IN THE CIRCUIT COURT OF JACKSON COUNTY, MISSOURI
AT KANSAS CITY

Keiona Doctor, sister and heir-at-law of A.J.,
Judy Conway, Special Administrator of the Estate of A.J., deceased,
Dainna Pearce, disclaimed heir-at-law of A.J.,
PLAINTIFFS,

v.

Case No.
Division:

State of Missouri Employees:
Rebecca Caldwell,
Jamie Pinney,
Kallie Fewins,
Julie King,
Mari Wheeler,
Michael Beetsma,
Megan Bruce,
Richard Bird,
Britany Burleson,
Madonna Forthofer,
Jane Doe, real name unknown,
John Doe, real name unknown,
and,
The State of Kansas,
Department for Children and Families,
Phyllis Gilmore,
In her Official Capacity as Secretary,
and,
Family Guidance Center of St. Joseph,
a/k/a Family Guidance Center
Northwest Health Services,
Chave May,
Employee of FGC,
and,
Spofford
n/k/a Cornerstones of Care,
Kiara Ohle,
Former Therapist for A.J.,
Employee of Spofford.
DEFENDANTS.

PETITION

Plaintiffs state as follows:

INTRODUCTION

This wrongful death lawsuit involves the grotesque circumstances surrounding the tragically short and brutish life of A.J., a little boy who died a horrific, unimaginably gruesome death at the hands of his father and stepmother, an entirely avoidable child-homicide that gives rise to this civil action on behalf of A.J.'s heirs.

Unlike many other abused and neglected children whose abuse occurs under a veil of darkness and secrecy, A.J.'s mistreatment was the repeated subject of a seemingly endless series of reports and hotline calls to social workers and social service agencies in both Missouri and Kansas. But instead of responding by permanently removing the child from his home, the agencies and social workers took a strangely different approach: They meticulously investigated and carefully documented every violent kick, punch, slap, and injury inflicted upon A.J. by his sadistic father and stepmother, and generated stacks of records and reports chronicling the ceaseless, stomach-churning abuse. But their idea of intervention was limited, almost exclusively, to having A.J.'s father and stepmother sign a piece of paper agreeing to stop torturing the child – the legal equivalent of a "pinky swear." As it turned out, that signed paper might as well have been A.J.'s death warrant.

When the abuse reached such a level that the social workers were finally forced to act, A.J. was temporarily removed from his squalid home and placed in a facility for medically neglected children. But A.J.'s reprieve was short lived, and he was eventually returned to his abusive father and stepmother where, predictably and unsurprisingly, he suffered a tragic but completely avoidable

death at their hands in October of 2015. Naked, tortured, and starved to death, his remains were found discarded in a pig pen on a farm in Kansas.

The child service agencies and social workers who were A.J.'s only chance for survival, and who are the subject of this lawsuit, could have stepped in and rescued A.J. at any point during the child's lengthy, unimaginable ordeal – that was their job, after all. But instead of intervening, they chose to act like disinterested bystanders. Despite all the warning signs, the hotline calls, and the evidence of the child's mistreatment, they effectively allowed his father and stepmother to continue to abuse, torture, and ultimately murder the little boy, while they stood idly by, writing it all down.

This wrongful death action is being brought by the heirs of A.J., who seek to hold accountable, in a court of law, the numerous individuals who failed miserably in their duty to intervene and protect the life of this helpless, vulnerable young victim.

INDEX

PARTIES

1. Plaintiffs incorporate by reference all paragraphs in this document, as if fully set forth herein.
2. A.J. was born May 2008.
3. A.J. died sometime in mid-September to mid- October, 2015, when he was seven years old.
4. The last known addresses for A.J. are in Kansas City, Kansas, St. Joseph, Missouri, and Plattsburg, Missouri.
5. A.J.'s remains were found in a pig pen in Kansas City, Kansas, in November, 2015.
6. A.J.'s biological oldest adult sister is Keiona Doctor, born 1996.
7. Keiona Doctor is A.J.'s sister and heir-at-law.
8. Judy Conway, A.J.'s maternal grandmother, is appointed as Special Administrator in *In the Matter of the Estate of [A.J.]*, 2017-PR-000141, filed in the District Court of Wyandotte County, Kansas.
9. A.J.'s biological mother is Dainna Pearce.
10. A.J.'s biological father is Michael Jones.
11. A.J.'s parents were never married.
12. Dainna Pearce (Mother) has disclaimed **all** personal financial interest in A.J.'s estate.
13. On May 8, 2017, Michael Jones (Father) was convicted of murder in the first degree of A.J., disqualifying him of any inheritance as an heir-at-law of A.J.
14. The Missouri Department of Social Services (MoDSS) is an entity created by Missouri statute.
15. MoDSS is an agency of the State of Missouri.

16. The following persons were, at all relevant times, employees of MoDSS, acting in his or her capacity as an employee of and in the course of his or her employment with MoDSS, and at all relevant times, were under the direct supervision, employ and control of MoDSS:

    a. Rebecca Caldwell

    b. Jamie Pinney

    c. Kallie Fewins

    d. Julie King

    e. Mari Wheeler

    f. Michael Beetsma

    g. Megan Bruce

    h. Richard Bird

    i. Brittany Burleson

    j. Madonna Forthofer

    k. Jane Doe, real name unknown.

    l. John Doe, real name unknown.

17. The Kansas Department for Children and Families (KsDCF) is an entity created by Kansas statute.

18. KsDCF is an agency of the State of Kansas.

19. The Secretary for KsDCF is Phyllis Gilmore.

20. KsDCF was formerly known as the Department of Social and Rehabilitation Services (SRS).

21. On July 1, 2012, SRS changed its name per Executive Reorganization Order No. 41 to the Kansas Department for Children and Families (KsDCF). For purposes of this lawsuit, KsDCF

and SRS are considered the same entity.

22. For purposes of this lawsuit, KsDCF transacted business in Missouri by making and receiving telephone calls to persons in Missouri, faxing pages of documents to persons in Missouri, and sharing information about A.J., who is the subject of this litigation with persons in Missouri; by contracting with Missouri under the Interstate Compact on the Placement of Children (ICPC) for the purpose of fixing responsibility for children such as A.J., a child placed in a residential treatment facility, and by committing acts of negligence producing actionable consequences in Missouri.

23. The Family Guidance Center (FGC) f/k/a The Family Guidance Center of St. Joseph, Missouri, a/k/a Family Guidance Center for Behavioral Healthcare, is a business operating in the State of Missouri, at 724 North 22nd Street, St. Joseph, Missouri 64506.

24. FGC is currently owned by Northwest Health Services, Inc., 2303 Village Drive, St. Joseph, Missouri 64506, with a registered agent of Susan Daniels, 2303 Village Drive, P.O. Box 8612, St. Joseph, Missouri 64506.

25. FGC's registered agent is Garry Hammond, 724 N. 22nd Street, St. Joseph, Missouri 64506.

26. At all relevant times, within the State of Missouri, FGC employees, including Chave May, were acting within the authority and permission of FGC.

27. Spofford is a nonprofit corporation with an address of 9700 Grandview Road, Kansas City, Missouri 64137, and a registered agent designated as the Secretary of State of Missouri, 600 W. Main Street, Jefferson City, Missouri 65102.

28. On or about January 1, 2017, Spofford merged with Cornerstones of Care, a nonprofit corporation with an address of 300 East 36th Street, Kansas City, Missouri 64111, with a

registered agent of BC Agent Services, Inc. 3800 One Kansas City Place 1200 Main Street, Kansas City, Missouri 64105.

29. At all relevant times, within the State of Missouri, Spofford employees, including Kiera Ohle, were under the direct supervision, employment and control of Spofford, and acted upon the authority and permission of Spofford.

30. Chave May is an individual, residence unknown.

31. Kiara Ohle is an individual, residence unknown.

JURISDICTION AND VENUE

32. Plaintiffs incorporate by reference all paragraphs in this document, as if fully set forth herein.

33. This is a wrongful death claim brought by A.J.'s heirs under Section 537.080 RSMo, alleging negligence against the defendants.

34. Dainna Pearce, as A.J.'s mother, has standing to bring a wrongful death action in Missouri, under Section 537.080 RSMo.

35. To the extent the disclaimer filed by Dainna Pearce in *In the Matter of the Estate of [A.J.]*, 2017-PR-000141, filed in the District Court of Wyandotte County, Kansas, waives Ms. Pearce's standing to bring this action, Kionna Doctor, sister of A.J., brings a wrongful death action in Missouri, under Section 537.080 RSMo.

36. To the extent Kansas law applies, as authorized under K.S.A. 60-1801 *et seq*. the special administrator of A.J.'s estate, Judy Conway, brings a survival action for damages sustained by A.J. prior to death as a result of defendants' improper conduct.

37. A.J. was injured in and outside the state of Missouri.

38. The acts that give rise to this action occurred in Missouri.

39. Venue is proper in Jackson County on the following grounds: Spofford's registered agent is located in Jackson County, Missouri, and the exposure to danger resulting in death to A.J. from MoDSS employees named in this lawsuit, DCF, FGC, and Spofford occurred in Jackson County, Missouri.

