. Allegations were that the KVC worker first allowed the father to leave the building with one of his children and go to the parking lot. Later in the visit, she allowed him to leave the room with the same child who was a substantiated victim in the above-referenced finding. It was reported he was allowed to leave the room with the child, without supervision, in order to change his diaper. During this unsupervised period, it was alleged the child sustained a broken femur. Though KVC logs indicate the worker reported the child was crying for the 10-15 minutes he was out of the room and other children reported he came back into the room crying hysterically, his injury was not discovered until he returned to his placement and his crying did not subside. The child was then taken in for medical evaluation.

  KVC was cited for areas of noncompliance including failure to supervise and failure to provide qualified staff necessary to ensure proper services, K.A.R 28-4-174(i) and K.A.R. 28-4-172(g). The worker was terminated from employment with the agency.

- In Crawford County, a child was substantiated for medical neglect by a foster parent after it was alleged the foster parent ignored the medical advice of the nurse providing in-home care for the child. The DCF report indicates the nurse made her supervisor and KVC staff aware of her concerns regarding the foster parent, but these seemingly went unaddressed. Upon questioning of one KVC staff member by DCF, the person reported that "she is aware of (the) concerns, but that the foster parent states there aren't any concerns." DCF indicated a previous report was received

four months prior to this one regarding the same allegation toward the foster parent, but the report was unsubstantiated. Upon review of this finding, the Unit had an abundance of concerns about the actions of the foster parent and the apparent inactions of the child placing agency. The Unit requested to review the complete DCF file for this investigation on April 18, 2014. The file was received on May 7, 2014. On May 28, multiple questions were sent to DCF to clarify the facts in this case. It was also staffed with Central Office at quarterly meetings on June 5 and October 7. As of the writing of this report, those questions remain unanswered. KDHE denied receiving any complaints on the child placing agency or notice of the DCF finding, which DCF is required by policy to send (PPM 2540).

Furthermore, on September 9, the Unit received a subsequent finding on this child for medical neglect by yet another foster parent in Shawnee County. Prior to that investigation, initiated May 9, the child died. During multiple inquiries to DCF regarding the original investigation, the Unit was never informed of the child's death or of the subsequent pending investigation. The Unit continues to investigate the responses by the involved agencies in these matters. It is known that the child was not autopsied. The Unit is unaware of whom or which agency made a determination not to autopsy the child. As such, it is unknown whether failure to provide care could have contributed to his death in any way.

Recommendation: The Unit encourages stronger oversight of DCF contracting agencies and monitoring of children who have been placed in state custody. In addition, the Unit recommends mandatory autopsy of children who die in state custody when there is concurrent suspicion of abuse. Furthermore, though this has been more thoroughly discussed in past years, the Unit is beginning to once again see an indication that notices of findings may not have been sent to KDHE as is required in policy. The Unit would reiterate the need for DCF to maintain a system of checks and balances to ensure policy is being complied with in this area.

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

In the last five 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 Gray County, a mother was substantiated for physical abuse of her child. It was reported that abuse occurred over the span of many years and included the child being struck with belts and spoons. Though the child had no current visible injury, the mother did admit to hitting him with objects in the past, including objects that broke on contact. Despite the reported lengthy history of physical abuse, DCF denied notifying law enforcement of the finding.

- In Johnson County, a mother was substantiated for emotional abuse of her children after it was alleged she chased one child through the house with scissors, held him down and threatened to cut his tongue off. She reportedly admitted to a third party that if the child would have stuck his tongue out, she probably would have followed through on the threat. The mother was hospitalized to receive care, but this potential crime was not reported to law enforcement despite this being a situation that appears to have a high risk for lethality.

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

- In Johnson County, a facility staff person was substantiated for the physical abuse of a child after it was reported that the staff person grabbed the child, backed him into a corner, put his forearm under the child's chin and was strangling him. A nurse on staff found the child to have bruising to his arms and legs with a red area on his upper back. The DCF finding does not indicate other witnesses were interviewed. The finding reports this alleged perpetrator "has had prior incidents where this has occurred in other facilities", including a 2008 incident where, while working in what is only identified as a KVC facility, he "put (a) kid in a hold." After multiple inquiries by the Unit, DCF reported this facility was not a licensed KDADS or

KDHE facility but did not identify its nature more clearly. Further, DCF denied investigating the previously-referenced 2008 incident and reported that neither the facility nor DCF reported this current possible crime to law enforcement. The Unit requested and reviewed the DCF file and noted the department identified the facility as a psychiatric residential treatment facility licensed by KDADS and did notify a representative of the agency of the report. However, notice of finding did not appear to be sent to KDADS as is required in policy. As of the writing of this report, the Unit continues to review this matter with staff from both DCF and KDADS.

- In Lyon County, a mother was substantiated for physical abuse of her 9-month-old child after she admitted being "very stressed" and "frustrated" when she picked up her crying child and "threw him over onto the couch. She was very angry and overwhelmed at that time." The family was already receiving family preservation services at the time the report was received. DCF reported law enforcement was not involved in the investigation, nor forwarded the finding. The Department indicated that local law enforcement was not notified of the event because "the child did not have any injuries at the time of DCF's contact with the family." This matter was discussed with Central Office staff at a quarterly meeting with DCF in June 2014. The Unit expressed concern with the level of injury this child could have suffered given the allegations, that severe injuries may not have been visible and that there was no mention of any medical evaluation being completed on the child. The Unit then directed that question back to region staff who indicated the child was not medically evaluated and admitted the timeframe for when the event occurred was unknown as the mother would not disclose this. The Unit believes medical evaluation could have discovered or ruled out internal, invisible injuries, such as healing fractures, often discovered in non-verbal infants; the presence of which could have resulted in notification to law enforcement and an appropriate plan to protect the safety of child when a pattern of abuse is apparent, the lack of which could have been conclusive evidence that there was no serious physical injury sustained by the child.

  Region supervisors maintained that while "it is standard DCF practice to have a child of this age with physical abuse concerns of this nature medically evaluated…" they determined not to do so in this case because the date the event occurred was unknown, the child had no visible injury and no concerning behaviors. It wasn't until November 2014, when the matter was again staffed with Central Office staff that DCF agreed the child should have been medically evaluated and indicated intent to follow up with staff regarding training on this policy.

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 or County Attorney.

It remains a concern that while some child cases may be forwarded to the juvenile Child in Need of Care divisions within the District or County Attorney's Office, if these cases have not been reported to a law

enforcement agency for criminal investigation, they may not be screened for criminal charges. Further, though some juvenile CINC divisions within the district or county attorney's offices may refer appropriate cases to their criminal division for charging, not all offices have an internal practice for this as a matter of routine. Additionally, critical evidence of the incident could be lost by the time the case is reviewed by the District or County Attorney's Office and referred back to a law enforcement agency for criminal investigation.

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

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 of 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.

In addition, the Unit has also found instances where abuse of a vulnerable adult went unreported to law enforcement, contrary to statute. K.S.A 39-1433 (1) requires that "upon receiving a report that an adult is being, or has been abused, neglected or exploited or is in need of protective services" DCF shall "when a criminal act has occurred or has appeared to have occurred, immediately notify, in writing, the appropriate law enforcement agency." Also, section 1150B of Title XI of the Social Security Act, as established by section 6703(b)(3) of the Affordable Care Act, requires specific individuals in applicable long-term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility. Those reports must be made to the survey agency (KDADS) and to at least one law enforcement agency.

In support:

- In Ford County, a daughter was substantiated for the neglect of her parents due to the condition of her home. It was described as having trash laying around, laundry piled on beds used for sleeping, soiled countertops, dirty dishes, trash piled on the floor against an exit door, soiled carpets and floors, a broken front door, doors off the hinges, cabinet doors missing, with an odor present in the home and an infestation of cockroaches. The couple's daughter was being paid to be their in-home caregiver and was not completing the tasks for which she was paid. It should be noted that this finding was actually issued in March 2012 during the previous fiscal year, but not sent to the Unit in compliance with statutory requirement by DCF and thus not received until October 2013, during this reporting period. (This is discussed on page 32 of this report.) Though this would be the second such finding received by the Unit that was issued against this perpetrator, it was actually found to be the first event that occurred. (The second event being a finding issued in October 2012 and received the same month by the Unit.) Indications are that law enforcement was not notified of either investigation or subsequent finding, though DCF did report sending notice of the October 2012 finding only after Unit inquiry. In October of 2013, a third investigation was

