2016

KANSAS ATTORNEY GENERAL
Derek Schmidt

Abuse, Neglect & Exploitation Unit
Kansas Fiscal Year 2016
Annual Report

July 1, 2015 – June 30, 2016

www.ag.ks.gov

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Executive Summary

The Abuse, Neglect, and Exploitation (ANE) Unit was established by statutory mandate in the summer of 2006, largely in response to the Kaufman case, which occurred in Newton, Kansas. Arlan and Linda Kaufman operated a mental health group home for adults, in which complaints of abuse had been made by residents over a period of years. Due to inadequacies in the State's system of reporting and investigation, the complaints went uninvestigated. The Disability Rights Center of Kansas eventually gained access to the home. A subsequent law enforcement investigation led to arrest, prosecution, and conviction of the Kaufmans in U.S. District Court. During the criminal investigation and subsequent review, it became clear there had been systemic failures which led to the abuse going undetected. As a result, the Legislature in 2006 created the Abuse, Neglect, and Exploitation Unit pursuant to K.S.A. 75-723.

The ANE Unit is required to review all cases involving a confirmed (substantiated) finding of abuse by a state agency. For the current reporting period, the statute applied to both children and adults. The Abuse, Neglect, and Exploitation (ANE) Unit received 1,927 substantiated findings in the 2016 fiscal year. A total of 1,567, or 81 percent of the substantiations involved children, and 360 or 19 percent of the substantiations involved adults.

In addition to sharing statistical data for the reports received, this annual report highlights the activities, investigations and findings for the preceding fiscal year. This report focuses on the ways the Unit's work has resulted in intervention or investigation of the abuse of children and vulnerable adults. It also looks at ways in which state agencies can improve in protecting vulnerable adults and children from abuse. In addition, the report provides ways to improve the quick identification of perpetrators of abuse and holding them accountable.

This report will outline several needs for improvement by state agencies regarding the investigation, substantiation and follow-up in regards to adult and child cases. One area which continues to need improvement, is the transfer and receipt of information between agencies. This report identifies cases where abuse is substantiated and yet there is a failure to report this to law enforcement. There also continues to be a considerable number of cases where the substantiation is forwarded to law enforcement but no action is taken. It is not clear whether law enforcement never received the information or they did receive the information and failed to act. This Unit believes either scenario is simply unacceptable.

The past fiscal year has also seen great transformation on the legislative front. The Unit's statutory authority was recently amended resulting in significant changes for the Unit in the next fiscal year. State agencies will no longer be required to forward confirmations of abuse of children to the Unit. The Unit will still be able to intervene on cases involving children, but it will not be statutorily mandated to review every case. The Legislature also added a new requirement that all state agencies which refer a case to law enforcement must now send a copy of this referral to the Unit. Finally, the Legislature saw fit to allow the Unit to assist in the investigation and prosecution of cases involving abuse, neglect, or exploitation of adults and children. These significant changes will result in significant differences in activities from the previous year. The Unit will be making a transition from simply a monitoring or auditing unit, to one which actually participates in the investigation and prosecution of cases. The Unit looks forward to the challenges in the coming year of such a transition.

Legislative Action

The ANE Unit created by statute in 2006, was required to review all cases involving a confirmed finding of abuse by a state agency. The statute applied to both children and adults. The Unit was also required to provide a report to the Legislature every year detailing its activities. This resulted in the Unit reviewing around 1,800 cases of substantiated abuse every year, with roughly 375 of those cases involving adults and the rest involving children. Available resources in the Attorney General's Office were simply not adequate to handle such a case load.

The Attorney General was faced with only two realistic options. First, to add enough skilled staff to the Unit to properly review and follow up on all cases (child and adult) which are referred to the office. This was Attorney General Schmidt's preferred option. However, at an estimated annual cost of $400,000, this solution proved to be unfeasible at the current time. The second option, which was ultimately adopted, was to amend the ANE statute to focus resources on adult cases by amending K.S.A. 75-723.

In spring 2016, the Legislature passed and the Governor signed Senate Bill 408, amending K.S.A. 75-723. While retaining the ability to review cases of child abuse, neglect and exploitation within the limits of available resources, the statute narrowed the focus of cases requiring mandatory review by our office. Under the amended statute state agencies are now only required to forward substantiated findings of adult abuse, neglect, or exploitation to our office. In addition, the amended statute provides a new requirement that state agencies concurrently notify our office when a case of suspected adult abuse, neglect, or exploitation is referred to law enforcement. This allows us to make timely contact with local law enforcement agencies to determine from the outset whether they desire assistance in what can be very difficult cases to investigate.

The amended statute also provides that the Attorney General's Office may assist in the investigation, prosecution, and prevention of cases involving abuse, neglect, and exploitation. This means the ANE Unit is no longer just simply a monitoring or auditing unit. This change of focus to investigation and prosecution meant it was no longer appropriate for the ANE unit to be located in Victims Services Division. As part of Attorney General Schmidt's focus on fraud and abuse cases, in July 2016 the ANE Unit was moved to a newly created division named the "Fraud and Abuse Litigation Division".