40. Venue and jurisdiction are proper under 506.500, and 508.010 RSMo.

ALLEGATIONS COMMON TO ALL CLAIMS

41. Plaintiff incorporates by reference all paragraphs in this document, as if fully set forth herein.

42. After A.J. was born, he lived with his mother and siblings in Lawrence, Kansas, until he was approximately 2 ½ years old.

43. The first (1st) hotline call concerning A.J.'s welfare occurred in August, 2011, when KsDCF received a report that A.J. was left alone at his mother's home without adult supervision.

44. KsDCF determined A.J.'s mother failed to adequately supervise A.J., and A.J. was removed by KsDCF from his mother's physical custody.

45. A.J. was alive and healthy when he was removed from his mother's care in 2011.

46. In August, 2011, KsDCF placed A.J. in the physical custody of his Father, and noted on its records, "SRS services not indicated."

47. KsDCF failed to provide A.J. with services necessary for transition from his biological mother's home to his father's home in 2011.

48. A.J. never returned to live with his Mother after KsDCF placed A.J. with his Father.

49. In December 2011, approximately three months after A.J. was placed with his Father, a second (2nd) hotline call to KsDCF reported one of A.J.'s siblings (who was living with A.J.

and A.J.'s father) lost 23 pounds, Father had guns all over his house, in reach of the children, and Heather Jones (Stepmother) had been observed high on drugs.

50. In December 2011, KsDCF received a third (3rd) hotline call reporting A.J.'s sibling (who was living with A.J. and A.J.'s father) fell down stairs and suffered internal bleeding and extensive bruising on his forehead; a medical provider advised KsDCF the injury to A.J.'s sibling would not have been caused by falling down carpeted stairs.

51. During the investigation of the third (3rd) hotline call, Father admitted A.J. "busted his head open" about four weeks earlier, and A.J.'s siblings disclosed Stepmother caused the injuries to A.J.

52. During the investigation of the third (3rd) hotline call, Stepmother also reported to KsDCF that Father pulls down the children's pants, spanks and pushes the children away leaving marks, and there was domestic violence between her and Father in the home.

53. During the investigation of third (3rd) hotline call, KsDCF received information from a police officer that A.J. had a black eye and bruising on his face; when A.J. was interviewed by KsDCF, A.J. disclosed that his Father and siblings hit him and he fell down the stairs.

54. During the investigation of the third (3rd) hotline call, KsDCF interviewed A.J.'s siblings who disclosed Stepmother would take A.J. in the bathroom, after which choking sounds would occur, and Stepmother hit A.J. for urinating on the floor.

55. During the investigation of the third (3rd) hotline call, KsDCF conducted a forensic interview of A.J.'s siblings, who disclosed Father hits the children on the head, Father puts the children in a corner and hits the legs, stomach, and hands, Father's hands were red after he hit the children, and Stepmother kicked A.J. with a boot, hit A.J. in the head with toys and other

objects, and on one occasion, after A.J. went into the bathroom with Stepmother and choking sounds were heard, A.J.'s sibling thought A.J. was dead.

56. KsDCF's response to their investigation of the third (3rd) hotline call was to request Father sign a document promising to keep the children safe from physical abuse, not use physical discipline, and not allow Stepmother to have any contact with any of the children during the investigation.

57. After the third (3rd) hotline call, A.J. remained in Father's custody, but Stepmother's children were removed from Stepmother's custody and placed with a relative, pursuant to a District Court order stating an emergency existed threatening the safety of the children who were in danger of being harmed or injured.

58. KsDCF failed to remove A.J. from Father's care during their investigation of the third (3rd) hotline call involving Father's abuse and neglect of A.J.

59. By January, 2012, Father admitted to KsDCF that Stepmother was welcome to visit his home at any time notwithstanding Stepmother having been previously determined by KsDCF to be a child abuser; yet KsDCF took no action to enforce the document Father signed promising to keep A.J. safe, and KsDCF did not remove A.J. from Father's care.

60. On September 5, 2012, a Journal Entry was filed formalizing the placement made by KsDCF of A.J. to his Father's custody, in the District Court of Shawnee County, Kansas, case number 08D2414.

61. On December 6, 2012, barely three months after A.J. was formally placed with his Father, a fourth (4th) hotline call reported Father's children were getting spanked until their buttocks were bleeding; Father reported Stepmother inflicted the abuse (Stepmother reported that

Father inflicted the abuse), pigs are coming in and out of the home; and Stepmother filed a restraining order against Father.

62. During the investigation of the fourth (4th) hotline call, Stepmother admitted to KsDCF that Father spanked the children but denied that the children were bleeding as a result of the spanking, rather, Stepmother blamed the injuries on an innocuous skin condition.

63. KsDCF took no action to remove A.J. from his Father's care during the fourth (4th) hotline call, notwithstanding the documented history of abuse against A.J. in his Father's home, and that KsDCF removed A.J. from his biological mother's care for less severe allegations.

64. On December 13, 2012, A.J. was admitted to the Family Service and Guidance Center of Topeka, Kansas, as a danger to himself, with a diagnosis of disruptive behavior disorder, parent-child relational problem, and a Global Assessment of Functioning (GAF) score of 55.

65. During A.J.'s assessment with FGC Topeka, Father admitted A.J. was bedwetting, stealing and hoarding food, picking at sores on his body, and lighting fires.

66. Bedwetting, stealing and hoarding food, picking and sores, and lighting fires are behavioral characteristics of trauma responses in pre-school children who are victims of child abuse.

67. Sometime between December 2012, and March 2013, A.J. moved to Missouri with his Father, Stepmother and siblings.

68. On March 4, 2013, barely three months after the fourth hotline call to Kansas, a fifth (5th) hotline call reported to MoDSS that A.J. was forced to stand in the corner for over an hour as punishment and was forgotten by his Father and Stepmother, A.J. had locks on his bedroom door on the outside, A.J. starts fires, dead animals are in the garage and the house was filthy with mice and chicken bones.

69. MoDSS determined the fifth (5th) hotline call required a Level 2 response, which is considered a mid-range emergency relating to harm to a child.

70. On March 4, 2013, Rebecca Caldwell was assigned by MoDSS to investigate the fifth (5th) hotline call, supervised by Jamie Pinney.

71. Within one day of the fifth (5th) hotline call, as part of her investigation, on March 5, 2013, Caldwell went to Father's home located in Plattsburg, Missouri, where she conducted the following investigation:

a. Talked with Stepmother and Father;

b. Interviewed A.J. in front of Father and Stepmother, and while A.J. was explaining getting locked into his bedroom, Stepmother interrupted and attempted to offer an explanation;

c. Interviewed Father's landlord;

d. Requested history from KsDCF on Stepmother.

72. Caldwell reached the following conclusions during her March 4, 2013, investigation of the fifth (5th) hotline call:

a. Stepmother and Father were residing in the same home;

b. The floors of the home were filthy;

c. Father agreed the house was filthy and explained they were in process of moving in the home over the weekend;

d. The garage had bags with dead rabbits;

e. There was a lock outside of A.J.'s bedroom door but not attached to the trim of the door;

f. Father and Stepmother admitted to a history with Kansas social services for lack of supervision, with removal of the children, and Stepmother attempted to blame it of A.J. hitting another child;

g. A.J. disclosed that his Father locked him in his bedroom when he was in trouble;

h. KsDCF reported Stepmother physically abused her children, Stepmother blamed the child's bruising on falling down the stairs, and children were removed from her care;

i. A.J. started fires.

73. On April 5, 2013, Caldwell returned to Father's home, where she conducted the following follow-up investigation:

a. A.J. was interviewed in the presence of Stepmother about whether A.J. liked his new home, but A.J. was not interviewed about physical abuse or neglect;

b. A.J. appeared to having bruising on his right cheek and forehead;

c. Caldwell did not seek a medical opinion concerning the bruising on A.J.'s right cheek and forehead and concluded the marks were "dirt";

d. Stepmother again admitted to past involvement with KsDCF where children were removed from her care.

74. On April 7, 2013, Caldwell received seven (7) pages of typed reports from KsDCF showing a significant prior history involving Stepmother's lack of supervision of children in her care; children being removed from Stepmother's care due to physical abuse, and an incident where Stepmother shot herself in the foot.

75. On April 7, 2013, Caldwell concluded her investigation and indicated the following on the MoDSS form: (1) "case will not be opened" without explanation; (2) "home-schooling"

was checked as the "results" of her child abuse and neglect report; (3) MoDSS services were not provided, except Caldwell provided a phone number to Stepmother for counseling; (4) the school liaison for A.J. was not notified even though none of the school-age children were attending school.

76. On April 8, 2013, Caldwell's supervisor, Pinney signed the MoDSS form prepared by Caldwell (containing the results of Caldwell's investigation of the fifth (5th) hotline call) indicating Pinney concurred with and approved of Caldwell's conclusions.