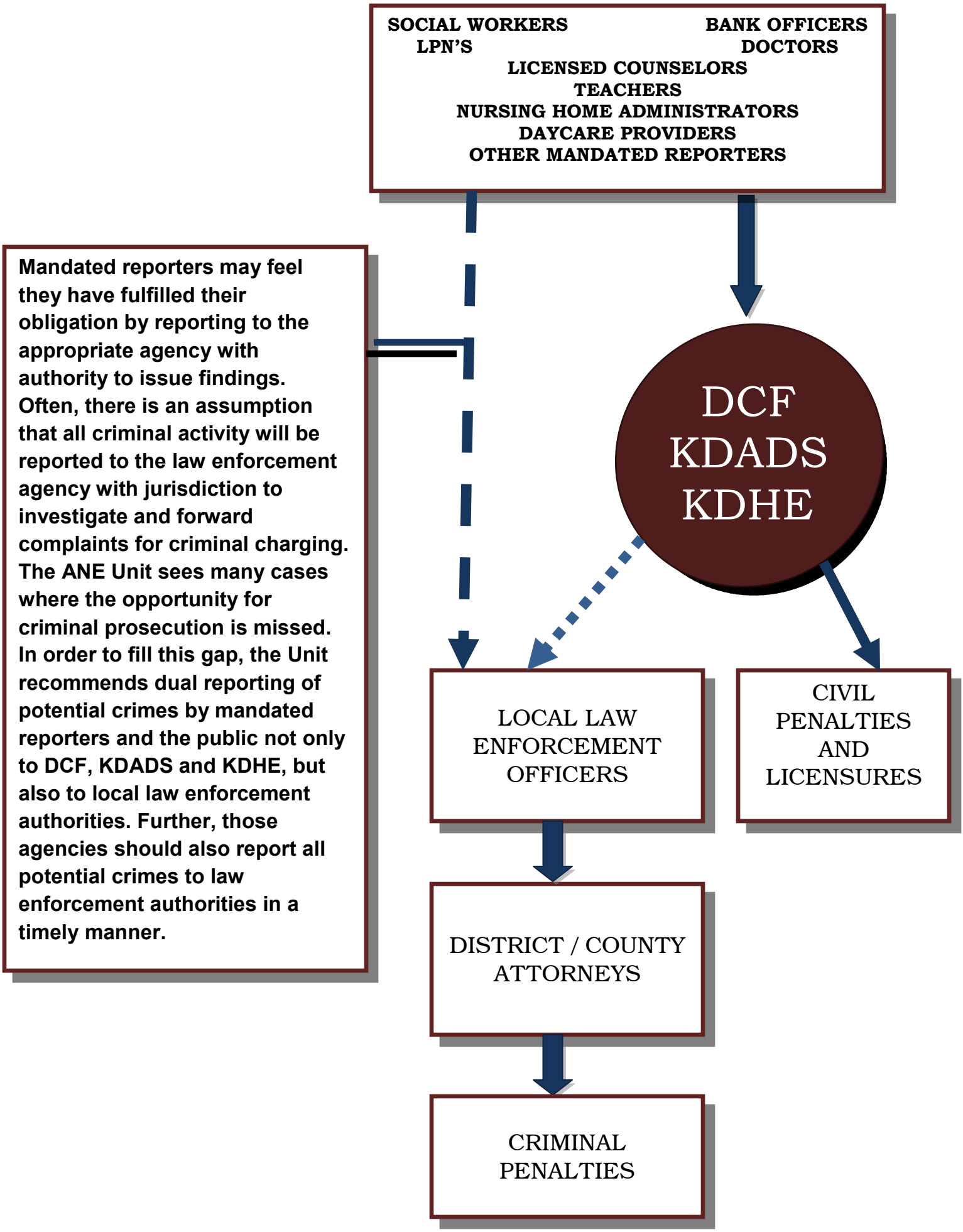
opened regarding abuse of one of the parents, but closed when he passed away before any worker could contact him and complete an interview. The third investigation resulted after he was transported to the hospital with bed sores and lesions on his body and maggots in his Depends undergarments. Though the Unit found no record of prosecution of Mistreatment of a Dependent Adult, the Medicaid Fraud and Abuse division of the Attorney General's Office completed an investigation whereby the perpetrator was eventually convicted relating to acts of Making a False Claim to the Medicaid Program and Theft.

- In Lyon County, a CNA was substantiated by KDADS for exploitation of a resident when she borrowed money from the resident and never paid it back. Though the amount of monetary loss may have been considered to be inconsequential, KDADS and the facility are required by federal regulation to report all possible crimes to law enforcement. KDADS indicated this occurrence was not reported to law enforcement and cited in their report that the resident declined to contact law enforcement. It should be noted that this CNA had previously been given corrective action for the same behavior.

- In Jefferson County, a CNA was substantiated by KDADS for abuse and neglect of a facility resident. The resident was identified as suffering from dementia, Parkinson's disease and depression, in addition to multiple physical ailments. The finding alleges that while the CNA was transferring the resident to a wheelchair, the resident struck the CNA in the face. The CNA then reportedly grabbed the resident's arms, restrained her, screamed and cursed at her. After other staff physically separated the parties, the CNA then returned to the resident, poked her in the face and hit her in the face with a urine-soaked pad. Despite this possible crime, neither the facility, nor KDADS reported the matter to law enforcement as both are required to do by federal mandate.

  Upon inquiry by the Unit, KDADS immediately forwarded a referral to local law enforcement. When the Unit followed up two months later, law enforcement acknowledged receipt of the referral, but indicated no action had been taken in response. The Unit facilitated the production of KDADS' investigative file and forwarded those documents to law enforcement who agreed to staff the matter with the County Attorney to determine whether there should be further action or investigation. As of the writing of this report, law enforcement confirms forwarding the matter to the County Attorney's Office, but the Unit has been unable to verify whether the case has been reviewed for a charging decision. This case is also cited on page 9 of this report.

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


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

Lack of Agency Communication

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

In support:

- In Ellsworth County, a man was substantiated for the sexual abuse of his partner's daughter, which was reported to have been previously investigated in 2006. The original event was unsubstantiated, but then substantiated in late 2012 after new information was reported to DCF. While researching and monitoring outcomes during this reporting period, the Unit has discovered indications of failures to communicate.

  The Unit was contacted by support staff to an Assistant Attorney General (AAG) assigned to the KBI. She reported her office had been contacted by law enforcement in another state as the alleged perpetrator in this matter was the suspect in an ongoing investigation for a similar offense. Out-of-state law enforcement officers were requesting production of any documents related to the original child abuse investigation and the AAG was aware the Unit had information.

  The Unit was subsequently contacted by child protective services in the other state. A representative indicated her agency sent a courtesy request to DCF seeking information on their investigations involving this alleged perpetrator. The representative indicated DCF informed her agency that they had no history on this perpetrator. However, the out-of-state agency was in possession of the local police report. When the police department released the report to her agency, they also sent a copy of correspondence from this Unit requesting to review the report. The representative requested Unit assistance in receiving the appropriate records from DCF.

  Upon further review of DCF records by the Unit, it appeared DCF was advised in 2006 that the criminal investigation had been formally transferred to the KBI. However, DCF only followed up with the local Chief of Police and unsubstantiated their original finding after the Chief informed DCF his case was closed. The only interview of the alleged perpetrator available for review was conducted by a DCF special investigator and not a law enforcement officer. Furthermore, the Unit finds inconsistencies in the alleged perpetrator's interviews between 2006 and 2012, as they pertain to his contact with the victim.

  The Unit continues to monitor the many facets of this investigation, including ensuring DCF provides complete and accurate history to the child protection agency in the other state – a matter that has proven difficult due to continued failure by DCF to report accurate history.

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

The Unit continues to see a significant opportunity for cases involving abuse of vulnerable adults to "fall through the cracks" when those cases are referred to law enforcement. For APS and KDADS, this referral process involves sending written notice to a law enforcement agency. However, for the most part, there is no follow up to these documents to verify they were received, let alone acted upon. For the Unit, two concerning patterns have emerged: 1) law enforcement cannot verify receipt of any notice, or 2) they express concern at not being brought into the process at the outset of an investigation.

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

Tracking further actions by law enforcement has proven difficult for the Unit. Often we are receiving the information after some significant time has passed. If there is not a documented report on file, the law enforcement agency's ability to locate information 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 the clear reluctance of APS to require staff to follow up on these 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.

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 or County Attorney and (if a possible crime occurred) to file a report with the law enforcement agency in the jurisdiction where the abuse occurred. Such notification should be documented in the case file. In the event 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 to 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 Where There is a Lack of Proper Evidence Collection

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.

In support:

- In Douglas County, a staff caregiver employed in a group home was substantiated for abuse of a resident after the resident complained to other staff. The finding was reversed three months later upon review with the legal department, though what prompted the review is not

noted. DCF reported the legal department determined there wasn't enough evidence to support the allegation.

Upon review of the DCF file, the Unit learned that a facility staff person reportedly reviewed a video tape after the resident complained. In this video tape, the staff person claimed to witness the alleged perpetrator "come up from behind (the resident) and forcefully grab" him in attempt to turn him around "with enough force that she almost knocked herself off balance. (The resident) can be seen veering to his left from her force." When the parties entered a part of the house where audio was available on the video, the staff person indicated the resident told the alleged perpetrator that she hit him. Shortly, the staff person reports home managers entered the video viewing area and "things calmed down". The staff person reported physical aggression on the part of the alleged perpetrator, who was suspended immediately, pending the outcome of an investigation. Despite DCF being made aware of the video's existence at the time of report on November 8, 2012, the assigned worker did not request a copy of the facility's internal investigation until December 19. On December 21, the facility reported the video had been erased.

Additionally, this finding was not issued until the end of May 2013. DCF reported the finding was delayed until the social worker was able to interview the alleged perpetrator, but it should be noted the alleged perpetrator returned to work three days after the incident and should have been easily located to offer an interview. In addition, despite the allegation of physical abuse which could constitute a crime, DCF did not notify law enforcement at the outset of their investigation, which also might have aided in the timely interview of the alleged perpetrator.