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

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

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

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

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

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

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

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

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

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

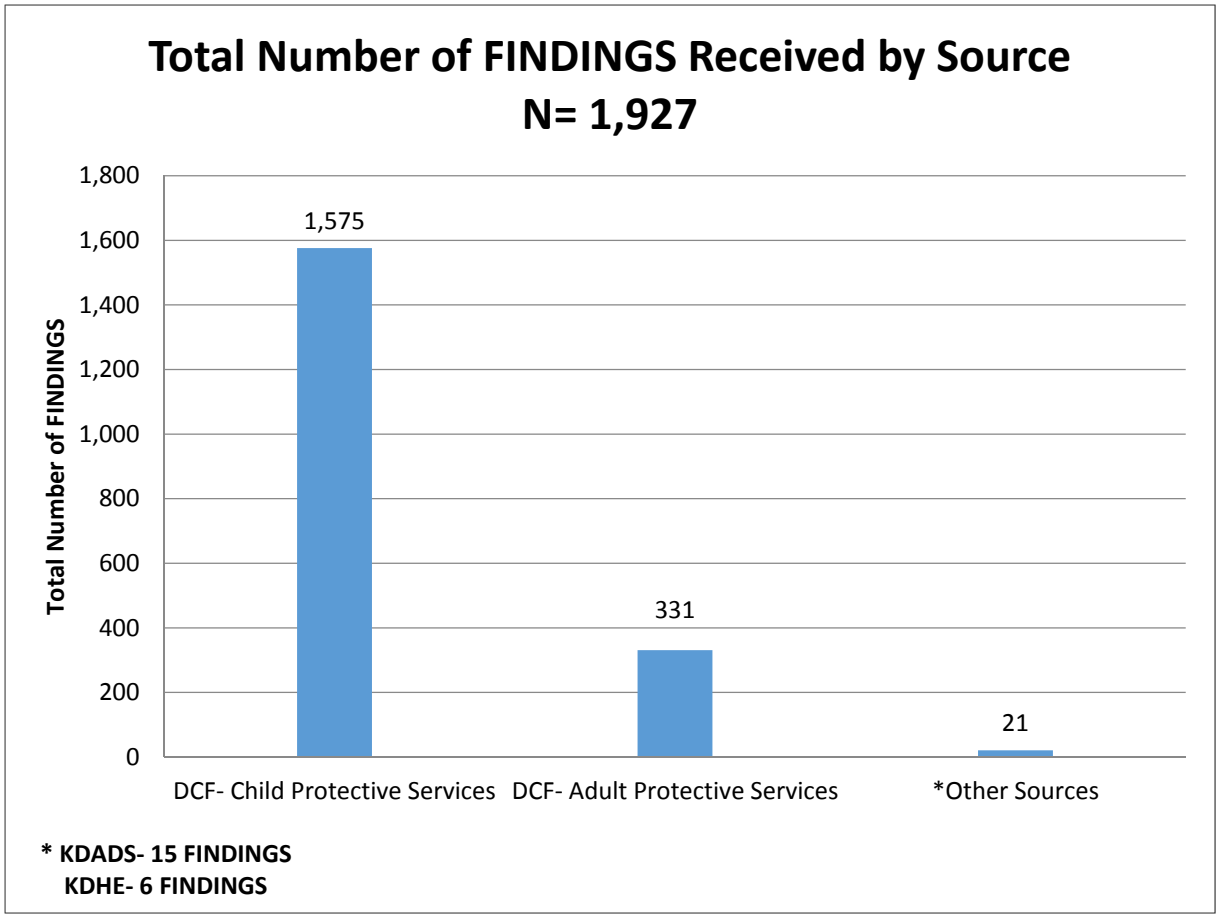
(h) Notwithstanding any other provision of law, nothing shall prohibit the attorney general or the unit from distributing or utilizing only that information obtained pursuant to a confirmed case of abuse, neglect or exploitation or cases in which there is reasonable suspicion to believe abuse, neglect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

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

Note: *This reflects the statute as it read during the 2016 fiscal year, covered by this report. The statute was amended during the 2016 legislative session (see previous page). These changes took effect July 1, 2016.*

2016 Findings Overview

For the period July 1, 2015, to June 30, 2016, the ANE Unit received 1,927 findings of substantiated abuse, neglect or exploitation from the Kansas Department for Children and Families (DCF), Kansas Department for Aging and Disability Services (KDADS) and Kansas Department of Health and Environment (KDHE). The findings consisted of 1,575 from DCF Child Protective Services (CPS), 331 from DCF Adult Protective Services (APS), 15 from KDADS and 6 from KDHE. Of the 1,927 findings of substantiated abuse, neglect or exploitation from the above agencies a majority (82%) of substantiated findings were on children, the remaining 18% were on adults.