77. Neither Caldwell nor Pinney followed up with the Jones' family to determine if A.J. was safe, attending school, or receiving appropriate medical care.

78. On July 8, 2013, MoDSS received a sixth (6th) hotline call, reporting emergency abuse and neglect occurring at Father's Plattsburg address including that Stepmother beats the "living daylights out of the kids for no reason," with the use of objects; Stepmother sells "meth" out of the home; children were unattended outside; children were locked in a room; and the abuse happened more than once.

79. MoDSS assigned the sixth (6th) hotline call a Level 2 response, and MoDSS caseworker Caldwell was assigned to investigate, with Pinney as supervisor.

80. Miller contacted Clinton County Sheriff's Office law enforcement for assistance, and was advised by Officer Jackson--who was familiar with Father, *never* go to Father's home without two officers, for safety reasons.

81. On July 17, 2013, MoDSS caseworker Heather Miller went to Father's home, and interviewed A.J., who disclosed Father and Stepmother yell at him, Father kicks him in the head on the top and back, and a "bone" comes out; it hurts when Father kicks him, Father punches him

in the stomach, Stepmother pulls on his ears and it hurts; Stepmother throws him on the floor and is mean; Stepmother and Father lock him in his bedroom by himself; and a lock was observed on A.J.'s bedroom door.

82. As part of the investigation of the sixth hotline call, in July 2013, the Children's Advocacy Center located in St. Joseph, Missouri, conducted a forensic interview of A.J., where he disclosed being locked in his room and physical abuse by Stepmother and Father.

83. At this point, the central data base accessible to all MoDSS caseworkers (maintained by MoDSS) contained a severe history of abuse and neglect of A.J. by his Father and Stepmother, numerous hotline calls in Missouri, documented removal of children from Stepmother in Kansas due to child abuse, and a history of denial by Father and Stepmother that abuse and neglect were occurring in the home.

84. Based on the July 2013, hotline call investigation, MoDSS determined A.J. was a victim of neglect by a preponderance of the evidence, by Father and Stepmother, and this finding was not appealed by Father or Stepmother.

85. On July 18, 2017, a safety assessment was completed by MoDSS, where A.J. was determined to be "unsafe" in the home of Stepmother and Father.

86. After consultation with the Juvenile Office, MoDSS determined A.J. would not be removed from the Jones' home, and, instead, MoDSS would first attempt to provide intensive in-home services (IIS) and Family Centered Services (FCS) services to prevent abuse and neglect of A.J.

87. MoDSS assigned Kallie Fewins to provide ISS services, with Julie King as IIS supervisor.

88. On July 19, 2013, a meeting was held for ISS screening of Father and Stepmother for ISS services, with attendance by the Juvenile Officer, Father, Stepmother, Foster, Pinney, and King, at Father's home in Plattsburg.

89. During the July 19, 2013, meeting, as described in the previous paragraph, Stepmother admitted to more abuse of A.J., stating that she pulled A.J. by the ear and by his arm when A.J. could not be controlled by her, and she locked A.J. in his bedroom.

90. During the July 19, 2013, meeting described in previous paragraphs, MoDSS determined the following:

a. A.J. had serious mental health problems;

b. A.J. needed counseling and a new prescription for his medication;

c. Father and Stepmother have no medical coverage to pay for mental health services for A.J. and had not located a medical provider for A.J.;

d. A.J. had an immediate need of a psychiatrist for medication management;

e. A.J. needed a psychological evaluation and play therapy;

f. Father and Stepmother needed child management education;

g. A.J. was not to be locked in his room;

h. Door alarms were needed;

i. There was an "imminent risk of physical abuse."

91. After two more ISS "visits" with MoDSS caseworkers at the Jones' home (on July 22 and July23, 2013) on August 1, 2013, Father and Stepmother instructed Fewins that they would no longer meet with MoDSS, they (including A.J.) were moving to Kansas, they did not feel a need for a psychiatrist for A.J. because they were not going to give A.J. medication, and it

would not be possible to meet every day for the required ISS services once they moved to Kansas.

92. On August 1, 2013, Fewins closed the Missouri DSS case and terminated MoDSS services, "due to the family residing in Kansas."

93. MoDSS took no action to remove A.J. from his Father and Stepmother's care or to notify Kansas authorities of harm to A.J., notwithstanding that MoDSS determined A.J. was presently "unsafe" in their care, Stepmother admitted to the abuse in the presence of MoDSS caseworkers, and neither Father nor Stepmother intended to follow or cooperate with a safety plan, or complete ISS services.

94. Almost ten days later, on August 9, 2013, MoDSS caseworker Sarah Ragan made a seventh (7th) hotline call to KsDCF and reported an IIS and FCS case had been opened in Missouri, Father and Stepmother did not cooperate, did not keep appointments or schedule services for A.J., Father and Mother's residence was primarily in Kansas, and there were continued concerns for A.J. including lack of mental health services and physical abuse, and that A.J. was homeschooled and not seen by outside members of the family on a regular basis which heightened concerns for A.J.'s safety.

95. On an unknown date, in response to the seventh (7th) hotline call, KsDCF made contact with Father and Stepmother, who advised they lived in Missouri.

96. On August 21, 2013, an eighth (8th) hotline call was made to MoDSS reporting A.J. was not being treated or provided for his medical needs, A.J. was locked in his room at night, A.J. was not being treated for mental health needs, and A.J. was "targeted" by Stepmother; KsDCF was notified by a hotline call.

97. MoDSS assigned the investigation of the eighth (8th) hotline call to MoDSS caseworker Mari Wheeler, with Michael Beetsma as supervisor.

98. MoDSS assigned a "priority response" Level 1 response to the August 21, 2013, which is the highest level of emergency for a child abuse hotline call, and contacted law enforcement for assistance for a visit at Father's Plattsburg, Missouri, home.

99. On August 21, 2013, a MoDSS caseworker (name unknown) and law enforcement went to Father's Plattsburg home, where the caseworker documented that Stepmother did not want the caseworker to enter the home, Stepmother stated she was instructed to discontinue A.J.'s medication, Father did not have medical coverage for A.J., Father has not arranged medical care for A.J., Stepmother was instructed to lock A.J. in his bedroom at night; Stepmother denied telling MoDSS that they were moving to Kansas; and Stepmother stated they did not need MoDSS ISS services.

100. On August 21, 2013, Wheeler documented risk factors for A.J.'s safety included the history of involvement with social services in Missouri and Kansas; six children in the home with guns, A.J.'s untreated mental illness, A.J. being locked in his bedroom, and MoDSS FCS and ISS terminated previously because family claimed to have moved to Kansas but appeared to remain in Missouri.

101. On October 7, 2013, MoDSS Wheeler entered a "final" risk level as "high," yet determined a case would not be opened, and signed her name indicating she approved of the facts and evidence; her supervisor, Bettmwa signed her name as the supervisor, certifying that she reviewed the document and concurred with the conclusions.

102. By October 7, 2013, the circumstances imperiling A.J.'s life were significantly higher than during the July 8, 2013, hotline call, when MoDSS determined removal of A.J. from the Jones' home would take place if ISS services failed to prevent abuse and neglect of A.J.

103. On February 25, 2014, MsDSS received a ninth (9th) hotline call reporting A.J. was being locked in his room, Father could not provide for A.J.'s mental health needs because of a lack of insurance, and A.J. was vulnerable for abuse and neglect.

104. The ninth (9th) hotline call was assigned a "Priority 1 response," the highest level available requiring a three hour response from MoDSS.

105. The ninth (9th) hotline call was determined by MoDSS to meet the definition of child abuse or neglect requiring further action, based on the determination that A.J.'s "Parent/caretaker ignored/disregarded pertinent information about either the child's behavioral history or self-management abilities or the history of the person harming the child."

106. MoDSS case worker Amanda Donnelly was assigned to investigate the ninth (9th) hotline call, and she made telephone contact with Father, who stated the family was living in Kansas, A.J. was eating everything in sight, Father did not have insurance to meet A.J.'s mental health needs, Father locked A.J. in his room at night, Father kept the other children away from A.J., Father stated it would be best for A.J. to be in State custody, and Father did not want A.J. to return to his home.

107. Donnelly contacted KsDCF caseworker Kaitlyn White and advised White about the ninth (9th) hotline call, and that A.J. was in Kansas, according to her conversation with Father.

108. On March 3, 2014, Donnelly, with the assistance of law enforcement, went to Father's home in Missouri where she met with A.J., who appeared to have suspicious marks on his chin and

forehead, and A.J. disclosed to Donnelly that he was forced to stand in the corner and do jumping jacks and pushups all day.

109. On March 3, 2014, during Donnelly's visit to Father's home, A.J. showed Donnelly a two inch vertical line on his wrist where A.J. said Father taped his arms and legs as punishment; Donnelly observed the lines on A.J.'s wrist, and concluded the mark appeared older than A.J.'s description of when the taping occurred without seeking a medical opinion.