The Unit is concerned that a failure to properly investigate this report by requesting and viewing the available evidence timely, i.e. the video tape, resulted in a reversal of finding and the inability to protect vulnerable adults by failing to substantiate this alleged perpetrator. In further explaining their reversal, DCF also maintains that since the facility returned the alleged perpetrator to work, "it would appear that they did not consider the incident to be particularly serious." This conclusion is contrary to what staff reported initially. Furthermore, the facility's internal investigation contained in the DCF file amounts to a one page summary and a one page transcript of the video. No witness statements are attached. Though it recommends further training for alleged perpetrator as well as "counseling" with the home's managers for failing to report to ANE and failing to complete required documentation, there is no evidence such training was completed. DCF reports there was no follow up with the home regarding the recommended training.

Recommendation: DCF should ensure proper investigative procedures are followed so that the best evidence available is documented and secured in order to support a substantiated finding. Further, in cases where there is the possibility that a crime has been committed, workers should follow policy (PPM 10200) and statute (K.S.A. 39-1433) by notifying law enforcement immediately.

Abuse Registries

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

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

While nursing facilities are required to check the KNAR regarding the licensure status for certified nurse aides (CNAs), certified medication aides (CMAs) and home health aides, they are not required to check the DCF Central Registry. In the past, APS has reported sending notices of finding to KDADS. However, 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 continues to believe this process creates a gap whereby, for example, perpetrators who are substantiated by DCF for abuse, neglect or exploitation of children or vulnerable adults, are able to go on to obtain positions in health care facilities. This exposes a new group of potential victims to those who have already been known to perpetrate upon individuals who cannot necessarily protect themselves.

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

Failure to Send Notice of Finding to KDHE/KDADS

In reports from past years, the Unit has identified concerns where DCF 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, the case identified below, and others referenced in earlier portions of this report (such as the Johnson County case discussed on page 20) resume concern that these notices are not being sent in accordance with policy.

In support:

- In Sedgwick County, an unknown perpetrator was substantiated for the physical abuse of a 4-month-old child who was in foster care. (This case is previously cited on pages 10-11 of this report.) The DCF investigation established that during the possible time of injury, the child was in the care of foster parents, the parents of the foster parents, and a licensed daycare provider. PPM 2540, Notice of Department Finding, section A(6) requires KDHE to receive notice "if abuse occurred in a facility or a foster home." Upon review of this finding, the Unit inquired if such notice was sent and was advised by a DCF supervisor that notice was not sent to KDHE as the substantiated perpetrator was identified as unknown. The Unit inquired further as to whether notice was required to be sent, especially in light of all of the possible perpetrators being licensed (or required to be approved caregivers) by KDHE. Only after further discussion did DCF admit the error in not sending notice and indicated the department would complete this policy requirement. Subsequent follow up with both involved departments within KDHE revealed they found no record of receiving notice of finding. The Unit continues to facilitate this exchange of information as of the writing of this report.

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

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

The Unit has continued to monitor case findings to ensure they are received timely. K.S.A 75-723 requires agencies to submit their findings to the Unit within 10 days. Though the language does not specify whether 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 been able to determine that during this reporting year, a minimum of 104 findings submitted by DCF were received outside statutory requirement. 78 of those were submitted late by CPS staff, while 26 were from APS staff. That equates to a rate of at least 5.41% for CPS (an increase over the percentage reported two years ago) and 7.34% for APS (a decrease in the percentage reported two years ago).

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

In support:

- In Ford County, a daughter was substantiated for the neglect of both of her parents. These findings were received by the Unit during the previous fiscal year. While in process of reviewing these findings, the Unit conferred with the Medicaid Fraud and Abuse division. While reviewing

documents provided to that division, it became apparent to the Unit that previous findings had been issued by APS involving these parties. Those findings had not been received by the Unit as is required in statute. They were subsequently requested and received from APS and were reviewed during this fiscal year. These findings are discussed further on page 22 of this report.

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.

DCF Compliance with Timely Findings

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

While some of these delays may ultimately still occur for reasons allowable in policy, others may not. In many cases, where workers did not follow policy in stating the reasons for delay, the Unit had to request

this information. In some cases, where reasons for the delay are stated in compliance with policy, the listed reasons have turned out to be inaccurate or incorrect. Such situations test the credibility of information provided to the Unit by DCF.

In fulfilling its mission of examining the systemic response to abuse, neglect and exploitation, it is helpful for the Unit to be aware if the lack of cooperation by other involved agencies causes social workers to delay findings beyond the established timeframes. In a case where 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 beginning 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. However, the Unit continues to see cases where workers fail to check the box, the box is checked incorrectly, or where workers continue to use out-of-date forms where this prompt is not included at all.

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

Communications with DCF

Exchange of information with DCF continues to provide many of the same challenges discussed in previous fiscal year 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 Unit has examined many cases where it becomes apparent social workers are responding promptly to the inquiries, but those responses are languishing in the inboxes of supervisory staff before being returned to the Unit. This has significantly extended the time it takes for information to be shared with the Unit. It has also resulted in the Unit having to make repeated inquiries to DCF staff when responses haven't been received at all. The delay in receiving 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 DCF central office staff to discuss ongoing concerns. Though at the beginning of this reporting period DCF implemented changes to their cover sheets to include custody and placement information regarding children, as well as the aforementioned prompt regarding the reasons for delay in issuing finding, the Unit continues to see workers failing to complete this information or many who continue to use older, outdated forms that do not contain these prompts. DCF and the Unit could reduce communications based on these factors alone if workers become consistent in using current forms and completing them thoroughly and accurately. The Unit has continued to see occasions where requests for information are not resolved at the meetings despite detailed agendas being provided in advance. Though there has been no significant improvement 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.

In support:

- In the Johnson County finding, previously cited on page 20, initial questions to clarify the facts of the investigation were sent to DCF staff on April 8, 2014, and again on May 29. When no response was received, the case was staffed at the quarterly meeting with Central Office staff on June 5. The requested information was also not provided at this meeting and was not received by the Unit until June 21. As a result of reviewing this information, the Unit requested to review the complete DCF file pertaining to this investigation on June 23. The file was never received and the matter was placed back on the agenda for the quarterly meeting scheduled for October 7. The

file was not provided at that meeting and Central Office staff reported it would be forthcoming. However, the Unit then discovered the file had been sent electronically on October 2 in response to DCF receiving the scheduled agenda. Email data attached to that file indicated that the social worker responded to her supervisor in regard to the Unit's April 8 inquiry on April 16. The supervisor, in turn, forwarded the response to the region program administrator (PA). However, when the PA attempted to forward the response to the Unit on April 22, the PA used an invalid email address.

Upon reviewing the DCF file, the Unit sent additional questions and concerns to DCF Central Office on October 23. Though staff indicated they would respond the following week, such was not received and the inquiry was resent on November 6. On November 13, Central Office staff responded that they were reviewing the matter and would follow up with the Unit on a later date. Identified concerns for which DCF has yet to respond or clarify include:

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

- In the Ellsworth County finding previously cited on page 12, DCF log notes for the event were requested for review twice in November 2013. Region staff indicated the notes had been sent to a member of the Central Office legal staff, though the Unit confirmed with said legal staff that this routine was unnecessary and that the region could provide the notes directly. Nonetheless, the notes were not received and this matter was placed on the March 2014 quarterly meeting agenda where it was requested the notes be provided by Central Office. Staff continued to fail to provide the notes at the meeting and copies of the previous requests, with Central Office staff copied on those email requests, were again provided to staff. The notes were received after close of business the same day.

  The substantiated finding was not issued for over a year and DCF explained the delay in finding as being allowable in policy due to an inability to locate and interview the alleged perpetrator. Review of the log notes (in the form of case activity notes reported in DCF assessment forms) finds no evidence of any effort to locate the alleged perpetrator in the intervening months. In fact, all case activity is documented in September 2012 and in September 2013 only. Other

correspondence received with these documents reflects communication between a DCF supervisor and a child welfare agency out of state, where the supervisor reported in September 2013 that the assigned DCF worker had left the agency while awaiting police reports in the case. The Unit received this finding in October 2013 and contacted the County Attorney's Office in November to inquire as to the status of a criminal case. As a result, the County Attorney forwarded a copy of the police report, which reflected no law enforcement interviews of the victim or the perpetrator. At that time, the County Attorney also sent a written request to the Chief of Police to follow up on the investigation. As of the writing of this report, the outcome of this case is unknown and the Unit continues to monitor.

- In the Crawford County finding, previously discussed on pages 18-19, the Unit requested to review the complete DCF file for this investigation on April 18, 2014. When no response had been received on April 29, the Unit inquired as to the status of the request and was informed it was in process. The file was received on May 7, 2014, and on May 28, multiple questions were sent to DCF to clarify the facts in this case. It was staffed with Central Office at the quarterly meeting June 5, and again on October 7, where the questions remained unanswered by DCF. Furthermore, on September 9, the Unit received a subsequent finding on this child for medical neglect by yet another foster parent in Shawnee County. Prior to that investigation, initiated May 9, the child died. During multiple inquiries to DCF regarding the original investigation, the Unit was never informed of the child's death or of the subsequent pending investigation. The Unit also requested the DCF file for the latter event and asked that this be provided at the October 7 quarterly meeting. A file was sent electronically on October 3, but it was the wrong file. Despite being made aware of this, the correct file was not provided on October 7 and neither it, nor the answers to the previously-directed questions of May 28 have been provided as of the writing of this report.