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

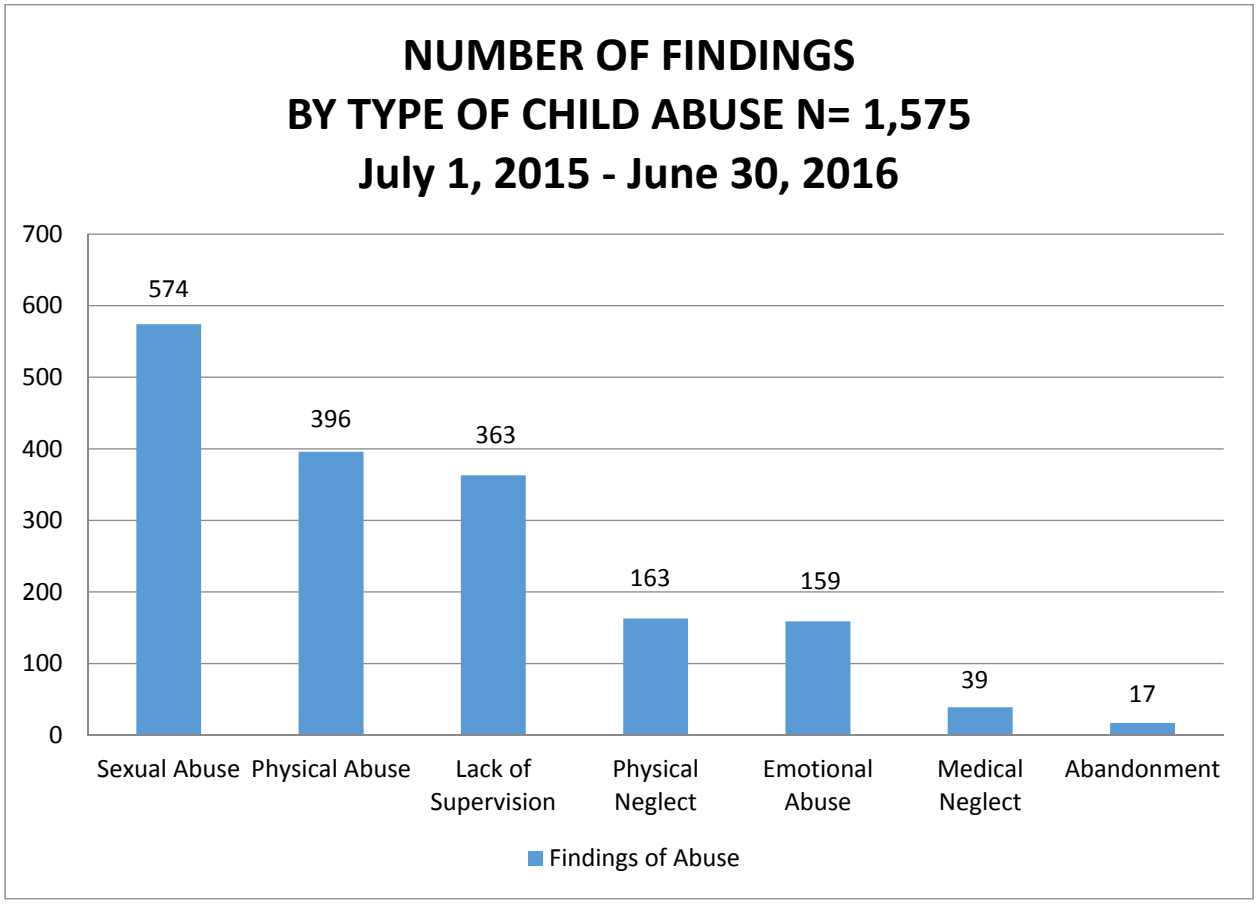
DCF Adult Protective Services (APS) - Social workers investigate reports and provide protective services to adults, with their consent, who reside in the community, adults residing in facilities licensed/certified by DCF, and to adults residing in adult care homes and other facilities licensed by KDADS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

KDADS - Investigates reports of adult abuse, neglect and exploitation occurring in adult care homes (ACH). Examples: nursing home facilities, assisted living facilities, boarding care. www.kdads.ks.gov

In addition, the Aging and Disability Resource Center (ADRC) is now available and is a trusted source of information where people of all ages, abilities and income levels – and their caregivers – can go to obtain assistance in planning for their future long-term service and support needs. The ADRC website is found at http://kdads.ks.gov/commissions/commission-on-aging/aging-and-disability-resource-centers

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

The 1,575 substantiated findings of child abuse received by the Unit include abandonment, emotional abuse, lack of supervision, medical neglect, physical abuse, physical neglect and sexual abuse. Some findings contained substantiations of more than one type of abuse or may involve multiple victims or perpetrators. Sexual abuse continues to be the most frequently substantiated form of abuse. [1]