110. On March 4, 2014, MoDSS caseworker Megan Bruce screened Father and Stepmother for a Voluntary Placement Agreement (VPA), using a form titled "Custody Diversion Protocol" and Bruce provided the following information:

a. Checkmark of "***no***" in response to the question "Is there a current allegation of abuse and/or neglect;

b. ***Blank line*** in response to the question "Any concerns related to the safety of the child?"

111. After the Custody Diversion Protocol screening form was completed by Bruce, on March 4, 2014, Bruce referred and A.J. was accepted into the VPA.

112. MoDSS referred A.J. to the Family Guidance Center (FGC) for A.J.'s placement and mental health treatment services.

113. Malia Clark, OSA 1, agent of FGC accepted A.J. as a referral from the MoDSS.

114. FGC diagnosed A.J. with post-traumatic stress disorder, with a GAF of 24, and determined A.J. qualified for services.

115. FGC placed A.J. with the Spofford Residential Treatment Center located in Grandview, Jackson County, Missouri.

116. FGC was aware A.J. was a referral from MoDSS, and that funding for A.J.'s residential treatment was provided by MoDMH.

117. A.J. was placed at Spofford by FGC from approximately March 7, 2014, to September 4, 2014.

118. While A.J. was placed at Spofford, on March 17, 2014, Bird sent an email to Bruce advising Father did not want A.J. "back," and Bird was concerned about paying for residential treatment when Father was not willing to take A.J. back into the home.

119. In his March 17, 2014, email from Bird to Bruce, nothing was mentioned about A.J.'s safety, or the risk of harm to A.J. of being released back to his Father's custody, who expressed his desire to abandon A.J.

120. Nine days later, as part of the ninth (9th) hotline investigation, MoDSS caseworker Cathy Coy, on behalf of Megan Bruce conducted a risk assessment and scored a "medium" risk for neglect of A.J., and the risk of "high" for abuse of A.J. for abuse; Richard Bird, supervisor, reviewed the assessment, concurred with the conclusion, and signed his name approving the document on March 26, 2014.

121. During A.J.'s placement at Spofford, A.J.'s medical records were obtained from numerous sources indicating A.J. had been hospitalized twice at Crittenton in 2013, hospitalized once at KVC in 2013, and diagnosed with post-traumatic stress disorder.

122. A.J.'s medical records maintained by Spofford, revealed A.J. experienced severe abuse and neglect, and exhibited behaviors confirming A.J. suffered severe trauma, including night terrors, hoarding food, running from home, suicidal ideations, homicidal ideations, sexual acting out, aggression, hurting animals and people, and setting fires.

123. During A.J.'s placement at Spofford, Father and Stepmother were required, but refused to participate in A.J.'s treatment plan that required them to attend the initial treatment plan meeting, weekly treatment updates, telephone communication with A.J., and in-person contact with A.J.

124. During the first three months of A.J.'s placement at Spofford, A.J.'s first primary therapist Kevin Wilburn characterized Father and Stepmother's lack of participation as "abandonment" in an email sent to Father on May 5, 2014, and he indicated he planned on contacting MoDSS to advise them his concerns. (Wilburn left Spofford employment shortly therafter.)

125. Wilburn's characterization of Father's lack of participation with A.J.'s treatment plan is consistent with Father's statement to MoDSS employee Bird that he did not want A.J. back.

126. Wilburn's email to Father and Stepmother was electronically signed and made part of A.J.'s electronic file at Spofford.

127. Throughout A.J.'s placement at Spofford, a representative from the FGC appeared in person for A.J.s treatment planning meetings, where A.J.'s treatment plan, A.J.'s circumstances that led to admission, A.J.'s history and diagnosis, and other issues relating to A.J. were discussed.

128. Throughout A.J.'s placement at Spofford, several Spofford employees attempted to communicate with Father and Stepmother about their lack of participation in A.J.'s treatment plan, but Father and Mother refused to respond to the communication.

129. A.J. progressed in treatment at Spofford, when his Father and Stepmother did not participate or communicate with him for several months.

130. Spofford determined A.J.'s discharged date as September 4, 2014.

131. On August 11, 2017, as A.J.'s discharge date was approaching, Chave May, employee of FGC, sent an email to Spofford, stating that Father and Stepmother would be required to meet the "minimum requirements" set by FGC and Spofford for A.J. to be discharged into their custody, including a transition period where Father would have three face-to-face interactions with A.J. per week, family therapy, overnight pass, family visits, and other requirements.

132. On August 19, 2014, Spofford's Director of Therapy sent an email to FGC acknowledging the lack of participation by Father, stating that Father leads a "crisis oriented lifestyle" and Father needed to be held "accountable."

133. On August 27, 2014, Spottford conducted a review of A.J.'s treatment plan and estimated a "completion" date for A.J.'s level of care as December 13, 2014; with a plan for aftercare to include coordination of services with parents, Spottford staff, school, psychiatrist, nursing, MoDSS, and community resources through monthly reports, meetings,, and other contacts as appropriate.

134. On August 27, 2014, Spofford determined A.J.'s discharge date of September 4, 2014, was contingent upon Father and Stepmother completing the transition plan as described in the previous paragraphs.

135. On August 28, 2014, a tenth (10th) hotline call was made to MoDSS at 12:45 p.m., reporting Father was unwilling to meet A.J.'s needs, A.J. was placed at Spofford by MoDSS due to a hotline call, A.J. was diagnosed with post-traumatic stress disorder, A.J. was soon to be discharged from Spofford to Father but Father would not return phone calls, Father was not cooperative with A.J.'s mental health treatment, and Father expressly stated he would not follow up to set appointments for outpatient after A.J. was discharged.

136. MoDSS records indicate other agencies may have been notified about the tenth (10th) hotline call.

137. The tenth (10th) hotline call reported Father's address as 5201 N. 99th Street, Kansas City, Kansas.

138. MoDSS caseworker Brittany Burleson was assigned to investigate the tenth (10th) hotline call, supervised by Madonna Forthofer.

139. Father and Mother failed to participate or cooperate with Spofford's transition plan.

140. On September 4, 2014, Spofford discharged A.J. to Father and Stepmother's care at 8:00 a.m. with recommendations for A.J. to continue the aftercare plan, including enrollment in school, individual therapy with family therapy.

141. Spofford did not follow up with A.J. after he was discharged into Father's care.

142. On September 23, 2014, Burleson placed a telephone call to a Crystal Deets, MoDSS caseworker, who advised Burleson that A.J. was discharged to his father, and after the discharge, Father moved A.J. to Kansas.

143. Burleson concluded the tenth (10th) hotline report did not meet the statutory definitions or conditions for a child abuse or neglect report, notwithstanding that she received the same information about A.J. in the tenth (10th) hotline call, that MoDSS received in its February 25, 2014, ninth (9th) hotline call which prompted a Priority 1 priority emergency response and investigation by MoDSS of A.J.'s safety.

144. On September 23, 2014, Burleson concluded that a case file would not be opened, and she closed the case, with her action approved on that same date by Forthofer.

145. On October 4, 2014, Stepmother sent an email to Kiara Ohle, A.J.'s primary therapist employed by Spofford, stating A.J. "was back to the same stuff he was doing that got him put into the facility," A.J. had "outbursts," and was "threatening and hurting of his sister," A.J. was not enrolled in school, and A.J. was "getting to be too much all over again."

146. On October 9, 2014, Ohle responded to Stepmother by email, reminding Stepmother of A.J.'s treatment plan requiring Stepmother and Father to maintain a structured environment, psychiatric appointments, individual therapy, and family therapy, and if she and Father could not provide this, A.J. should not remain in the home. Ohle, also advised Stepmother that a failure to enroll A.J. in school is educational neglect, and Stepmother should consider making a hotline report to the DCF in Kansas to ask for assistance since A.J.'s "safety and the safety of the other children are in jeopardy" and Stepmother's "ability to keep them safe."

147. Ohle's communication with Stepmother in October 2014 was electronically signed, and made part of A.J.'s electronic file at Spofford.

148. Ohle failed to warn any authorities of the risk of harm to A.J., despite her knowledge that Stepmother provided information to her about A.J. in her October 2014, email, that Ohle believed should be hot-lined to Kansas.

149. On October 14, 2014, KsDCF filed an action to collect child support on Father and A.J's behalf, against A.J.'s mother in the District Court of Wyandotte County, Kansas, based on Father's address in Kansas City, Kansas.

150. The KsDCF child support case was concluded in May, 2015, after a court order was entered providing KsDCF receive all child support monies collected from A.J.'s mother as reimbursement for the welfare KsDCF provided to Father on A.J.'s behalf.

151. KsDCF was aware of Father's address through Father's contact with child support division of KsDCF.

152. Sometime during 2014 and 2015, KsDCF received several hotline calls reporting pictures of A.J. tortured and abused posted on Stepmother's Facebook page.

153. KsDCF failed to properly respond to the hotline calls received in 2014, and in 2015, concerning A.J. safety, notwithstanding that KsDCF had knowledge of A.J.'s whereabouts through its child support division.