- In Ellsworth County, a man was substantiated for the sexual abuse of his partner's daughter, which was reported to have been previously investigated in 2006. The Unit was contacted by child protective services in another state. A representative indicated her agency sent a courtesy request to DCF seeking information on their investigations involving this alleged perpetrator. The representative indicated DCF informed her agency that they had no history on this perpetrator. However, the out-of-state agency was in possession of the police report for the Kansas offense. When the police department released the report to her agency, they also sent correspondence from this Unit requesting a copy of the report. The representative requested Unit assistance in receiving the appropriate records from DCF.

  The Unit has made multiple requests to DCF to ensure the correct records are sent to the child protection agency in the other state. DCF continued to provide incorrect information regarding their investigations of this alleged perpetrator, even to this Unit, denying any substantiation though such records had already been provided. This matter remains under review and a more in-depth summary of this case appears on page 25 of this report.

Recommendations: The Unit recommends that DCF staff increase efficiency, accuracy and timeliness of response to all Unit inquiries. Prompt response reduces the risk of children and adults remaining in dangerous and vulnerable positions.

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, 2013 - JUNE 30, 2014
KANSAS CITY METRO REGION

SOURCE				DCF REGION		FINDING							
DCF - CPS	Other (not substantiated)	Total Reports Received	Percent by Population	County	2013 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
4	1	5	0.03%	Atchison	16,749	-	-	1	-	1	1	1	1
36	1	37	0.03%	Douglas	114,322	2	3	9	2	11	1	8	1
195	-	195	0.03%	Johnson	566,933	-	39	41	1	47	13	75	-
40	-	40	0.05%	Leavenworth	78,185	-	8	8	-	10	2	17	-
118	1	119	0.07%	Wyandotte	160,384	1	9	28	5	29	12	45	1
393	3	396	0.04%	KC Metro	936,573	3	59	87	8	98	29	146	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, 2013

Source: U.S. Census Bureau, Population Division. Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

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

CHILD REPORTS RECEIVED JULY 1, 2013 - JUNE 30, 2014
EAST REGION

SOURCE				DCF REGION		FINDING							
DCF - CPS	Other (not substantiated)	Total Reports Received	Percent by Population	County	2013 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
4	-	4	0.03%	Allen	13,124	-	1	1	1	1	-	2	-
1	-	1	0.01%	Anderson	7,897	-	-	-	-	-	-	1	-
16	1	17	0.11%	Bourbon	14,852	-	4	5	1	4	3	2	1
12	1	13	0.13%	Brown	9,997	-	-	2	2	5	1	3	1
3	-	3	0.08%	Chautauqua	3,552	1	-	-	-	-	1	1	-
20	-	20	0.10%	Cherokee	20,978	1	3	2	1	7	1	5	-
4	-	4	0.05%	Coffey	8,412	-	1	1	-	1	1	1	-
45	-	45	0.11%	Crawford	39,278	2	7	12	3	8	10	12	-
7	-	7	0.09%	Doniphan	7,851	-	-	2	1	3	1	1	-
16	-	16	0.06%	Franklin	25,740	-	1	3	-	7	3	3	-
14	-	14	0.10%	Jackson	13,366	-	2	5	-	3	1	5	-
10	-	10	0.05%	Jefferson	18,813	-	2	2	-	2	5	3	-
16	-	16	0.08%	Labette	20,916	2	2	3	2	1	4	3	-
7	1	8	0.08%	Linn	9,516	-	-	3	1	1	-	5	1
3	-	3	0.03%	Marshall	10,002	-	1	1	-	-	-	1	-
21	-	21	0.06%	Miami	32,835	1	3	9	-	6	6	3	-
41	-	41	0.12%	Montgomery	34,292	-	6	12	-	11	13	7	-
2	-	2	0.02%	Nemaha	10,161	-	-	-	-	-	-	2	-
17	-	17	0.10%	Neosho	16,430	-	-	6	1	6	5	4	-
7	-	7	0.04%	Osage	16,142	-	-	2	-	3	-	4	-
12	-	12	0.05%	Pottawatomie	22,691	-	-	3	-	5	1	3	-
162	-	162	0.09%	Shawnee	178,831	4	20	43	10	45	18	35	-
3	-	3	0.04%	Wabaunsee	7,051	-	-	-	-	2	-	1	-
14	-	14	0.15%	Wilson	9,105	-	3	4	-	5	3	3	-
3	-	3	0.09%	Woodson	3,221	-	2	-	-	-	3	-	-
460	3	463	0.08%	East	555,053	11	58	121	23	126	80	110	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, 2013
Source: U.S. Census Bureau, Population Division. Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios , metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

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

CHILD REPORTS RECEIVED JULY 1, 2013 - JUNE 30, 2014
WEST REGION

SOURCE				DCF REGION		FINDING							
DCF - CPS	Other (not substantiated)	Total Reports Received	Percent by Population	County	2013 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
30	-	30	0.11%	Barton	27,509	-	1	5	-	8	2	18	-
-	-	-	0.00%	Chase	2,700	-	-	-	-	-	-	-	-
-	-	-	0.00%	Cheyenne	2,694	-	-	-	-	-	-	-	-
1	-	1	0.05%	Clark	2,193	-	-	-	-	-	-	1	-
2	-	2	0.02%	Clay	8,406	-	1	-	-	1	-	-	-
12	-	12	0.13%	Cloud	9,292	-	1	2	-	3	2	5	-
-	-	-	0.00%	Comanche	1,955	-	-	-	-	-	-	-	-
3	-	3	0.10%	Decatur	2,930	-	-	-	-	1	-	2	-
16	1	17	0.09%	Dickinson	19,609	-	1	2	-	5	1	8	1
-	-	-	0.00%	Edwards	2,945	-	-	-	-	-	-	-	-
8	-	8	0.03%	Ellis	29,061	-	-	-	-	4	-	4	-
1	-	1	0.02%	Ellsworth	6,398	-	-	-	-	-	-	1	-
27	-	27	0.07%	Finney	37,098	-	2	7	1	5	5	8	-
24	-	24	0.07%	Ford	34,819	-	-	1	-	2	3	19	-
10	-	10	0.03%	Geary	37,384	-	-	2	-	3	2	4	-
1	-	1	0.04%	Gove	2,769	-	-	-	-	1	-	-	-
1	-	1	0.04%	Graham	2,593	1	-	-	-	-	-	-	-
3	-	3	0.04%	Grant	7,950	-	-	1	-	-	-	2	-
7	-	7	0.12%	Gray	6,009	-	-	3	-	4	-	1	-
3	-	3	0.23%	Greeley	1,290	-	-	-	-	-	1	2	-
2	-	2	0.08%	Hamilton	2,609	-	-	1	-	1	-	1	-
18	-	18	0.05%	Harvey	34,741	-	1	3	2	3	2	7	-
3	-	3	0.07%	Haskell	4,141	1	-	-	-	1	-	1	-
-	-	-	0.00%	Hodgeman	1,950	-	-	-	-	-	-	-	-
1	-	1	0.03%	Jewell	3,046	-	-	-	-	-	-	1	-
4	-	4	0.10%	Kearny	3,923	-	-	3	-	1	1	-	-
-	-	-	0.00%	Kiowa	2,523	-	-	-	-	-	-	-	-
-	-	-	0.00%	Lane	1,720	-	-	-	-	-	-	-	-
1	-	1	0.03%	Lincoln	3,147	-	-	-	-	-	-	1	-
-	-	-	0.00%	Logan	2,798	-	-	-	-	-	-	-	-
27	-	27	0.08%	Lyon	33,510	-	4	6	-	8	4	8	-

3	-	3	0.02%	Marion	12,219	-	1	1	-	-	-	1	-
7	1	8	0.03%	McPherson	29,569	-	1	-	-	1	1	3	1
3	-	3	0.07%	Meade	4,343	-	-	-	-	1	-	2	-
7	-	7	0.11%	Mitchell	6,378	-	-	2	-	-	-	5	-
5	-	5	0.09%	Morris	5,741	-	-	-	-	2	-	3	-
1	-	1	0.03%	Morton	3,143	-	-	-	-	-	-	1	-
1	-	1	0.03%	Ness	3,073	-	-	-	-	-	-	1	-
2	-	2	0.04%	Norton	5,622	-	-	-	-	2	-	-	-
5	-	5	0.13%	Osborne	3,818	-	1	-	-	2	-	2	-
3	-	3	0.05%	Ottawa	6,042	-	1	1	-	1	-	2	-
4	-	4	0.06%	Pawnee	6,971	-	-	1	-	1	-	3	-
4	-	4	0.07%	Phillips	5,540	-	-	3	-	-	1	-	-
2	-	2	0.08%	Rawlins	2,589	-	-	2	-	-	-	1	-
17	-	17	0.03%	Reno	64,190	-	-	3	1	5	3	7	-
2	-	2	0.04%	Republic	4,820	-	-	-	-	1	1	-	-
5	-	5	0.05%	Rice	10,011	-	-	-	-	1	-	4	-
17	-	17	0.02%	Riley	75,394	-	-	3	-	8	2	5	-
9	-	9	0.17%	Rooks	5,190	-	1	7	-	-	1	1	-
1	-	1	0.03%	Rush	3,186	-	-	-	-	-	-	1	-
2	-	2	0.03%	Russell	6,933	-	-	-	-	-	-	2	-
38	-	38	0.07%	Saline	55,740	-	4	4	-	13	2	19	-
5	1	6	0.12%	Scott	5,035	-	-	-	1	1	1	2	1
19	1	20	0.09%	Seward	23,390	1	1	4	1	1	2	11	1
-	-	-	0.00%	Sheridan	2,553	-	-	-	-	-	-	-	-
4	-	4	0.07%	Sherman	6,115	-	1	-	1	1	1	1	-
2	-	2	0.05%	Smith	3,706	-	-	-	-	2	-	-	-
-	-	-	0.00%	Stafford	4,359	-	-	-	-	-	-	-	-
2	-	2	0.09%	Stanton	2,194	-	-	2	-	-	-	1	-
3	-	3	0.05%	Stevens	5,816	-	-	1	1	-	-	1	-
5	-	5	0.06%	Thomas	7,948	-	-	1	-	1	1	2	-
-	-	-	0.00%	Trego	2,980	-	-	-	-	-	-	-	-
3	-	3	0.19%	Wallace	1,569	-	-	1	-	-	1	1	-
1	1	2	0.04%	Washington	5,629	-	1	-	-	-	-	-	1
1	-	1	0.05%	Wichita	2,192	-	-	-	-	-	-	1	-
388	5	393	0.05%	West	733,710	3	23	72	8	95	40	177	5