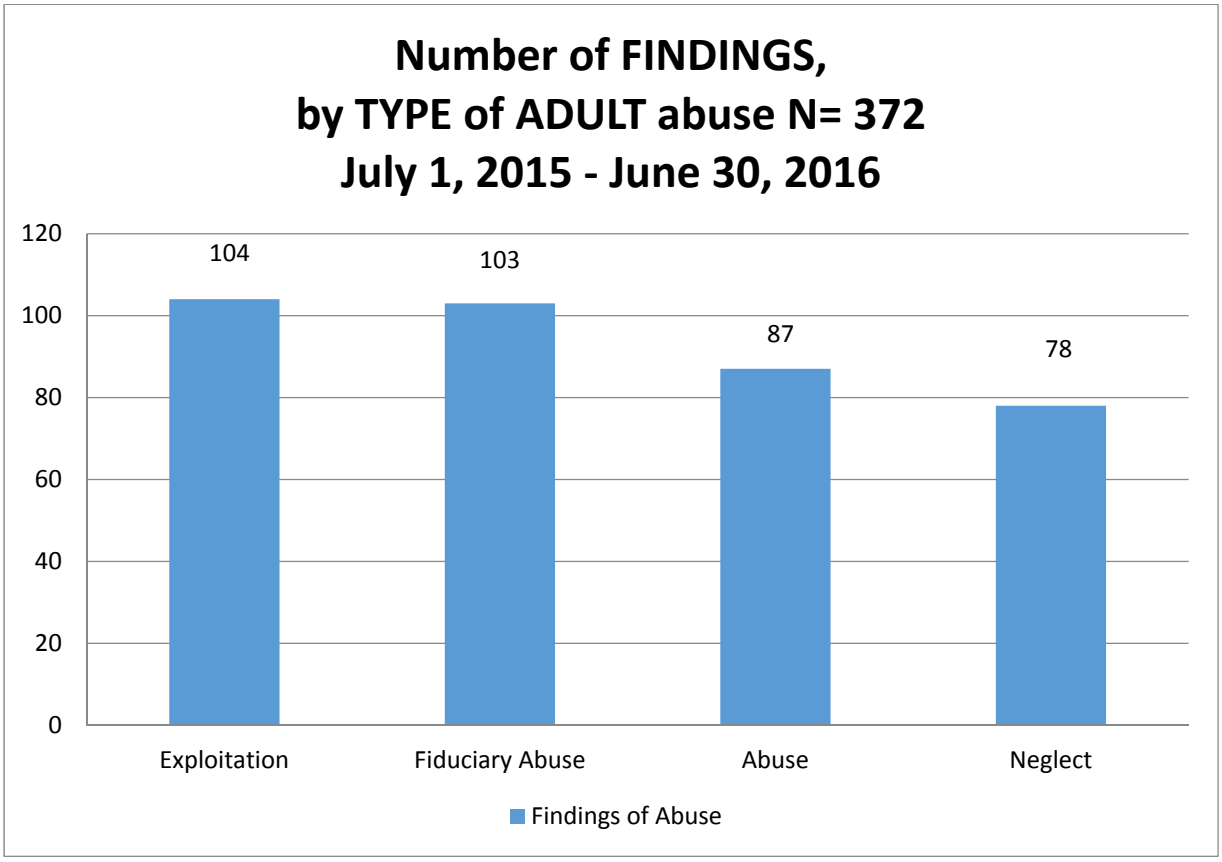


[1] Substantiated forms of abuse can be found here, http://content.dcf.ks.gov/PPS/robohelp/PPMGenerate/ or at the end of this report.

Compared to last year, when 1,471 substantiated findings were received, the following variances are noted:

Abandonment	increased	0.26%
Emotional Abuse	decreased	1.46%
Lack of Supervision	increased	1.84%
Medical Neglect	decreased	1.46%
Physical Abuse	decreased	1.03%
Physical Neglect	decreased	0.32%
Sexual Abuse	increased	0.89%

The 352 substantiated findings of adult abuse received by the Unit, included the following types: abuse, exploitation, fiduciary abuse and neglect, as defined by APS. Some findings contained substantiations of more than one type of abuse or may have involved multiple victims or perpetrators. Nearly all the exploitation findings 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.



Compared to the 2014-2015 reporting year, when 326 substantiated reports of adult abuse were received, the following variances were noted in comparing to this year's totals.

Abuse	decreased	2.99%
Exploitation	increased	0.35%
Fiduciary Abuse	increased	6.83%
Neglect	decreased	11.55%

Areas for Improvement in All Cases

Adhering to Statutory Requirements

The Unit has continued to monitor case findings to ensure they are received timely. K.S.A 75-723 requires agencies to submit their findings to the Unit within 10 days. Though the language does not specify whether such is required to be calendar days or business days, in the interest of good faith and allowing the maximum timeframe, the Unit has considered this requirement to be business days. While staffing and database abilities, along with caseload volume causes difficulty in ensuring this factor is documented for every finding received, the Unit has been able to determine that during this reporting year, a minimum of 158 findings submitted by agencies were received outside statutory requirement. Of those, 130 were submitted late by DCF-CPS staff, while 27 were from DCF-APS staff, and only one case was received late from KDHE. This rate is 70 cases higher than the number reported last year, and the Unit will continue to track this number to report on in future reports.

Failure to Report by Mandated Reporters

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

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

Unit Interventions

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, findings were found to be stalled within an individual agency. Unit inquiry brought these cases back to the attention of persons who were able to take additional action which, in some cases, furthered investigations toward completion, if not prosecution.

For example:

1. The Unit received a substantiation of physical abuse where the mother was initially the suspected perpetrator. DCF substantiated on an unknown perpetrator solely based on the fact that during their

interview with the mother she denied hitting the child. Upon initial review by the Unit it was discovered criminal charges had already been filed on the mother prior to the receipt of substantiation. The Unit inquired with DCF as to whether they knew the mother had been criminally charged for the abuse. As a result of Unit inquiry, DCF amended their finding, naming the mother as the substantiated perpetrator.

2. An ongoing concern of the Unit was having findings sent to the incorrect email address, thus resulting in missed findings. The Unit inquired about an adult abuse case after the initial review an associated finding. The Unit discovered the social worker had sent several findings to the wrong email address. Had the Unit not inquired on the associated case, these substantiations never would have been received appropriately by the Unit.

3. Regarding an adult fiduciary abuse substantiation, the Unit learned local law enforcement had not responded to the initial referral they had received from APS. The police chief told the social worker he questioned whether the case was a violation of criminal statute, as the account in question was a "joint account" and indicated they have not been prosecuted successfully in the past. The Unit followed up with the police chief to which the Unit again learned the case had not been acted upon because the suspect was in the role of power of attorney. The chief advised he would collect records from APS and follow up with the county attorney to see what they could advise him to do. As a result, the case was referred to the Attorney General's Office, which resulted in prosecution.

4. Upon review of a KDADS finding from the previous reporting year, it was discovered an employment prohibition was never entered on the perpetrator's Nurse Aide Registry. In following up with KDADS regarding the prohibition, the Unit discovered the perpetrator had appealed the substantiation and entered into a settlement agreement. The perpetrator then failed to comply with the settlement agreement to which KDADS never followed up by placing this CNA (Certified Nurse Aide) on the registry. The Unit followed up twice again with KDADS and as a result the prohibition memo was drafted resulting in her name being entered onto the nurse aide registry employment prohibition list.

5. The Unit received a substantiation of physical abuse to a 3-year-old by his mother. The substantiation stated the mother was making false claims of medical symptoms which resulted in unnecessary medical tests and surgeries on the child. The child had an extensive history of medical evaluations and treatments due to feeding difficulties, and diarrhea as reported by the mother. The child's past medical history included a diagnosis of caregiver fabricated illness in a child, previously referred to as Munchausen Syndrome by Proxy. The child had been exposed to risks including but not limited to pain, bleeding, infection, esophageal/gastric/intestinal injury, allergic reactions and drug reactions.