154. A little over a year after his discharge from Spofford, A.J. died.

155. In November, 2015, A.J.'s remains were found by law enforcement in Kansas City, Kansas.

156. Following the discovery of A.J.'s remains, A.J.'s Father and Stepmother were convicted of first degree murder of A.J.

157. In April, 2017,the Performance Audit Report, part 1, prepared by the Legislative Division of Post Audit for the State of Kansas, found that KsDCF did not respond to all report center calls in a timely manner.

MINISTERIAL DUTIES IMPOSED BY STATUTE, RULE, AND REGULATION

158. Plaintiffs incorporate by reference all paragraphs in this document, as if fully set forth herein.

Missouri

159. MoDSS is charged with addressing the needs of the homeless, dependent and neglected children in the supervision and custody of MoDSS by insuring appropriate social services are provided to the family and developing and implementing preventive and early intervention social services. Section 210.001.1 RSMo.

160. MoDSS mandates protocols which give priority to ensuring the well-being and safety of the child in instances where child abuse and neglect has been alleged. Section 210.145.1 RSMo.

161. MoDSS is required to maintain an information system with the results of all investigations, family assessments and services, and other relevant information, operating at all times. Section 210.1(4) RSMo.

162. MoDSS is required to utilize structured decision-making protocols for classification of all child abuse and neglect reports, the protocols shall be given priority to ensuring the well-being and safety of the child, and the division shall promulgate rules regarding the structured decision-making protocols to be utilized for all child abuse and neglect reports. Section 210.145.2.

163. MoDSS is required to utilize protocol based on structured decision-making principles for classification of all child abuse and neglect hotline reports, criteria for classification, task assignment guidelines, and response priority. 13 CSR 35-31.010 *et. al.*

164. All child abuse and neglect reports received by MoDSS shall be classified based upon the reported safety risk and injury to the child including but not limited to the following factors:

a. If there is alleged physical abuse currently occurring;

b. If the child is in need of immediate psychiatric care due to alleged abuse;

c. Is the child afraid to go home;

d. Does the alleged perpetrator have access to the child in the next twenty-four hours;

e. If there are prior reports of child abuse or neglect;

f. If the child is exhibiting severe emotional trauma or physical injury due to sexual abuse. 13 CSR 35-31.020. Child Welfare Manual Sec. 2, Chapt. 1.

165. MoDSS structured decision making protocol, includes but is not limited to:

a. Screening the hotline report to determine if the allegations meet the statutory definition of abuse or neglect;

b. Properly determining whether to place case on investigative or family assessment track;

c. Investigating allegations of abuse and neglect;

d. Properly concluding a child abuse and neglect report;

e. Maintaining minimum contacts after a child abuse and neglect report has been concluded. Child Welfare Manual, Section 2, Chapt. 5.

166. MoDSS provides mandated protocol, policy, and procedure to divert a child from entering or remaining in state custody solely to access mental health services through its Voluntary Placement Agreement (VPA). 13 CSR 35-30.101(2).

167. In Missouri, child abuse is defined as any physical injury, sexual abuse, or emotional abuse inflicted on a child other than by accidental means; child neglect is defined as failure to provide, by those responsible for the care, custody, and control of the child, the proper or necessary support, education as required by law, nutrition, or medical, surgical, or other care necessary for the child's well-being. Section 210.110 RSMo.

168. The Missouri Department of Mental Health (MoDMH) is an entity created by Section 630.003 RSMo.

169. The MoDMH is defined as a child-placing agency for children under a VPA. Section 210.122.2.

170. Any function delegated from MoDSS to MoDMH regarding placement and care of children

shall be administered and supervised by MoDSS. Section 210.122(3).

171. Pursuant to Child Welfare Manual, Section 4, Chapter 24, MoDSS, required protocol for children under a VPA, include the following relevant steps:

a. To initiate the process, MoDSS must complete a screening/feedback form to ensure protocol is being applied under appropriate circumstances;

b. If a parent refuses to take the child home, MoDSS shall call an emergency meeting with the contacts of the other agencies including the MoDMH provider;

c. The parents shall be actively involved in assessment, development, and implementation of the treatment plan;

d. The VPA can only be used in conjunction with the Custody Diversion Protocol where no reason has been found to suspect abuse or neglect;

e. If abuse or neglect is suspected, the child abuse and neglect hotline should be contacted as required by law under Section 210.115.

f. The VPA is only to be used in conjunction with the Custody Diversion Protocol, and only made available to a parent *after* MoDSS has utilized the Custody Diversion Protocol.

g. If VPA is utilized, the MoDMH provider is responsible for locating an appropriate out-of-home placement and for monitoring that placement;

h. The MoDMH provider should notify MoDSS of any outstanding issues related to the child and/or parents while VPA is in place;

i. If a parent rejects the services offered and refuses to take the child home or find alternative means to care for the child, MoDSS shall initiate a referral to the Court.

172. MoDMH has statutory authority to recognize providers of psychiatric services as administrative entities where the provider serves as an agent of MoDMH in a defined region under Section 630.407 RSMo.

173. MoDSS authorizes MoDMH to place the child, administer the placement, and provide care and treatment for the child while the child is under the Voluntary Placement Agreement. 13 CSR 35-30.010(4).

174. FGC is a certified mental health provider for the Missouri Department of Mental Health (MoDMH) for the Western Region of Missouri, including St. Joseph, Missouri.

175. FGC serves as an independent contractor for MoDMH for Service Area 1, with responsibility for assessment and services to children in its assignee areas, and for providing follow-up services.

176. Spofford is a children's services provider as defined under Section 210.110(5), required to have the appropriate training, education, and expertise to provide the highest quality of services possible consistent with the federal standards but not less than the standards and policies used by MoDSS. Section 210.112(4).

Kansas

177. The Secretary of KsDCF is required by Kansas statute to adopt all general policies, rules, and regulations relating to all forms of KsDCF services provided to children. K.S.A. 75-5321.

178. K.S.A. 38-2230 provides KsDCF owes a duty to investigate reports of child abuse, and if reasonable grounds exist to believe abuse or neglect exist, immediate steps shall be taken to protect the health and welfare of the abused or neglected child.

179. K.A.R. 30-46-10(b) defines “Abuse” as “physical, mental or emotional abuse” or “sexual abuse,” as these two terms are defined in K.S.A. 38-2202 and amendments thereto and as “sexual abuse” is further defined in this regulation, involving a child who resides in Kansas or is found in Kansas, regardless of where the act occurred. The term “abuse” shall include any act that occurred in Kansas, regardless of where the child is found or resides, and shall include any act, behavior, or omission that impairs or endangers a child's social or intellectual functioning.

180. “Neglect,” as defined under K.S.A. 38-2202 means neglect involving a child who resides in Kansas or is found in Kansas, regardless of where the act or failure to act occurred and regardless of where the child is found or resides. K.A.R. 30-46-10

181. “Investigation” means the gathering and assessing of information to determine if a child has been harmed, as defined in K.S.A. 38-2202 and amendments thereto, as the result of abuse or neglect, to identify the individual or individuals responsible, and to determine if the individual or individuals identified should reside, work, or regularly volunteer in a child care facility. K.A.R. 30-46-10

182. “Harm” means physical or psychological injury, or damage. K.S.A. 38-2202(l).

183. Once KsDCF opens a case for investigation, KsDCF has a specific duty to conduct the investigation in a non-negligent manner.

184. KsDCF is responsible for administering child welfare services to all counties in Kansas.

185. KsDCF through its employees is responsible for making and enforcing rules, regulations, and policies for the proper management of children placed in its care.

186. KsDCF’s Policy and Procedure Manual (PPM) 0100 states that the PPM contains statements

of the principles and courses of action required for use by KsDCF employees and staff.

187. PPM 0110 states that "shall," "will," and "must" are words used in PPM that indicate a policy is applicable and that a course of action must be taken without discretion.

188. PPM 1015.A provides child protection service alerts received from a child welfare agency in other states are required to be forwarded to the Kansas Report Center, where staff shall search FACTS and KAECSES to determine current or past agency involvement, and if the family has current or past agency involvement, the alert shall be forwarded to the local office with the most recent information.

189. PPM 1015.B provides when KsDCF needs to send a child protection service alert, critical information relating to protection concern shall be forwarded to any state's child welfare by the local office as needed, and the alert shall contain identifying information for the family, summarize the protection concern, and list a KsDCF contact person.

190. PPM 1400 provides that if a report alleging abuse or neglect received from out of state, the procedures for opening a case are to be followed as indicated in PPM 1410.

191. PPM 1410 provides if services by another state or DCF office are required, the assigned DCF office is responsible for coordinating services.

192. PPM1422 provides the tasks of the investigating office are to accept the report of abuse or neglect, assess the report and make appropriate findings, make necessary FACTS entries for assessment and findings; investigate the report, and take emergency protective action if necessary.

193. PPM 1500 provides the response time assessment mandates that when there are reasonable grounds to believe abuse or neglect exists, immediate steps shall be taken to protect the

health and welfare of the abused and neglected child.

194. PPM 0600 provides all KsDCF agencies are one entity, including child support division, and all work together to carry out KsDCF mission.