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

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013

Source: U.S. Census Bureau, Population Division. Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

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

CHILD REPORTS RECEIVED JULY 1, 2013 - JUNE 30, 2014
WICHITA REGION

SOURCE				DCF REGION		FINDING							
DCF - CPS	Other (not substantiated)	Total Reports Received	Percent by Population	County	2013 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
1	-	1	0.02%	Barber	4,947	-	-	-	-	1	-	-	-
14	1	15	0.02%	Butler	65,803	-	2	4	-	4	4	2	1
5	-	5	0.01%	Cowley	36,204	-	1	1	-	2	1	-	-
-	-	-	0.00%	Elk	2,655	-	-	-	-	-	-	-	-
4	-	4	0.06%	Greenwood	6,424	-	-	-	-	3	-	1	-
2	-	2	0.03%	Harper	5,860	-	-	-	-	1	1	-	-
6	-	6	0.08%	Kingman	7,844	-	-	-	-	1	-	3	-
-	1	1	0.01%	Pratt	9,878	-	-	-	-	-	-	-	1
164	1	165	0.03%	Sedgwick	505,415	-	1	19	4	9	10	101	1
4	-	4	0.02%	Sumner	23,591	-	1	-	-	2	-	1	-
200	3	203	0.03%	Wichita	668,621	0	5	24	4	53	18	108	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, 2013

Source: U.S. Census Bureau, Population Division. Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

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CHILD REPORTS RECEIVED JULY 1, 2013 - JUNE 30, 2014
STATEWIDE

SOURCE				DCF REGION		FINDING							
DCF - CPS	Other (not substantiated)	Total Reports Received	Percent by Population	County	2013 Population Estimate	Abandonment	Emotional Abuse	Lack of Supervision	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse	None
393	3	396	0.04%	KC Metro	936,573	3	59	87	8	98	29	146	3
460	3	463	0.08%	East	555,053	11	58	121	23	126	80	110	3
388	5	393	0.05%	West	733,710	3	23	72	8	95	40	177	5
200	3	203	0.03%	Wichita	668,621	0	5	24	4	53	18	108	3
1,441	14	1,455	0.05%	STATEWIDE	2,893,957	17	145	304	43	372	167	541	14

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

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013

Source: U.S. Census Bureau, Population Division. Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

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ADULT REPORTS RECEIVED JULY 1, 2013 - JUNE 30, 2014
KANSAS CITY METRO REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other (not substantiated)	KDHE - CP (Corrective Action - not substantiated)	Total Reports Received	Percent by Population	County	2013 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
-	1	-	-	-	1	0.01%	Atchison	16,749	1	-	-	1	-
7	1	-	-	-	8	0.01%	Douglas	114,322	6	1	1	1	-
35	13	-	1	-	49	0.01%	Johnson	566,933	13	19	13	15	1
3	1	-	-	-	4	0.01%	Leavenworth	78,185	1	3	-	-	-
4	3	-	-	-	17	0.01%	Wyandotte	160,384	5	6	8	4	-
59	19	0	1	0	79	0.01%	KC Metro	936,573	26	29	22	21	1

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

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013

Source: U.S. Census Bureau, Population Division. Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

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ADULT REPORTS RECEIVED JULY 1, 2013 - JUNE 30, 2014
EAST REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other (not substantiated)	KDHE - CP (Corrective Action - not substantiated)	Total Reports Received	Percent by Population	County	2013 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
-	1	-	-	-	1	0.01%	Allen	13,124	-	1	-	-	-
-	-	-	-	-	-	0.00%	Anderson	7,897	-	-	-	-	-
4	-	-	-	-	4	0.03%	Bourbon	14,852	1	-	-	3	-
1	2	-	-	-	3	0.03%	Brown	9,997	2	-	1	2	-
-	-	-	-	-	-	0.00%	Chautauqua	3,552	-	-	-	-	-
3	2	-	2	-	7	0.03%	Cherokee	20,978	2	1	2	1	2
1	-	-	-	-	1	0.01%	Coffey	8,412	-	-	1	-	-
6	1	-	-	-	7	0.02%	Crawford	39,278	2	1	3	1	-
1	-	-	-	-	1	0.01%	Doniphan	7,851	-	1	-	-	-
5	1	-	-	-	6	0.02%	Franklin	25,740	2	1	-	4	-
2	1	-	-	-	3	0.02%	Jackson	13,366	1	1	2	-	-
2	3	-	-	-	5	0.03%	Jefferson	18,813	4	1	-	3	-
6	-	-	-	-	6	0.03%	Labette	20,916	2	-	-	5	-
-	-	-	-	-	-	0.00%	Linn	9,516	-	-	-	-	-
-	-	-	-	-	-	0.00%	Marshall	10,002	-	-	-	-	-
2	-	-	-	-	2	0.01%	Miami	32,835	-	1	-	1	-
2	-	-	2	-	4	0.01%	Montgomery	34,292	-	-	1	1	2
1	1	-	-	-	2	0.02%	Nemaha	10,161	1	-	-	2	-
2	2	-	-	-	4	0.02%	Neosho	16,430	1	1	1	2	-
6	1	-	-	-	7	0.04%	Osage	16,142	2	2	1	3	-
-	-	-	1	-	1	0.00%	Pottawatomie	22,691	-	-	-	-	1
46	3	-	3	-	52	0.03%	Shawnee	178,831	9	12	6	21	3
-	-	-	-	-	-	0.00%	Wabaunsee	7,051	-	-	-	-	-
-	-	-	1	-	1	0.01%	Wilson	9,105	-	-	-	-	1
-	1	-	-	-	1	0.03%	Woodson	3,221	1	-	-	1	-
90	19	0	9	0	118	0.02%	East	555,053	30	23	18	50	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, 2013

Source: U.S. Census Bureau, Population Division. Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

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ADULT REPORTS RECEIVED JULY 1, 2013 - JUNE 30, 2014
WEST REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other (not substantiated)	KDHE - CP (Corrective Action - not substantiated)	Total Reports Received	Percent by Population	County	2013 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
10	-	-	-	-	10	0.04%	Barton	27,509	1	4	3	2	-
-	-	-	-	-	-	0.00%	Chase	2,700	-	-	-	-	-
-	-	-	-	-	-	0.00%	Cheyenne	2,694	-	-	-	-	-
-	-	-	-	-	-	0.00%	Clark	2,193	-	-	-	-	-
-	-	-	-	-	-	0.00%	Clay	8,406	-	-	-	-	-
3	-	-	-	-	3	0.03%	Cloud	9,292	-	-	2	1	-
-	-	-	-	-	-	0.00%	Comanche	1,955	-	-	-	-	-
-	-	-	-	-	-	0.00%	Decatur	2,930	-	-	-	-	-
3	2	-	-	-	5	0.03%	Dickinson	19,609	1	1	3	1	-
-	-	-	-	-	-	0.00%	Edwards	2,945	-	-	-	-	-
2	-	-	-	-	2	0.01%	Ellis	29,061	-	-	2	-	-
-	-	-	-	-	-	0.00%	Ellsworth	6,398	-	-	-	-	-
2	-	-	-	-	2	0.01%	Finney	37,098	-	-	-	2	-
4	-	-	-	-	4	0.01%	Ford	34,819	-	2	-	2	-
1	1	-	-	-	2	0.01%	Geary	37,384	1	-	-	1	-
-	1	-	-	-	1	0.04%	Gove	2,769	1	-	-	1	-
-	1	-	-	-	1	0.04%	Graham	2,593	-	1	-	-	-
-	-	-	-	-	-	0.00%	Grant	7,950	-	-	-	-	-
-	-	-	-	-	-	0.00%	Gray	6,009	-	-	-	-	-
-	-	-	-	-	-	0.00%	Greeley	1,290	-	-	-	-	-
-	-	-	-	-	-	0.00%	Hamilton	2,609	-	-	-	-	-
6	-	-	-	-	6	0.02%	Harvey	34,741	1	-	1	4	-
1	-	-	-	-	1	0.02%	Haskell	4,141	-	1	-	-	-
-	-	-	-	-	-	0.00%	Hodgeman	1,950	-	-	-	-	-
1	-	-	-	-	1	0.03%	Jewell	3,046	-	1	-	-	-
-	-	-	-	-	-	0.00%	Kearny	3,923	-	-	-	-	-
2	-	-	-	-	2	0.08%	Kiowa	2,523	-	2	-	-	-
-	-	-	-	-	-	0.00%	Lane	1,720	-	-	-	-	-
-	-	-	-	-	-	0.00%	Lincoln	3,147	-	-	-	-	-
-	1	-	-	-	1	0.04%	Logan	2,798	1	-	-	1	-