   When the child was interviewed by the social worker, it came out in conversation that the family was a licensed foster home, and two foster children would be joining their home in a couple days. When the Unit inquired with DCF as to whether foster care licensure had been notified of this substantiation, it became apparent notice was never sent to ensure licensure action. As a result of the Unit's inquiry, notice of the substantiation was sent to the licensure division of DCF, and the foster parent's license was revoked.

Areas for Improvement in Child Cases

Ensuring Cases are Closed Timely

The Unit reviewed at least 12 cases in which DCF issued findings outside of the statutory timeframe. Social workers have 30 working days to complete investigations involving adults, and 25 working days to complete investigations involving children. The Unit finds reasons for extending these time frames are due to requests by law enforcement and county attorneys a majority of the time. On occasion a finding will be made late due to "social worker error".

For example:

1. DCF was assigned a sexual abuse case in 2013. It would appear that the initial investigation was completed timely within about a two-week timeframe; however the finding was not made by DCF until July 2015, nearly two years after the assignment date. DCF only states the finding was late due to "social worker error."

2. A physical abuse case was assigned to DCF in August 2013. The initial interviews were all completed within seven days of the initial report assignment. DCF did not substantiate until July 2015, providing only "worker error" as the factor for issuing the finding late.

Effective Monitoring by DCF Contractors

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

For example:

> In September 2015 the Unit received a substantiation for lack of supervision on a foster mother regarding two children that had been placed in her care. Prior to leaving for a scheduled supervised visit with their biological mother, the children were loaded into the transport vehicle. Upon arrival at the park for their visitation, the children's biological mother noticed the children had "suspicious burns/marks" in various places, including blisters which had popped.
>
> According to the foster home, the children did not have any marks on them prior to their visit. The transport driver was interviewed and stated the children had appeared to be happy and healthy on the way to the visit. He did not note any injuries to the children prior to or during drop off. The transport driver left and returned an hour later to pick the children up. He was then informed of the injuries found on the children.
>
> The children were observed the day after the incident at a local hospital and were both diagnosed with second degree burns to various parts of their bodies including inner thighs, elbow, top of hand, and back of arm. Both children were given a topical cream for the burns, and the only answer given by hospital staff was that the injuries were not caused by a lighter, but no other possible causes were given.

Neither the contractor nor DCF made any attempt to contact local law enforcement to assist in the investigation. The burns appeared to be pattern in nature and indicative of possible physical abuse or lack of supervision. Reports failed to show a thorough investigation was completed to confirm what in fact could have left these pattern injuries on the children.

This is the type of case which also needs law enforcement notification. Law enforcement has access to forensic resources not available to DCF or their contractors. These resources could have been used in this case to possibly identify the object used to create the burn patterns which, in turn, may have shed light on the circumstances which led to the injuries.

Joint Investigations with Law Enforcement

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

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

While agencies empowered to investigate these cases like DCF and KDADS have civil remedies available to them as well as the ability to offer services to individuals and families, failure to properly investigate and prosecute crimes can send a message to perpetrators that such actions do not hold a measureable consequence. The Unit understands not all of these cases would result in prosecution and for some, it may not be the best course of action, but when facilities and state agencies fail to report such cases to law enforcement, those agencies are preventing the criminal justice system from conducting its own investigation and inhibiting authority to review the cases based on the available evidence.

For Example:

1. A 4-year-old at a daycare facility was observed with red marks in what appeared to be a large hand print shape underneath his jaw and down his throat. The daycare teacher had put the child down for a nap, and another teacher heard the child screaming and crying. The 4-year-old stated the teacher had put his hands on his jaw line causing the child's teeth to grind. Several other complaints had been made regarding this same teacher alleging pinching of other children and his "tone of voice" when talking. The teacher was terminated from the facility, however, no report was made to law enforcement.

2. A 16 year old was a substantiated victim of physical abuse by her grandfather. Injuries to the child included a two-inch line on her eye lid which was blue in color from what appeared to be bruising caused by her falling into a trash can after being hit by her grandfather. Although these injuries may not have appeared severe to the social worker, there were statements made by the perpetrator indicating he would hit her again. The perpetrator tells the social worker that the siblings go outside and beat each other up in the front yard for the whole town to see. One of the victims reported her siblings are made to put socks in their mouths and smack each other until the grandfather tells them to stop. The narrative basis within the

finding stated the perpetrator, "…did not express remorse and reported he would hit her again if she lied." The social worker noted intent for physical harm was shown, however, no report was made to law enforcement for further follow up or reporting of this incident.

3. The Unit received a substantiated finding of physical abuse of a 6-year-old by his mother. The child reported he had been hit with a belt numerous times on his back, and red marks were observed by the social worker. Initially the mother's boyfriend was the suspected perpetrator until the mother admitted to hitting the child due to being "fed up with his lying." Photos of the injuries were taken, yet no report was ever made to law enforcement.

Areas for Improvement in Adult Cases

Law Enforcement Investigations on Adult Cases

The Unit continues to see a significant risk 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.

The Legislature as part of its consideration of K.S.A. 75-723, recognized the above difficulties and amended the statute to now require all law enforcement referrals made by a state agency must also be provided to the ANE unit. This will allow the Unit to both monitor and assist in ensuring all referrals are properly received, assigned and investigated by law enforcement.