Legal Duties Owed by All Parties to A.J.

195. A tort duty of all defendants to exercise reasonable care for A.J. arose when each defendant undertook to render services for A.J., which services were necessary for A.J.'s protection.

196. A special relationship giving rise to a duty to owe reasonable care to A.J. with regard to risk of harm from a third party, namely his Father and Stepmother, between A.J. and the defendants in this case, including MoDSS employees named in this lawsuit, DSF, FGC, Spofford, Chave May, and Kiera Ohle, on the grounds that one or more of these parties (1) stood in the shoes as a parent to A.J., (2) was a custodian with A.J. in his or her care; (3) an employer with employees whose employment facilitated the employee causing harm to A.J., and (4) a mental health professional with patients.

197. The knowledge of the risk of harm to A.J. from the foreseeable danger by A.J.'s Father and Stepmother, a condition which imperiled A.J.'s life, gives rise to a common-law duty to warn appropriate enforcement authorities of future harm to A.J., by the defendants in this case, including MoDSS employees named in this lawsuit, DCF, FGC, Spofford, Chave May, and Kiara Ohle.

CLAIMS

Negligence of Missouri Social Workers

198. All named parties employed by MoDSS owed a duty to A.J. to exercise ordinary care in the performance of their ministerial duties.

199. A tort duty of all named parties employed by MoDSS arose when they undertook to render services for A.J., which services were necessary for A.J.'s protection.

200. A special relationship between the named parties employed by MoDSS arose when MoDSS undertook to render services to A.J. necessary for his protection.

201. The knowledge of the danger to A.J. by his Father and Stepmother, gives rise to a duty to warn appropriate authorities of the risk of future harm to A.J.

202. All named parties employed by MoDSS breached his or her duties by failing to act or take any steps to protect A.J. from harm suffered in his Father and Stepmother's home including the following acts and omissions:

a. March 4, 2013, Hotline Call: MoDSS employees Rebecca Caldwell and her supervisor, Jamie Pinney

i. During her investigation of the March 2013, hotline call Caldwell went to the Jones' home where she obtained actual knowledge of danger to A.J., based on personally observing conditions in the home of abuse and neglect, hearing A.J.'s disclosure that his father locked him in his bedroom when he was in trouble, hearing other statements from witnesses that A.J. started fires, observing dead animals in A.J.'s home, and hearing the admissions by the family to a history of children being removed from Stepmother's custody by social workers in Kansas for several months based on physical abuse and lack of supervision.

ii. During her investigation of the March 2013, hotline call, Caldwell received confirmation of Stepmother's history of abuse and neglect from reviewing

written documents faxed from KsDCF documenting children were removed from the Jones' home (Heather Jones) due to physical abuse, and "quite a list of prior history with lack of supervision concerns" including an incident where Ms. Jones shot herself in the foot with a gun.

iii. On a follow up visit to the Jones' home on April 5, 2013, Caldwell obtained additional actual knowledge of danger to A.J. based on her observation of bruising on A.J.'s right cheek and forehead.

iv. Despite her actual knowledge, Caldwell failed to act or take any steps to protect A.J. from the harm he suffered in the Jones' home.

v. Caldwell breached her ministerial duty to follow mandated protocol by failing to seek an opinion from a medical provider about the bruising on A.J.'s face, and by improperly assessing and concluding A.J. was "safe" as a result of the safety assessment (Form CD17), and that no case should be opened with MoDSS.

vi. But for Caldwell's breach, she would have assessed and concluded A.J. was "unsafe," and she would have been required by the mandated protocol to prepare a "safety plan," consisting of safety interventions designed to protect A.J. from a threat of danger including removal of A.J. from the Jones' home; a plan for monitoring and verifying the safety plan for compliance if A.J. was not removed, assessing the safety plan for effectiveness of controlling threats of danger to A.J. until threats of danger were no longer present, and properly

closing out a safety plan once the threat of danger to A.J. was no longer present, and A.J. would be alive today.

vii. Caldwell's supervisor, Jamie Pinney, breached her ministerial duty to follow mandated protocol by approving Caldwell's assessment and conclusion that A.J. was "safe" after acquiring actual knowledge of the danger to A.J. as described above.

viii. Caldwell and her supervisor, Pinney, breached their duty to warn the appropriate authorities including law enforcement of the risk of future harm to A.J.

ix. As a direct and proximate cause of the breach of Caldwell's and Pinney's duties, A.J. was harmed and suffered damages, including death.

b. July 8, 2013 Hotline Call: MoDSS employees Kallie Fewins, supervised by Julie King

i. During the investigation of the July 2013 hotline call, MoDSS worker Kallie Fewins, supervised by Julie King, obtained actual knowledge of imminent danger to A.J. in the Jones' home, based on personal observations, A.J.'s disclosures of physical abuse including hitting and kicking him in the top and back of his head, and the MoDSS professional assessment tools, using mandated protocol which concluded A.J. was "unsafe" in the Jones' home, requiring a referral to the Juvenile Office for possible removal of A.J. from the Jones' home. In lieu of removal of A.J. from the Jones' home, after consultation with the Juvenile Officer, MoDSS required the Jones to first

accept and attempt intensive in-home services (ISS) and Family Centered Services (FCS) necessary for the protection of A.J.

ii. During the third home visit to the Jones' home, Fewins obtained additional actual knowledge of imminent danger to A.J. when Michael and Heather Jones stated unequivocally that they intended to refuse ISS and FCS, refuse medical treatment for A.J., and flee to Kansas with A.J.

iii. Despite her actual knowledge of the above described facts and that A.J. was still considered "unsafe" in the Jones' home, and that local law enforcement advised MoDSS to never go to the Jones' home without at least two law enforcement officers, Fewins failed to act or take any steps to protect A.J. from the harm he suffered in the Jones' home when she improperly terminated MoDSS ISS and FCS and closed A.J.'s case.

iv. Fewins breached her ministerial duty to follow mandated protocol by failing to change the MoDSS response (of requiring Jones' to accept ISS and FCS) to the July 2013 hotline call once Fewins realized the Jones refused to cooperate with the safety plan, and by failing to re-assess the safety plan to require immediate notification to law enforcement or other appropriate agencies for the purpose of taking A.J. into protective custody under Section 210.125, before the Joneses fled to Kansas with A.J.

v. But for Fewin's breach of her duty, A.J. would have been removed from the danger of the Jones' home, as required by the mandated protocol to assure A.J.'s safety, and A.J. would be alive today.

vi. Fewin's supervisor, Julie King, breached her ministerial duty to follow mandated protocol by approving Fewin's assessment and concluding that A.J.'s case should be closed with a termination of MoDSS services, after acquiring actual knowledge of the danger to A.J. as described above.

vii. Fewin and King breached their duty to warn the appropriate authorities including law enforcement and the State of Kansas, of the risk of future harm to A.J.

viii. As a direct and proximate cause of the breach of Fewin's and King's duties, A.J. was harmed and suffered damages, including death.

c. <u>August 21, 2013, Hotline Call: MoDSS employee Mari Wheeler and her supervisor, Michael Beetsma</u>

i. During her investigation of the August 2013, hotline call, Wheeler had actual knowledge based on document from a MoDSS caseworker who made a personl visit the Jones' home where she the case worker documented her observations of conditions in the Jones' home, including Stepmother's unwillingness to allow the social worker a face-to-face visit with the children, an admission by Stepmother that A.J. was not receiving mental health treatment, A.J. was locked in his room at night, and Stepmother was not willing to accept services by MoDSS.

ii. During her investigation of the August 2013, hotline call, Wheeler reviewed the file maintained by MoDSS for A.J., including the physical abuse disclosed

by A.J. in July 2013, and the KsDCF records showing a significant history of child abuse and neglect in the Jones' home.

iii. During her investigation of the August 2013, hotline call, Wheeler spoke with other MoDSS Fewins, who described how ISS was provided for only a short time before the Jones' refused to cooperate, and that A.J. was likely targeted in the home for abuse and neglect.

iv. Despite her actual knowledge, Wheeler failed to act or take any steps to protect A.J. from the harm he suffered in the Jones' home.

v. Wheeler breached her ministerial duty to follow mandated protocol by improperly assessing and concluding A.J. was "safe" and that no case should be opened with MoDSS.

vi. But for Wheeler's breach, she would have assessed and concluded A.J. was "unsafe," and she would have been required by the mandated protocol to prepare a "safety plan," consisting of safety interventions designed to protect A.J. from a threat of danger including removal of A.J. from the Jones' home; a plan for monitoring and verifying the safety plan for compliance if A.J. was not removed, assessing the safety plan for effectiveness of controlling threats of danger to A.J. until threats of danger were no longer present, and properly closing out a safety plan once the threat of danger to A.J. was no longer present, and A.J. would be alive today.

vii. Wheeler's supervisor, Michael Beetsma breached his ministerial duty to follow mandated protocol by approving Wheeler's assessment and conclusion that A.J. was "safe" after acquiring actual knowledge of the danger to A.J.