1	1	-	-	-	2	0.01%	Lyon	33,510	-	1	1	-	-
5	-	-	-	-	5	0.04%	Marion	12,219	-	-	5	-	-
9	-	-	-	-	9	0.03%	McPherson	29,569	2	-	5	2	-
-	1	-	-	-	1	0.02%	Meade	4,343	1	-	-	1	-
1	-	-	-	-	1	0.02%	Mitchell	6,378	-	-	1	-	-
-	-	-	-	-	-	0.00%	Morris	5,741	-	-	-	-	-
-	-	-	-	-	-	0.00%	Morton	3,143	-	-	-	-	-
-	1	-	-	-	1	0.03%	Ness	3,073	1	-	-	1	-
-	-	-	-	-	-	0.00%	Norton	5,622	-	-	-	-	-
-	-	-	-	-	-	0.00%	Osborne	3,818	-	-	-	-	-
1	-	-	-	-	1	0.02%	Ottawa	6,042	-	-	1	-	-
-	1	-	-	-	1	0.01%	Pawnee	6,971	-	1	-	-	-
-	-	-	-	-	-	0.00%	Phillips	5,540	-	-	-	-	-
-	-	-	-	-	-	0.00%	Rawlins	2,589	-	-	-	-	-
16	-	-	-	-	16	0.02%	Reno	64,190	4	5	5	2	-
1	-	-	-	-	1	0.02%	Republic	4,820	-	-	-	1	-
1	1	-	-	-	2	0.02%	Rice	10,011	2	-	-	1	-
2	-	1	1	-	4	0.01%	Riley	75,394	-	1	2	-	1
1	-	-	-	-	1	0.02%	Rooks	5,190	-	-	1	-	-
-	-	-	-	-	-	0.00%	Rush	3,186	-	-	-	-	-
-	1	-	-	-	1	0.01%	Russell	6,933	-	1	-	-	-
11	-	-	1	-	12	0.02%	Saline	55,740	2	3	3	3	1
-	-	-	-	-	-	0.00%	Scott	5,035	-	-	-	-	-
1	1	-	-	-	2	0.01%	Seward	23,390	1	1	-	-	-
-	-	-	-	-	-	0.00%	Sheridan	2,553	-	-	-	-	-
-	-	-	-	-	-	0.00%	Sherman	6,115	-	-	-	-	-
-	-	-	-	-	-	0.00%	Smith	3,706	-	-	-	-	-
1	-	-	-	-	1	0.02%	Stafford	4,359	-	1	-	-	-
-	-	-	-	-	-	0.00%	Stanton	2,194	-	-	-	-	-
-	-	-	-	-	-	0.00%	Stevens	5,816	-	-	-	-	-
-	-	-	-	-	-	0.00%	Thomas	7,948	-	-	-	-	-
-	-	-	-	-	-	0.00%	Trego	2,980	-	-	-	-	-
-	-	-	-	-	-	0.00%	Wallace	1,569	-	-	-	-	-
-	-	-	-	-	-	0.00%	Washington	5,629	-	-	-	-	-
-	-	-	-	-	-	0.00%	Wichita	2,192	-	-	-	-	-
86	13	1	2	0	102	0.01%	West	733,710	19	27	35	26	2

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

Population figures taken from:

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ADULT REPORTS RECEIVED JULY 1, 2013 - JUNE 30, 2014
WICHITA REGION

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other (not substantiated)	KDHE - CP (Corrective Action - not substantiated)	Total Reports Received	Percent by Population	County	2013 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
2	-	-	1	-	3	0.06%	Barber	4,947	-	-	1	1	1
9	3	-	-	-	22	0.03%	Butler	65,803	3	11	7	4	-
3	-	-	-	-	13	0.04%	Cowley	36,204	-	13	-	-	-
-	-	-	-	-	-	0.00%	Elk	2,655	-	-	-	-	-
-	-	-	-	-	2	0.03%	Greenwood	6,424	-	2	-	-	-
-	-	-	-	-	1	0.02%	Harper	5,860	-	-	1	-	-
-	3	-	-	-	3	0.04%	Kingman	7,844	3	3	-	3	-
2	-	-	1	-	3	0.03%	Pratt	9,878	-	1	1	-	1
7	6	3	2	-	88	0.02%	Sedgwick	505,415	16	30	26	21	2
3	1	-	-	-	4	0.02%	Sumner	23,591	1	3	-	-	-
119	13	3	4	0	139	0.02%	Wichita	668,621	23	63	36	29	4
354	64	4	16	0	438	0.02%	STATEWIDE	2,893,957	98	142	111	126	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, 2013

Source: U.S. Census Bureau, Population Division. Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

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ADULT REPORTS RECEIVED JULY 1, 2013 - JUNE 30, 2014
STATEWIDE

SOURCE							DCF REGION		FINDING				
DCF - APS	KDADS	KDHE	Other (not substantiated)	KDHE - CP (Corrective Action - not substantiated)	Total Reports Received	Percent by Population	County	2013 Population Estimate	Abuse	Exploitation	Fiduciary Abuse	Neglect	None
59	19	0	1	0	79	0.01%	KC Metro	936,573	26	29	22	21	1
90	19	0	9	0	118	0.02%	East	555,053	30	23	18	50	9
86	13	1	2	0	102	0.01%	West	733,710	19	27	35	26	2
119	13	3	4	0	139	0.02%	Wichita	668,621	23	63	36	29	4
354	64	4	16	0	438	0.02%	STATEWIDE	2,893,957	98	142	111	126	16

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

DISPOSITION OF 2012-2013 CHILD CASES BY COUNTY
KANSAS CITY METRO REGION

	DCF REGION		Outcome as a Percentage of Reports Received									
Total Reports Received	County	2013 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	SRS Custody	Receiving Services	All Other	No Known Action	Pending
18	Atchison	16,749	-	28%	-	-	-	39%	22%	-	6%	28%
54	Douglas	114,322	4%	17%	-	-	7%	9%	2%	4%	4%	59%
205	Johnson	566,933	2%	14%	-	1%	6%	12%	5%	3%	1%	63%
43	Leavenworth	78,185	5%	21%	-	-	12%	14%	7%	-	-	51%
122	Wyandotte	160,384	1%	7%	1%	4%	7%	13%	5%	2%	-	68%
442	KC Metro	936,573	2%	13%	0%	2%	7%	13%	6%	2%	1%	61%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013
Source: U.S. Census Bureau, Population Division
Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

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

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

DISPOSITION OF 2012-2013 CHILD CASES BY COUNTY
EAST REGION

	DCF REGION		Outcome as a Percentage of Reports Received									
Total Reports Received	County	2013 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	SRS Custody	Receiving Services	All Other	No Known Action	Pending
6	Allen	13,124	-	33%	-	17%	-	50%	-	-	-	33%
3	Anderson	7,897	-	67%	-	-	-	-	-	-	-	33%
5	Bourbon	14,852	-	60%	-	-	-	20%	-	-	-	40%
17	Brown	9,997	-	59%	-	-	-	29%	-	-	-	35%
6	Chautauqua	3,552	-	17%	-	-	-	-	-	17%	-	67%
29	Cherokee	20,978	7%	7%	-	3%	-	14%	3%	7%	-	62%
3	Coffey	8,412	-	33%	-	-	-	-	-	-	-	67%
37	Crawford	39,278	-	14%	-	8%	5%	5%	-	3%	-	68%
11	Doniphan	7,851	-	45%	-	-	-	27%	-	-	-	55%
12	Franklin	25,740	-	17%	-	-	-	17%	-	-	-	67%
11	Jackson	13,366	-	9%	-	-	-	9%	-	9%	-	73%
6	Jefferson	18,813	-	33%	-	-	-	-	-	-	-	67%
15	Labette	20,916	-	27%	-	7%	-	40%	-	7%	-	40%
6	Linn	9,516	-	67%	-	-	-	17%	-	-	-	17%
4	Marshall	10,002	-	-	-	-	-	25%	-	-	-	75%
23	Miami	32,835	-	22%	-	4%	9%	4%	-	9%	-	57%
30	Montgomery	34,292	-	17%	-	-	-	13%	7%	3%	-	70%
4	Nemaha	10,161	-	25%	-	-	-	-	-	-	-	75%
13	Neosho	16,430	-	15%	-	8%	-	15%	-	-	-	62%
17	Osage	16,142	-	12%	-	-	-	-	-	6%	-	82%
9	Pottawatomie	22,691	-	-	-	-	-	22%	-	-	-	78%
189	Shawnee	178,831	2%	6%	1%	1%	3%	7%	7%	5%	1%	72%
0	Wabaunsee	7,051	-	-	-	-	-	-	-	-	-	-
14	Wilson	9,105	-	-	-	14%	-	-	14%	-	-	79%
6	Woodson	3,221	17%	17%	-	-	-	-	17%	17%	-	33%
476	East	555,053	1%	15%	0%	2%	2%	11%	4%	4%	0%	66%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013
Source: U.S. Census Bureau, Population Division
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* Percentages are rounded to the nearest whole number. Those reported as 0% are under 0.5%