Communication Among Agencies

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

For example:

> The Unit received two associated substantiated findings of exploitation which named two different perpetrators for taking advantage of an elderly man by collecting money to do yard work and never following through on the job to be completed. Nine days after receiving the original findings, the Unit received notice from DCF that both findings were being amended to name "Unknown" perpetrators instead of the involved parties. Upon further review, the Unit learned that criminal cases had been filed on both perpetrators. In following up with DCF, they stated that they had contacted the District Attorney's office to obtain copies of the reports and interviews. DCF stated they would review the documents and follow up. DCF ultimately renamed one of the individuals as the substantiated perpetrator due to the outcome of the criminal case. It was 10 days from the date of the perpetrators guilty verdict to the date the Unit received the amended finding. The other criminal case is still pending; the Unit continues to monitor it for an outcome.

Appropriate Relationship Standards; Caregivers/Vulnerable Populations

Of great concern is the safety of citizens who are dependent on others for their care. The ANE Unit continues to hear from constituents who worry about the well-being of their family members when they are dependent on others to meet their daily needs. With this fact in mind, the Unit has long recommended legislation which would legally prohibit caregivers from engaging in sexual relations with their patients/clients, regardless of that person's ability to give consent. It would seem most logical to do so through modification of K.S.A 21-5512, the criminal statute prohibiting Unlawful Sexual Relations. Currently K.S.A. 21-5512 (7) reads as follows:

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

The current statute makes it a crime for employees of KDADS, as well as their contracting employees, to engage specific sexual acts with a patient in any aging and disability institution. However, these protections still do not extend to residents of long-term care or nursing facilities, which, even though they are licensed by KDADS, are privately owned institutions. The intent of K.S.A. 21-5512, is to criminalize consensual sexual relations where power disparity between the parties renders any consent inherently coerced and invalid. The power disparity remains unchanged simply because the institution is private versus state owned. All patients deserve the protection of K.S.A. 21-5512(7), regardless the facility to which they are a patient.

Collaboration with Other Attorney General Divisions for Investigation/Prosecution

The Unit continues to collaborate with the Medicaid Fraud and Abuse Division and the Consumer Protection Division within the attorney general's office to assist in cases outside of the Unit's spectrum. These divisions are referred findings that our Unit received. Those divisions are able to use their resources to investigate further, and prosecute cases where crimes may have occurred. This year the Unit has referred at least 15 cases between both the Consumer and Medicaid Fraud Divisions. We expect this number to increase tremendously throughout the next reporting year with the legislative changes and development of the Fraud and Abuse Litigation Division.

Recommendations

In response to the areas needing improvement, the Unit provides the following recommendations:

Adhering to Statutory Requirements

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

Failure to Report by Mandated Reporters

The Unit recommends implementation of policy requiring DCF workers to appropriately gather facts, secondary to their investigation, regarding the action or inaction of any identified mandated reporter related to the case. When there is an indication a mandated reporter did not comply with law, DCF should make a report to local law enforcement separate from an abuse finding.

Ensuring Cases are Closed Timely

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.

Effective Monitoring by DCF Contractors

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

Joint Investigations with Law Enforcement

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

Appropriate Relationship Standards; Caregivers/Vulnerable Populations

The Unit continues to encourage legislation that would legally prohibit caregivers in both residential and facility settings from engaging in sexual relations with their patients/clients, regardless of the person’s ability to give consent and regardless of whether the facility is state or privately owned. This is most effectively accomplished by modifying K.S.A. 21-2512(7).

Appendix: Child and Adult Findings by County

Child Findings Received July 1, 2015, to June 30, 2016

By County

SOURCE									
DCF - CPS	Total Number of Victims	County	Abandon-ment	Emotional Abuse	Lack of Supervi-sion	Medical Neglect	Physical Abuse	Physical Neglect	Sexual Abuse
3	3	Allen	-	1	1	-	1	-	1
5	7	Anderson	-	1	3	-	1	-	2
10	15	Atchison	-	-	4	-	3	2	3
1	1	Barber	-	-	-	-	-	-	1
16	25	Barton	-	1	3	1	6	3	4
40	54	Bourbon	1	6	7	-	10	5	11
17	29	Brown	-	1	3	2	4	2	4
24	34	Butler	-	-	6	-	7	1	10
5	9	Chautauqua	-	1	-	-	-	1	3
18	18	Cherokee	-	-	3	-	5	3	9
1	1	Cheyenne	-	-	-	-	-	-	1
2	3	Clay	-	-	-	-	-	-	2
9	11	Cloud	-	-	2	-	3	1	5
7	14	Coffey	-	-	2	-	1	3	2
1	5	Comanche	-	-	-	-	-	1	-
11	17	Cowley	-	-	1	-	2	2	6
53	68	Crawford	1	10	12	2	13	4	18
2	2	Decatur	-	-	-	-	1	-	1
6	10	Dickinson	-	-	1	-	-	2	3

9	15	Doniphan	-	-	2	-	4	1	2
34	45	Douglas	-	4	10	1	12	5	8
2	2	Edwards	-	-	1	-	-	-	1
1	1	Elk	-	-	-	-	-	-	1
12	16	Ellis	-	-	3	-	4	-	6
8	10	Ellsworth	-	-	2	-	4	-	4
32	49	Finney	1	4	6	-	5	8	10
25	27	Ford	-	2	1	-	4	-	18
29	49	Franklin	-	4	9	-	2	12	8
25	28	Geary	-	1	6	-	12	-	10
2	4	Gove	-	-	-	-	-	1	1
1	1	Graham	-	1	-	-	-	-	-
1	1	Grant	-	--	1	-	1	-	-
4	6	Gray	-	1	-	-	2	1	-
6	23	Greenwood	-	-	4	-	1	1	-
1	1	Hamilton	-	-	-	-	-	-	1
-	-	Harper	-	-	-	-	-	-	-
25	35	Harvey	-	6	8		12	1	7
2	2	Haskell	-	-	1	-	-	-	1
1	1	Hodgeman	-	-	-	-	-	-	1
6	6	Jackson	-	-	1	-	2	-	3
14	15	Jefferson	-	2	4	1	6	-	3
2	2	Jewell	-	1	1	-	-	-	1
170	237	Johnson	-	29	36	3	47	11	53
7	13	Kearny	-	2	2	-	3	-	-
2	2	Kingman	-	-	-	-	1	1	-