viii. Wheeler and Beetsma breached their duty to warn the appropriate authorities including law enforcement and the State of Kansas, of the risk of future harm to A.J.

ix. As a direct and proximate cause of the breach of Wheeler's and Beetsma's duties, A.J. was harmed and suffered damages including death.

a. <u>February 25, 2014, Hotline Call:MoDSS employee Megan Bruce and her supervisor, Richard Bird</u>

i. During her investigation of the March 2014, hotline call, Bruce had actual knowledge based on documentation provided by a MoDSS caseworker Donnelly who made a personal visit the Jones' home where she observed suspicious marks on A.J.'s chin and forehead, and a two inch vertical line on his wrist where A.J. said Father taped his arms; A.J also disclosed that he was required to stand in the corner or do jumping jacks and push-ups all day.

ii. During her investigation of the March 2014, hotline call, Bruce reviewed the file maintained by MoDSS for A.J., including the severe physical abuse disclosed by A.J. in July 2013, and the KsDCF records showing a significant history of child abuse and neglect in the Jones' home.

iii. During her investigation of the March 2014, hotline call, Bruce and Bird had actual knowledge that A.J. was the subject of abuse and neglect, making A.J. ineligible for the VPA.

iv. Bruce had constructive knowledge of A.J.s treatment plan at Spofford, including Father's inability and unwillingness to participate in A.J.'s treatment plan, or provide for A.J.'s needs upon discharge.

v. Despite her actual knowledge, Bruce failed to act or take any steps to protect A.J. from the harm he suffered in the Jones' home.

vi. Bruce breached her ministerial duty to follow mandated protocol by improperly assessing and screening A.J. for the Voluntary Placement Program (VPA), by failing during the custody diversion protocol to indicate "yes" in response to the question about A.J. as the subject of abuse or neglect and by failing to state the significant concerns related to A.J.'s safety which would have rendered A.J. ineligible for the VPA.

vii. Bruce additionally breached her ministerial duty to follow mandated protocol where the risk assessment scores indicate "medium" for neglect and "high" for abuse, and by failing to adequately monitor A.J.'s placement and services provided for A.J. while in-patient at Spofford, including discharge into his Father's care, who refused to participate in A.J.'s VPA treatment plan.

viii. But for Bruce's breach, she would have assessed and concluded A.J. was not eligible for the VPA, and that based on the risk assessment score, she would have been required by the mandated protocol to prepare a "safety plan,"

consisting of safety interventions designed to protect A.J. from a threat of danger including removal of A.J. from the Jones' home; a plan for monitoring and verifying the safety plan for compliance if A.J. was not removed, assessing the safety plan for effectiveness of controlling threats of danger to A.J. until threats of danger were no longer present, and properly closing out a safety plan once the threat of danger to A.J. was no longer present, and A.J. would be alive today, particularly considering that MoDSS considered removing A.J. from the Jones' home due to the risk of harm, six months prior to the February 25, 2014, hotline call, based on the similar allegations.

ix. Bruce's supervisor, Richard Bird, breached his ministerial duty to follow mandated protocol by approving Bruce's assessment and conclusion that A.J. was eligible for the VPA, after acquiring actual knowledge of the danger to A.J. as described above, rendering A.J. ineligible for the VPA.

x. Bruce and Bird breached their duty to warn the appropriate authorities including law enforcement and the State of Kansas, of the risk of future harm to A.J.

xi. As a direct and proximate cause of the breach of Bruce's and Bird's duties, A.J. was harmed and suffered damages including death.

b. <u>August 28, 2014 Hotline Call: Brittany Burleson, supervised by Madonna Forthofer</u>

i. During the investigation of the August 2014 hotline call, MoDSS worker, Brittany Burleson, supervised by Madonna Forthofer, obtained actual and constructive knowledge of danger and neglect to A.J. in the Jones' home,

based on the expressed concern of the reporter that A.J. was being discharged into the care of his Father, who stated that he would not provide mental health treatment for A.J, and the MoDSS central registry containing significant history of the danger to A.J. in the Jones' home.

ii. Burleson should have known A.J. was at risk for danger in Father's care, based on the significant history of abuse and neglect suffered by A.J. as recorded in his file maintained by the MoDSS central registry, as described in this lawsuit.

iii. Burleson failed to act or take any steps to protect A.J. from the harm he suffered in the Jones' home.

iv. Burleson breached her ministerial duty to follow mandated protocol to open a MoDSS case for investigation and further action where the allegations meet the statutory definition of abuse or neglect, and where similar allegations of abuse and neglect of A.J. reported in a previous hotline call received by MoDSS on February 25, 2014, were determined by MoDSS to be a "Level 1 Priority Response" requiring an immediate child abuse and neglect investigation under the same circumstances where the parent/caretaker ignored/disregarded pertinent information about either the child's behavioral history or self-management abilities or the history of the person harming the child.

v. But for Burleson's breach of her duty, A.J. would have been removed from the danger of the Jones' home, as required by the mandated protocol to assure A.J.'s safety, and A.J. would be alive today.

vi. Burleson 's supervisor, Madonna Forthofer, breached her ministerial duty to follow mandated protocol by approving Burleson''s assessment and conclusion that the August 2014 hotline report should not be opened for investigation or assessment, after acquiring actual and constructive knowledge of the danger to A.J. as described above.

vii. Burleson and Forthofer breached their duty to warn the appropriate authorities including law enforcement and the State of Kansas, of the risk of future harm to A.J.

x. As a direct and proximate cause of the breach of Burleson's and Forthofer's duties, A.J. was harmed and suffered damages including death.

c. Kansas Department for Children and Families; DCF employees who were assigned to the hotline calls concerning A.J. welfare from August 2013 through the time of A.J.'s death in 2015

i. From August 2013, through the time of A.J.'s death in 2015, KsDCF received numerous hotline calls concerning abuse and neglect of A.J. including documented hotline calls from MoDSS caseworkers in August 2013, and August 2014.

ii. During KsDCF's investigation of the hotline calls, KsDCF had actual knowledge of danger to A.J. in the Jones' home, based on DCF's significant history documenting abuse and neglect of A.J. suffered in the Jones' Kansas home, phone conversations with MoDSS caseworkers informing DCF of the significant history of abuse and neglect suffered by A.J. in the Jones' Missouri

home; hotline calls advising DCF about torture and abuse posted on Stepmother's Facebook page, and records from past court proceedings where children were removed from the Jones' home due to abuse and neglect.

iii. Despite KsDCF's actual knowledge, KsDCF failed to act or take any steps to protect A.J. from the harm he suffered in the Jones' home.

iv. KsDCF breached its special duty to A.J., who was a child whose history of abuse and neglect was documented in KsDCF's files, to accept and conduct a non-negligent investigation of the hotline calls concerning harm to A.J. in a non-negligent manner.

v. KsDCF breached their duty to warn the appropriate authorities including law enforcement and the State of Kansas, of the risk of future harm to A.J.

vi. But for KsDCF's breach, KsDCF would have assessed and concluded reasonable grounds existed to believe A.J. was in danger of harm, and KsDCF would have been required to take immediate emergency protective action to protect A.J.'s health and welfare, including removal of A.J. from the Jones' home, and A.J. would be alive today.

vii. As a direct and proximate cause of the breach of DCF's special duty, A.J. was harmed and suffered damages including death.

d. <u>Family Guidance Center: DMH provider for A.J. in 2014</u>

i. Upon MoDSS's referral of A.J. to DMH for the VPA program, FGC employee, Chave May, and other FGC employees obtained actual and constructive knowledge of danger and neglect to A.J. in the Jones' home,

based on the documentation contained in A.J.'s file, including that A.J.'s father and Stepmother did not meet the minimum requirements under the VPA for A.J. to be discharged into their custody, the March 7, 2014, FGC psychosocial assessment, A.J.'s previous medical records indicating severe abuse and neglect, A.J.'s quarterly psychiatric evaluations, A.J.'s treatment plan reports, and monthly in-person meetings, and the expressed concern of A.J.'s therapists employed by Spofford that A.J.'s father and Stepmother refused to participate in A.J.'s treatment plan throughout A.J.'s stay at Spofford, documentation that A.J. regressed and starting biting himself when he learned he might be discharged to his Father, and that in August 2014, Spofford planned to discharge A.J into the care of his Father, who expressly stated at the time of discharge that he would not follow through with A.J.'s treatment plan, including providing mental health treatment for A.J.

ii. FGC failed to act or take any steps to protect A.J. from the harm he suffered from his Father and Stepmother, who failed to meet the minimum requirements under the VPA program for accepting A.J. back into their physical care.

iii. FGC breached its duty to monitor placement and services provided by Spofford.

iv. FGC breached its duty to warn the appropriate authorities including law enforcement and the State of Kansas, of the risk of future harm to A.J.

v. But for FGC breach of her duty, the VPA program would have been extended, A.J. would not have been placed into his Father's care on September 4, 2014, MoDSS and KsDCF would have been warned of the danger to A.J. of Father's refusal to provide for A.J.'s needs, MoDSS and KsDCF would have taken emergency steps to assure A.J.'s safety upon release from Spofford, including notifying law enforcement for the purpose of taking A.J. into protective custody, and A.J. would be alive today.