DISPOSITION OF 2012-2013 CHILD CASES BY COUNTY
WEST REGION

	DCF REGION		Outcome as a Percentage of Reports Received									
Total Reports Received	County	2013 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	SRS Custody	Receiving Services	All Other	No Known Action	Pending
28	Barton	27,509	-	14%	-	7%	7%	29%	-	-	-	61%
3	Chase	2,700	-	-	-	-	-	33%	-	-	-	67%
0	Cheyenne	2,694	-	-	-	-	-	-	-	-	-	-
0	Clark	2,193	-	-	-	-	-	-	-	-	-	-
3	Clay	8,406	-	33%	-	-	-	-	-	-	-	67%
13	Cloud	9,292	8%	-	-	8%	15%	15%	15%	8%	-	54%
2	Comanche	1,955	-	-	-	-	50%	50%	50%	-	-	50%
1	Decatur	2,930	-	-	-	-	-	-	-	-	-	100%
15	Dickinson	19,609	-	27%	-	-	7%	13%	-	-	-	60%
1	Edwards	2,945	-	100%	-	-	-	100%	-	-	-	-
6	Ellis	29,061	-	-	-	-	17%	17%	-	-	-	83%
5	Ellsworth	6,398	-	20%	-	-	-	-	-	-	-	80%
29	Finney	37,098	3%	21%	-	7%	3%	45%	10%	-	3%	34%
27	Ford	34,819	4%	33%	-	4%	-	11%	4%	-	-	56%
34	Geary	37,384	3%	32%	3%	3%	-	32%	3%	-	-	53%
0	Gove	2,769	-	-	-	-	-	-	-	-	-	-
0	Graham	2,593	-	-	-	-	-	-	-	-	-	-
3	Grant	7,950	-	-	-	-	-	-	-	-	-	100%
2	Gray	6,009	-	-	-	-	-	-	-	-	-	100%
2	Greeley	1,290	-	-	-	-	-	50%	-	-	-	50%
3	Hamilton	2,609	-	33%	-	-	-	-	-	-	-	67%
12	Harvey	34,741	8%	17%	-	-	-	8%	-	8%	-	67%
1	Haskell	4,141	-	-	-	100%	-	100%	-	-	-	-
3	Hodgeman	1,950	-	-	-	-	-	-	-	-	-	100%
1	Jewell	3,046	-	-	-	-	-	-	-	100%	-	-
5	Kearny	3,923	-	40%	-	-	20%	60%	-	-	-	20%
0	Kiowa	2,523	-	-	-	-	-	-	-	-	-	-
0	Lane	1,720	-	-	-	-	-	-	-	-	-	-
1	Lincoln	3,147	-	-	-	-	-	-	-	-	-	100%
1	Logan	2,798	-	100%	-	-	-	-	-	-	-	-
13	Lyon	33,510	-	31%	-	-	-	15%	-	-	-	69%
2	Marion	12,219	-	-	-	-	-	-	-	-	-	100%
3	McPherson	29,569	-	33%	-	-	-	-	-	-	-	67%
1	Meade	4,343	-	-	-	-	-	-	-	-	-	100%

5	Mitchell	6,378	-	40%	-	-	-	20%	-	-	-	60%
2	Morris	5,741	-	-	-	-	-	-	-	-	-	100%
1	Morton	3,143	-	-	-	-	-	-	-	-	-	100%
1	Ness	3,073	-	-	-	-	-	-	-	-	-	100%
2	Norton	5,622	-	-	-	-	-	-	50%	-	-	50%
0	Osborne	3,818	-	-	-	-	-	-	-	-	-	-
5	Ottawa	6,042	-	60%	-	20%	-	40%	-	-	-	20%
6	Pawnee	6,971	17%	33%	-	-	-	50%	-	-	-	50%
3	Phillips	5,540	-	33%	-	-	-	33%	-	-	-	67%
0	Rawlins	2,589	-	-	-	-	-	-	-	-	-	-
24	Reno	64,190	-	21%	-	-	4%	29%	-	-	-	54%
3	Republic	4,820	33%	33%	-	-	-	33%	-	-	-	33%
7	Rice	10,011	-	14%	-	-	-	-	-	-	-	86%
11	Riley	75,394	9%	18%	-	-	18%	18%	9%	-	-	55%
1	Rooks	5,190	-	-	-	-	-	-	-	-	-	100%
2	Rush	3,186	-	-	-	-	-	-	-	-	-	100%
5	Russell	6,933	-	-	-	-	-	-	-	-	-	100%
45	Saline	55,740	2%	20%	2%	7%	-	16%	7%	7%	-	58%
2	Scott	5,035	-	-	-	-	-	-	-	-	-	100%
3	Seward	23,390	-	33%	-	-	-	67%	-	-	-	33%
0	Sheridan	2,553	-	-	-	-	-	-	-	-	-	-
1	Sherman	6,115	-	100%	-	-	-	100%	-	-	-	-
0	Smith	3,706	-	-	-	-	-	-	-	-	-	-
0	Stafford	4,359	-	-	-	-	-	-	-	-	-	-
0	Stanton	2,194	-	-	-	-	-	-	-	-	-	-
1	Stevens	5,816	-	-	-	-	-	100%	100%	-	-	-
0	Thomas	7,948	-	-	-	-	-	-	-	-	-	-
3	Trego	2,980	-	-	-	-	-	-	-	-	-	100%
0	Wallace	1,569	-	-	-	-	-	-	-	-	-	-
4	Washington	5,629	-	25%	-	-	-	-	-	-	-	75%
0	Wichita	2,192	-	-	-	-	-	-	-	-	-	-
357	West	733,710	3%	22%	1%	3%	3%	22%	4%	2%	0%	59%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013
Source: U.S. Census Bureau, Population Division
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* Percentages are rounded to the nearest whole number. Those reported as 0% are under 0.5%

DISPOSITION OF 2012-2013 CHILD CASES BY COUNTY
WICHITA REGION

	DCF REGION		Outcome as a Percentage of Reports Received									
Total Reports Received	County	2013 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	SRS Custody	Receiving Services	All Other	No Known Action	Pending
3	Barber	4,947	-	33%	-	-	-	33%	-	33%	-	33%
14	Butler	65,803	-	14%	-	-	-	36%	-	-	-	64%
16	Cowley	36,204	-	19%	-	13%	13%	19%	13%	6%	-	44%
1	Elk	2,655	-	-	-	-	-	100%	-	-	-	-
0	Greenwood	6,424	-	-	-	-	-	-	-	-	-	-
1	Harper	5,860	-	100%	-	-	-	100%	-	-	-	-
1	Kingman	7,844	-	-	-	-	-	-	-	-	-	100%
3	Pratt	9,878	-	-	-	-	-	-	-	-	-	100%
186	Sedgwick	505,415	-	23%	-	2%	8%	10%	4%	2%	-	62%
1	Sumner	23,591	-	100%	-	-	-	-	-	-	-	-
226	Wichita	668,621	-	23%	-	3%	7%	13%	4%	3%	-	60%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013
Source: U.S. Census Bureau, Population Division
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DISPOSITION OF 2012-2013 CHILD CASES BY COUNTY
STATEWIDE

	DCF REGION		Outcome as a Percentage of Reports Received									
Total Reports Received	County	2013 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	SRS Custody	Receiving Services	All Other	No Known Action	Pending
442	KC Metro	936,573	2%	13%	0%	2%	7%	13%	6%	2%	1%	61%
476	East	555,053	1%	15%	0%	2%	2%	11%	4%	4%	0%	66%
357	West	733,710	3%	22%	1%	3%	3%	22%	4%	2%	0%	59%
226	Wichita	668,621	-	23%	-	3%	7%	13%	4%	3%	-	60%
1,501	STATEWIDE	2,893,957	2%	17%	0%	2%	4%	15%	5%	3%	1%	62%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013
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DISPOSITION OF 2012-2013 ADULT CASES BY COUNTY
KANSAS CITY METRO REGION

	DCF REGION		Outcome as a Percentage of Reports Received								
Total Reports Received	County	2013 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	Receiving Services	All Other	No Known Action	Pending
3	Atchison	16,749	-	33%	-	-	-	-	-	-	67%
12	Douglas	114,322	-	17%	-	-	-	-	-	-	83%
13	Johnson	566,933	-	8%	-	-	-	-	-	-	92%
3	Leavenworth	78,185	-	-	-	-	-	-	-	-	100%
8	Wyandotte	160,384	-	13%	-	-	-	-	13%	-	75%
39	KC Metro	936,573	-	13%	-	-	-	-	3%	-	85%

Population figures taken from:

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Source: U.S. Census Bureau, Population Division
Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