1	1	Kiowa	-	-	-	-	-	-	1
18	25	Labette	-	3	6		9	2	1
19	26	Leavenworth	-	2	3	1	7	2	7
4	5	Lincoln	-	-	-	-	-	-	4
11	20	Linn	-	4	3	-	1	1	4
1	1	Logan	-	-	-	-	1	-	-
38	56	Lyon	-	-	20	1	5	6	13
6	8	Marion	-	-	1	-	2	1	2
5	6	Marshall	-	-	3	-	1	-	1
5	5	McPherson	1	-	-	-	2	-	2
1	1	Meade	-	-	1	-	-	-	-
30	61	Miami	1	8	13	3	6	6	4
3	3	Mitchell	-	1	-	-	2	-	-
63	100	Montgomery	-	11	14	4	16	14	11
3	4	Morris	-	-	-	-	2	-	1
2	2	Morton	-	-	1	-	-	-	1
1	1	Nemaha	-	-	-	-	-	-	1
19	21	Neosho	-	2	6	2	2	5	4
1	1	Ness	-	-	-	-	-	-	1
2	2	Norton	-	-	1	-	-	-	1
5	5	Osage	-	-	2	-	2	-	2
1	1	Ottawa	-	-	-	-	1	-	-
3	4	Pawnee	-	1	-	-	1	1	-
5	7	Phillips	-	2	-	-	1	1	1
5	8	Pottawatomie	-	-	3	-	-	2	1

5	8	Pratt	-	-	2	-	1	1	1
1	5	Rawlins	-	-	1	-	-	-	-
36	53	Reno	1	3	13	2	9	3	8
2	2	Republic	-	-	-	-	1	-	1
10	13	Rice	-	1	7	1	-	-	
15	17	Riley	-	-	1	-	5	2	8
10	13	Rooks	-	-	2	1	1	-	7
4	8	Russell	-	2	1	-	-	-	1
38	47	Saline	1	2	14	4	6	3	9
6	6	Scott	-	1	-	-	-	-	5
156	180	Sedgwick	3	2	12	-	32	10	100
10	14	Seward	1	1	2	-	1	-	6
197	234	Shawnee	2	15	51	6	58	13	67
1	1	Sheridan	-	-	-	-	-	-	1
4	4	Sherman	-	1	-	-	1	2	1
3	5	Smith	-	-	-	-	-	-	3
6	8	Stevens	-	-	1	-	1	1	3
6	10	Sumner	-	1	1	-	-	3	1
4	4	Thomas	-	-	3	-	-	-	1
5	8	Trego	-	-	1	-	-	-	4
5	5	Wabaunsee	-	-	2	-	2	-	1
2	2	Washington	-	-	-	-	-	-	2
17	25	Wilson	1	-	6	2	2	4	4
5	6	Woodson	-	-	-	2	1	2	-
119	180	Wyandotte	3	20	20	-	34	6	50
1574	**2156**	**Total**	**17**	**159**	**363**	**39**	**396**	**163**	**574**

Adult Findings Received July 1, 2015, to June 30, 2016
By County

SOURCE						
DCF – APS/ KDADS/ KDHE	Total Number of Victims	County	Abuse	Exploitation	Fiduciary Abuse	Neglect
1	1	Allen	-	-	1	-
0		Anderson	-	-	-	-
1	1	Atchison	-	1	-	-
0		Barber	-	-	-	-
3	3	Barton	3	-	-	--
4	4	Bourbon	-	1	3	-
		Brown	-	-	-	-
14	14	Butler	5	5	4	2
0		Chautauqua	-	-	-	-
4	4	Cherokee	2	1	2	-
0		Cheyenne	-	-	-	-
2	2	Clark	-	-	-	2
0		Clay	-	-	-	-
1	1	Cloud	-	-	-	-
2	2	Coffey	1	-	1	-
0		Comanche		-	-	-
16	16	Cowley	2	1	1	13
3	3	Crawford	1	-	2	-
0		Decatur	-	-	-	-
1	1	Dickinson	-	-	1	-
1	1	Doniphan	-	-	1	-

13	13	Douglas	3	5	4	2
1	1	Edwards	-	1	-	-
1	1	Elk	1	-	-	-
4	4	Ellis	2	-	2	-
0		Ellsworth	-	-	-	-
3	3	Finney	-	-	2	1
6	6	Ford	1	3	2	-
3	3	Franklin	-	-	3	-
4	4	Geary	1	-	3	-
0		Gove	-	-	-	-
0		Graham	-	-	-	-
0		Grant	-	-	-	-
0		Gray	-	-	-	-
3	3	Greenwood	-	1	-	2
0		Hamilton	-	-	-	-
2	2	Harper	2	-	-	2
5	5	Harvey	3	2	-	-
0		Haskell	-	-	-	-
0		Hodgeman	-	-	-	-
0		Jackson	-	-	-	-
1	1	Jefferson	-	-	1	-
0		Jewell	-	-	-	-
26	29	Johnson	7	5	5	10
0		Kearny	-	-	-	-
2	2	Kingman	-	-	2	-
1	1	Kiowa	-	1	-	-