vi. As a direct and proximate cause of the breach of FGC duties, A.J. was harmed and suffered damages including death.

e. Chave May: Employee of Family Guidance Center in 2014

i. Upon MoDSS's referral of A.J. to DMH for the VPA program, FGC employee, Chave May obtained actual and constructive knowledge of danger and neglect to A.J. in the Jones' home, based on the documentation contained in A.J.'s file, including that A.J.'s father and Stepmother did not meet the minimum requirements under the VPA for A.J. to be discharged into their custody, the March 7, 2014, FGC psychosocial assessment, A.J.'s previous medical records indicating severe abuse and neglect, A.J.'s quarterly psychiatric evaluations, A.J.'s treatment plan reports, and monthly in-person meetings, and the expressed concern of A.J.'s therapists employed by Spofford that A.J.'s father and Stepmother refused to participate in A.J.'s treatment plan throughout A.J.'s stay at Spofford, documentation that A.J. regressed and starting biting himself when he learned he might be discharged

to his Father, and that in August 2014, Spofford planned to discharge A.J into the care of his Father, who expressly stated at the time of discharge that he would not follow through with A.J.'s treatment plan, including providing mental health treatment for A.J.

ii. May failed to act or take any steps to protect A.J. from the harm he suffered from his Father and Stepmother, who failed to meet the minimum requirements under the VPA program for accepting A.J. back into their physical care.

iii. May breached her duty to monitor placement and services provided by Spofford.

iv. May breached her duty to warn the appropriate authorities including law enforcement and the State of Kansas, of the risk of future harm to A.J.

v. But for May's breach of her duty, the VPA program would have been extended, A.J. would not have been placed into his Father's care on September 4, 2014, MoDSS and KsDCF would have been warned of the danger to A.J. of Father's refusal to provide for A.J.'s needs, MoDSS and KsDCF would have taken emergency steps to assure A.J.'s safety upon release from Spofford, including notifying law enforcement for the purpose of taking A.J. into protective custody, and A.J. would be alive today.

vi. As a direct and proximate cause of the breach of May's duties, A.J. was harmed and suffered damages including death.

f. Spofford: Mental Health Services Provider for A.J. 2014

i. Upon FGC referral of A.J. to Spofford for the VPA program, Spofford employee, Kiara Ohle, and other Spofford employees obtained actual and constructive knowledge of danger and neglect to A.J. in the Jones' home, based on the documentation contained in A.J.'s file, the March 7, 2014, FGC psychosocial assessment, A.J.'s previous medical records indicating severe abuse and neglect, A.J.'s quarterly psychiatric evaluations, A.J.'s treatment plan reports, and monthly in-person meetings, and the expressed concern of A.J.'s therapists employed by Spofford that A.J.'s father and Stepmother refused to participate in A.J.'s treatment plan throughout A.J.'s stay at Spofford, the characterization of Father's lack of participation by A.J.'s therapist as "abandonment" requiring a hotline call to MoDSS, documentation that A.J. regressed and starting biting himself when he learned he might be discharged to his Father, and that in August 2014, Spofford planned to discharge A.J into the care of his Father, who expressly stated at the time of discharge that he would not follow through with A.J.'s treatment plan, including providing mental health treatment for A.J., and that A.J.'s father and Stepmother did not meet the minimum requirements under the VPA for A.J. to be discharged into their custody,

ii. In October, 2014, Spofford obtained actual knowledge of danger to A.J. during the period of Spofford's aftercare program, when Stepmother sent an email to Spofford employee Ohle in October 2014, stating that Father had not

enrolled A.J. in school, A.J. was out of control, and A.J.'s behaviors had regressed significantly, and Stepmother was unable to manage A.J.

iii. Spofford failed to act or take any steps to protect A.J. from the harm he suffered from his Father and Stepmother.

iv. Spofford breached its duty when its employees discharged A.J. back into the physical care of Father, who Spofford identified as a person unwilling and unable to meet A.J.'s needs necessary for A.J.'s health and welfare, without warning the appropriate persons of the risk of danger to A.J., and without performing the steps outlined in Spofford's aftercare program to monitor A.J.'s safety.

v. Spofford breached its duty to warn the appropriate authorities including law enforcement and the State of Kansas, of the risk of future harm to A.J.

vi. But for Spofford's breach of its duty, the VPA program would have been extended, A.J. would not have been placed into his Father's care on September 4, 2014, the appropriate persons would have been warned of the danger to A.J. from Father's inability and unwillingness to provide for A.J.'s needs, MoDSS or other appropriate persons or agencies would have taken emergency steps to assure A.J.'s safety upon release from Spofford, including notifying law enforcement for the purpose of taking A.J. into protective custody, and A.J. would be alive today.

vii. As a direct and proximate cause of the breach of Spofford's duties, A.J. was harmed and suffered damages including death.

g. Kiara Ohle, Spofford: Mental Health Services Primary Therapist for A.J. 2014

i. Upon FGC referral of A.J. to Spofford for the VPA program, Spofford employee, Kiara Ohle obtained actual and constructive knowledge of danger and neglect to A.J. in the Jones' home, based on the documentation contained in A.J.'s file, the March 7, 2014, FGC psychosocial assessment, A.J.'s previous medical records indicating severe abuse and neglect, A.J.'s quarterly psychiatric evaluations, A.J.'s treatment plan reports, and monthly in-person meetings, and the expressed concern of A.J.'s therapists employed by Spofford that A.J.'s father and Stepmother refused to participate in A.J.'s treatment plan throughout A.J.'s stay at Spofford, the characterization of Father's lack of participation by A.J.'s therapist as "abandonment" requiring a hotline call to MoDSS, documentation that A.J. regressed and starting biting himself when he learned he might be discharged to his Father, and that in August 2014, Spofford planned to discharge A.J into the care of his Father, who expressly stated at the time of discharge that he would not follow through with A.J.'s treatment plan, including providing mental health treatment for A.J., and that A.J.'s father and Stepmother did not meet the minimum requirements under the VPA for A.J. to be discharged into their custody,

ii. In October, 2014, Ohle obtained actual knowledge of danger to A.J. during the period of Spofford's aftercare program, when Stepmother sent an email to Ohle in October 2014, stating that Father had not enrolled A.J. in school, A.J.

was out of control, and A.J.'s behaviors had regressed significantly, and Stepmother was unable to manage A.J.

iii. Ohle failed to act or take any steps to protect A.J. from the harm he suffered from his Father and Stepmother.

iv. Ohle breached her duty when she approved of A.J.'s discharge back into the physical care of Father, who Ohle identified as a person unwilling and unable to meet A.J.'s needs necessary for A.J.'s health and welfare, without warning the appropriate persons of the risk of danger to A.J., and without performing the steps outlined in Spofford's aftercare program to monitor A.J.'s safety.

v. Ohle breached its duty to warn the appropriate authorities including MoDSS, law enforcement and the State of Kansas, of the risk of future harm to A.J.

vi. But for Ohle's breach of her duty, the VPA program would have been extended, A.J. would not have been placed into his Father's care on September 4, 2014, the appropriate persons would have been warned of the danger to A.J. from Father's inability and unwillingness to provide for A.J.'s needs, KsDCF, MoDSS or other appropriate persons or agencies would have taken emergency steps to assure A.J.'s safety upon release from Spofford, including notifying law enforcement for the purpose of taking A.J. into protective custody, and A.J. would be alive today.

vii. As a direct and proximate cause of the breach of Ohle's duties, A.J. was harmed and suffered damages including death.

DAMAGES

Plaintiffs are entitled to compensatory and non-compensatory damages in excess of $25,000.

Plaintiffs are entitled to punitive damages in excess of $25,000,000.

PLAINTIFFS PRAY that this court enter judgment in excess of $25,000 for compensatory and non-compensatory damages for Plaintiffs and that the court enter judgment in excess of $25,000,000 for Plaintiffs for punitive damages, together with costs, and for such further relief as the court may deem proper, notwithstanding there is no amount of money that makes up for the tragic and preventable loss of this child's life.

Respectfully submitted,

/s/Michaela Shelton
Michaela Shelton MO No. 41952
SHELTON LAW OFFICE, P.A.
10100 W. 87th Street Suite 303
Overland Park, Kansas 66212
(913) 341- 3001
(913) 341-4289 (Facsimile)
attorney@sheltonlawoffice.com
ATTORNEY FOR PLAINTIFFS

JURY TRIAL DEMAND

Plaintiffs demand trial by jury.

Respectfully submitted,

/s/Michaela Shelton
Michaela Shelton MO No. 41952
SHELTON LAW OFFICE, P.A.
10100 W. 87th Street Suite 303
Overland Park, Kansas 66212
(913) 341- 3001
(913) 341-4289 (Facsimile)
attorney@sheltonlawoffice.com
ATTORNEY FOR PLAINTIFFS