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

DISPOSITION OF 2012-2013 ADULT CASES BY COUNTY
EAST REGION

	DCF REGION		Outcome as a Percentage of Reports Received								
Total Reports Received	County	2013 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	Receiving Services	All Other	No Known Action	Pending
1	Allen	13,124	-	-	-	-	-	-	-	-	100%
0	Anderson	7,897	-	-	-	-	-	-	-	-	-
4	Bourbon	14,852	-	-	-	-	-	-	25%	-	75%
0	Brown	9,997	-	-	-	-	-	-	-	-	-
0	Chautauqua	3,552	-	-	-	-	-	-	-	-	-
1	Cherokee	20,978	-	-	-	-	-	-	-	-	100%
2	Coffey	8,412	-	-	-	-	-	-	-	-	100%
9	Crawford	39,278	11%	-	-	-	-	-	11%	-	78%
0	Doniphan	7,851	-	-	-	-	-	-	-	-	-
3	Franklin	25,740	-	33%	-	-	-	-	-	-	67%
1	Jackson	13,366	-	-	-	-	-	-	-	-	100%
0	Jefferson	18,813	-	-	-	-	-	-	-	-	-
2	Labette	20,916	-	50%	-	-	-	-	-	-	50%
0	Linn	9,516	-	-	-	-	-	-	-	-	-
0	Marshall	10,002	-	-	-	-	-	-	-	-	-
3	Miami	32,835	-	-	-	-	-	-	-	-	100%
5	Montgomery	34,292	-	20%	-	-	-	-	-	-	80%
0	Nemaha	10,161	-	-	-	-	-	-	-	-	-
3	Neosho	16,430	-	-	-	-	-	-	-	-	100%
0	Osage	16,142	-	-	-	-	-	-	-	-	-
2	Pottawatomie	22,691	-	-	-	-	-	-	-	-	100%
24	Shawnee	178,831	-	-	-	-	-	-	13%	-	88%
0	Wabaunsee	7,051	-	-	-	-	-	-	-	-	-
1	Wilson	9,105	-	-	-	-	-	-	-	-	100%
0	Woodson	3,221	-	-	-	-	-	-	-	-	-
61	East	555,053	2%	5%	-	-	-	-	8%	-	85%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013
Source: U.S. Census Bureau, Population Division
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DISPOSITION OF 2012-2013 ADULT CASES BY COUNTY
WEST REGION

	DCF REGION		Outcome as a Percentage of Reports Received								
Total Reports Received	County	2013 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	Receiving Services	All Other	No Known Action	Pending
5	Barton	27,509	20%	-	-	-	-	-	-	-	80%
0	Chase	2,700	-	-	-	-	-	-	-	-	-
0	Cheyenne	2,694	-	-	-	-	-	-	-	-	-
0	Clark	2,193	-	-	-	-	-	-	-	-	-
1	Clay	8,406	-	-	-	-	-	-	-	-	100%
1	Cloud	9,292	-	-	-	-	-	-	-	-	100%
0	Comanche	1,955	-	-	-	-	-	-	-	-	-
0	Decatur	2,930	-	-	-	-	-	-	-	-	-
2	Dickinson	19,609	-	-	-	-	-	-	-	-	100%
0	Edwards	2,945	-	-	-	-	-	-	-	-	-
2	Ellis	29,061	-	-	-	-	-	-	-	-	100%
2	Ellsworth	6,398	-	50%	-	-	-	50%	-	-	50%
2	Finney	37,098	-	50%	-	-	-	-	-	-	50%
5	Ford	34,819	-	-	-	-	-	-	-	-	100%
2	Geary	37,384	-	-	-	-	-	-	-	-	100%
0	Gove	2,769	-	-	-	-	-	-	-	-	-
0	Graham	2,593	-	-	-	-	-	-	-	-	-
0	Grant	7,950	-	-	-	-	-	-	-	-	-
0	Gray	6,009	-	-	-	-	-	-	-	-	-
0	Greeley	1,290	-	-	-	-	-	-	-	-	-
1	Hamilton	2,609	-	-	-	-	-	-	-	-	100%
3	Harvey	34,741	-	67%	-	-	-	-	-	-	33%
0	Haskell	4,141	-	-	-	-	-	-	-	-	-
0	Hodgeman	1,950	-	-	-	-	-	-	-	-	-
0	Jewell	3,046	-	-	-	-	-	-	-	-	-
0	Kearny	3,923	-	-	-	-	-	-	-	-	-
0	Kiowa	2,523	-	-	-	-	-	-	-	-	-
0	Lane	1,720	-	-	-	-	-	-	-	-	-
0	Lincoln	3,147	-	-	-	-	-	-	-	-	-
2	Logan	2,798	-	-	-	-	-	-	-	-	100%
5	Lyon	33,510	-	-	-	-	-	-	-	-	100%
0	Marion	12,219	-	-	-	-	-	-	-	-	-
9	McPherson	29,569	-	-	-	-	-	-	22%	-	78%
0	Meade	4,343	-	-	-	-	-	-	-	-	-

1	Mitchell	6,378	-	-	-	-	-	-	-	-	100%
0	Morris	5,741	-	-	-	-	-	-	-	-	-
0	Morton	3,143	-	-	-	-	-	-	-	-	-
0	Ness	3,073	-	-	-	-	-	-	-	-	-
0	Norton	5,622	-	-	-	-	-	-	-	-	-
0	Osborne	3,818	-	-	-	-	-	-	-	-	-
0	Ottawa	6,042	-	-	-	-	-	-	-	-	-
3	Pawnee	6,971	-	-	-	-	-	-	33%	-	67%
0	Phillips	5,540	-	-	-	-	-	-	-	-	-
0	Rawlins	2,589	-	-	-	-	-	-	-	-	-
8	Reno	64,190	-	-	-	-	-	-	-	-	100%
0	Republic	4,820	-	-	-	-	-	-	-	-	-
0	Rice	10,011	-	-	-	-	-	-	-	-	-
4	Riley	75,394	-	-	-	-	-	-	-	-	100%
0	Rooks	5,190	-	-	-	-	-	-	-	-	-
0	Rush	3,186	-	-	-	-	-	-	-	-	-
1	Russell	6,933	-	-	-	-	-	-	-	-	100%
15	Saline	55,740	-	-	-	-	-	-	-	-	100%
0	Scott	5,035	-	-	-	-	-	-	-	-	-
1	Seward	23,390	-	-	-	-	-	-	-	-	100%
0	Sheridan	2,553	-	-	-	-	-	-	-	-	-
1	Sherman	6,115	-	-	-	-	-	-	-	-	100%
0	Smith	3,706	-	-	-	-	-	-	-	-	-
1	Stafford	4,359	-	-	-	-	-	-	-	-	100%
0	Stanton	2,194	-	-	-	-	-	-	-	-	-
0	Stevens	5,816	-	-	-	-	-	-	-	-	-
1	Thomas	7,948	-	-	-	-	-	-	-	-	100%
1	Trego	2,980	-	-	-	-	-	-	-	-	100%
0	Wallace	1,569	-	-	-	-	-	-	-	-	-
1	Washington	5,629	-	-	-	-	-	-	-	-	100%
0	Wichita	2,192	-	-	-	-	-	-	-	-	-
80	West	733,710	1%	5%	-	-	-	1%	4%	-	90%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013
Source: U.S. Census Bureau, Population Division
Release Dates: For the United States, regions, divisions, states, and Puerto Rico Commonwealth, December 2013. For counties, municipios, metropolitan statistical areas, micropolitan statistical areas, metropolitan divisions, and combined statistical areas, March 2014. For Cities and Towns (Incorporated Places and Minor Civil Divisions), May 2014.

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

DISPOSITION OF 2012-2013 ADULT CASES BY COUNTY
WICHITA REGION

	DCF REGION		Outcome as a Percentage of Reports Received								
Total Reports Received	County	2013 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	Receiving Services	All Other	No Known Action	Pending
0	Barber	4,947	-	-	-	-	-	-	-	-	-
16	Butler	65,803	6%	-	-	-	6%	-	31%	-	56%
7	Cowley	36,204	-	-	-	-	-	-	-	-	100%
0	Elk	2,655	-	-	-	-	-	-	-	-	-
2	Greenwood	6,424	-	-	-	-	-	-	-	-	100%
2	Harper	5,860	-	100%	-	-	-	-	-	-	-
3	Kingman	7,844	-	-	-	-	67%	-	-	-	33%
3	Pratt	9,878	-	33%	-	-	-	-	33%	-	33%
124	Sedgwick	505,415	-	6%	-	-	2%	-	2%	-	90%
5	Sumner	23,591	-	-	-	-	-	-	-	-	100%
162	Wichita	668,621	1%	7%	-	-	3%	-	6%	-	84%

Population figures taken from:

Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2013
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DISPOSITION OF 2012-2013 ADULT CASES BY COUNTY
STATEWIDE

	DCF REGION		Outcome as a Percentage of Reports Received								
Total Reports Received	County	2013 Population Estimate	Diversion	Conviction	Acquitted	Dismissed	Declined	Receiving Services	All Other	No Known Action	Pending
39	KC Metro	936,573	-	13%	-	-	-	-	3%	-	85%
61	East	555,053	2%	5%	-	-	-	-	8%	-	85%
80	West	733,710	1%	5%	-	-	-	1%	4%	-	90%
162	Wichita	668,621	1%	7%	-	-	3%	-	6%	-	84%
342	STATEWIDE	2,893,957	1%	7%	-	-	1%	0%	5%	-	86%

Population figures taken from:

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