5	5	Labette	2	-	1	2
4	4	Leavenworth	-	2	2	-
0		Lincoln	-	-	-	-
0		Linn	-	-	-	-
0		Logan	-	-	-	-
2	2	Lyon	-	-	1	1
0		Marion	-	-	-	-
1	1	Marshall	1	-	-	-
8	10	McPherson	2	5	1	-
1	1	Meade	-	1	-	-
2	2	Miami	1	-	1	-
1	1	Mitchell	-	1	-	-
5	5	Montgomery	2	1	1	4
0		Morris	-	-	-	-
0		Morton	-	-	-	-
0		Nemaha	-	-	-	-
2	2	Neosho	-	-	2	-
0		Ness	-	-	-	-
0		Norton	-	-	-	-
3	4	Osage	1	1	1	-
2	2	Osborne	1	-	-	1
4	4	Ottawa	-	2	2	-
0		Pawnee	-	-	-	-
0		Phillips	-	-	-	-
5	5	Pottawatomie	1	1	3	-
1	1	Pratt	-	1	-	-

0		Rawlins	-	-	-	-
24	24	Reno	2	2	17	3
0		Republic	-	-		-
1	1	Rice	-	-	1	-
2	2	Riley	1	-	-	1
1	1	Rooks	-	1	-	-
2	2	Russell	-	2	-	-
7	7	Saline	2	3	1	2
65	67	Sedgwick	11	25	19	12
2	2	Seward	-	-	-	2
40	41	Shawnee	15	20	2	7
0		Sheridan	-	-	-	-
0		Sherman	-	-	-	-
1	1	Smith	-	1	-	-
0		Stevens	-	-	-	-
5	5	Sumner	-	1	4	-
1	1	Thomas	-	1	-	-
0		Trego	-	-	-	-
0		Wabaunsee	-	-	-	-
2	2	Washington	1	-	-	1
0		Wilson	-	-	-	-
0		Woodson	-	-	-	-
25	25	Wyandotte	9	7	4	7
352	**361**	**Total**	**87**	**104**	**103**	**78**

DCF Glossary Terms of Abuse

Child Abuse Definitions

Abuse/Neglect: Reports assigned for Abuse/Neglect require an investigation to determine the validity of the report and an assessment to determine if further action may be needed.

Physical Abuse: 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

Sexual Abuse: Any contact or interaction with a child in which the child is being used for the sexual stimulation of the perpetrator, the child, or another person. Sexual abuse shall include, but is not limited to, allowing, permitting, or encouraging a child to:

A. Be photographed, filmed, or depicted in obscene or pornographic material; or

B. be subjected to aggravated human trafficking, as defined in K.S.A. 2014 Supp. 21-5426(b), and amendments thereto, if committed in whole or in part for the purpose of the sexual gratification of the offender or another, or be subjected to an act which would constitute conduct proscribed by article 55 of chapter 21 of the Kansas Statutes Annotated or K.S.A. 2015 Supp. 21-6419 or 21-6422, and amendments thereto. K.S.A. 38-2202. (See Appendix 2A for Kansas Statutes Annotated references).

Contact solely between children shall meet the criteria only if the contact also involves force, intimidation, difference in maturity or coercion. K.A.R. 30-46-10 (i)

Mental or Emotional Abuse: Infliction of mental or emotional harm or the causing of a deterioration of a child, and may include, but shall not be limited to, maltreatment or exploiting a child to the extent the child's health or emotional wellbeing is endangered. This term may include any act, behavior, or omission that impairs or endangers a child's social or intellectual functioning. This term may include the following:

1. terrorizing a child, by creating a climate of fear or engaging in violent or threatening behavior toward the child or toward others in the child's presence that demonstrates a flagrant disregard for the child;

2. emotionally abandoning a child, by being psychologically unavailable to the child, demonstrating no attachment to the child, or failing to provide adequate nurturance of the child; and

3. corrupting a child, by teaching or rewarding the child for unlawful, antisocial, or sexually mature behavior. K.S.A. 38-2202 and K.A.R. 30-46-10

Physical Neglect: Acts or omissions by a parent, guardian, or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. This term may include but shall not be limited to: failure to provide the child with food, clothing, or shelter necessary to sustain the life or health of the child. K.S.A. 38-2202

Medical Neglect: Acts or omissions by a parent, guardian, or person responsible for the care of a child resulting in harm to a child, or presenting a likelihood of harm, and the acts or omissions are not due solely to the lack of financial means of the child's parents or other custodian. This term may include the following, but shall not be

limited to: failure to use resources available to treat a diagnosed medical condition if such treatment will make a child substantially more comfortable, reduce pain and suffering, or correct or substantially diminish a crippling condition from worsening. A parent legitimately practicing religious beliefs who does not provide specified medical treatment for a child because of religious beliefs shall not for that reason be considered a negligent parent. K.S.A. 38-2202

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

Abandonment: Forsake, desert or cease providing care for the child without making appropriate provisions for substitute care. K.S.A. 38-2202

Adult Abuse Definitions

Abuse: Any act or failure to act performed intentionally or recklessly that causes or is likely to cause harm to an adult.

Exploitation: Misappropriation of an adult’s property or intentionally taking unfair advantage of an adult’s physical or financial resources for another individual’s personal or financial advantage by the use of undue influence, coercion, harassment, duress, deception, false representation of false pretense by a caretaker or another person K.S.A. 39-1430(d).

Fiduciary Abuse: A situation in which any person who is the caretaker of, or who stands in a position of trust to, an adult, takes, secretes, or appropriates his/her money or property, to any use of purpose not in the due and lawful execution of such person’s trust or benefit.

Neglect: The failure or omission by one’s self, caretaker or another person with a duty to supply or to provide goods or services which are reasonably necessary to ensure safety and well-being and to avoid physical or mental harm or illness K.S.A. 39-1430 (c).