Kansas
Department for Children and Families

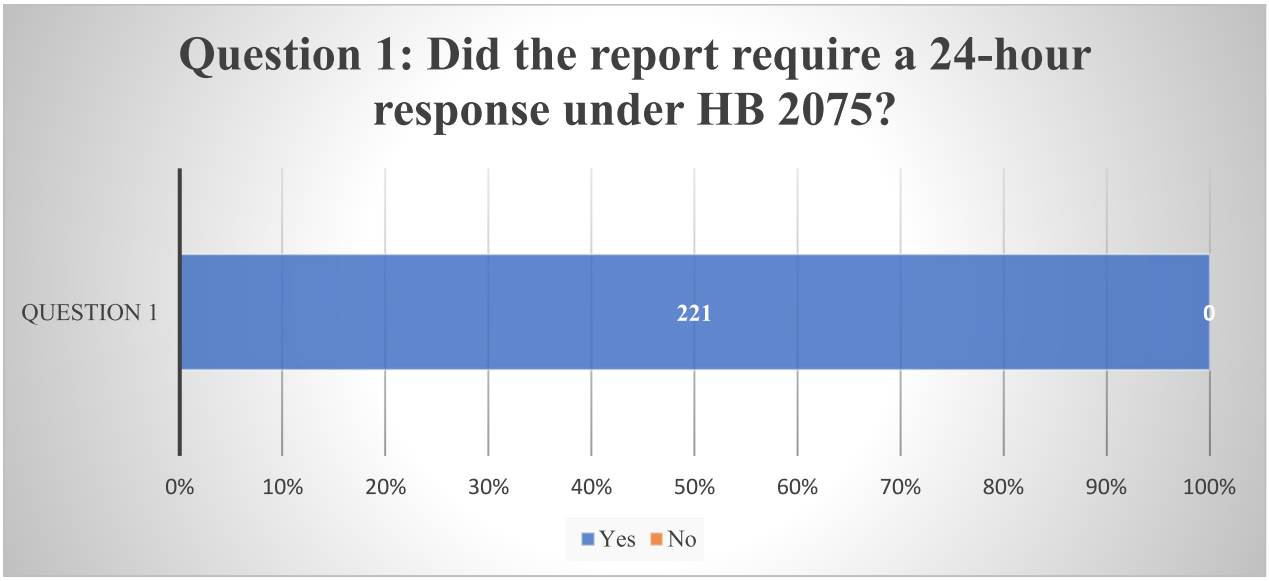
HB 2075

House Bill 2075 Law Enforcement Special Case Read

Purpose:	To measure performance related to House Bill 2075. Per House Bill number 2075, when law enforcement refers a child who may be the victim of abuse or neglect to the secretary, the secretary must 1) provide an electronic method for law enforcement to make such referrals, and 2) upon receipt, DCF must initiate an investigation and contact the persons subject to the investigation within 24 hours. Within 24 hours of that contact, DCF must provide the referring law enforcement agency with a status update. The intent of HB 2075 is to strengthen collaboration between DCF and law enforcement, ensure timely safety assessment when law enforcement has a concern, and support decisions that keep children safe while maintaining them in their homes whenever possible.
Population Criteria:	Events reported by law enforcement assigned July 1, 2025 – July 31, 2025; for abuse/neglect of children/youth.
Random Sample:	221 Events
Case Count:	Northeast- 15 Northwest- 18 Southeast- 27 Southwest- 23 Kansas City - 81 Wichita- 57
Period Under Review:	July 2025 – August 2025

1: Did the report require a 24-hour response under HB 2075?

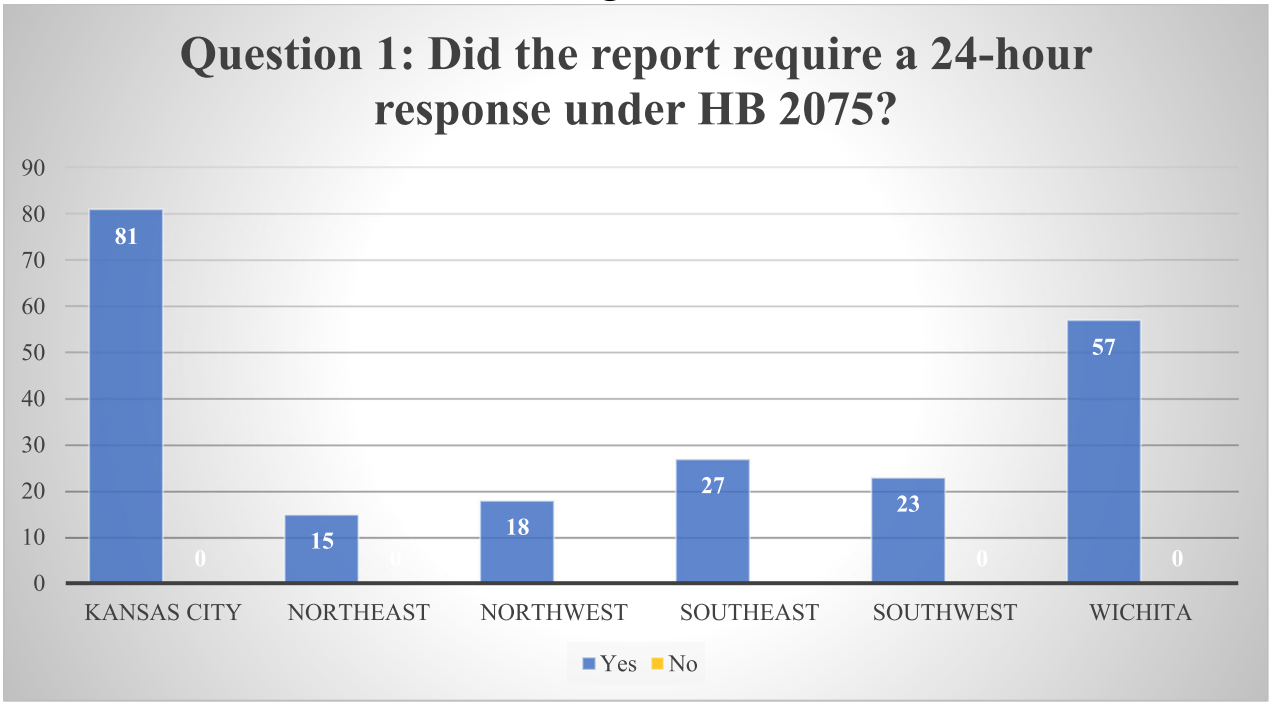
Statewide



This is the first review for House Bill 2075, and DCF reviewed 220 events. All events are applicable for assessment as criteria for this review requires elimination if they are not eligible for review.

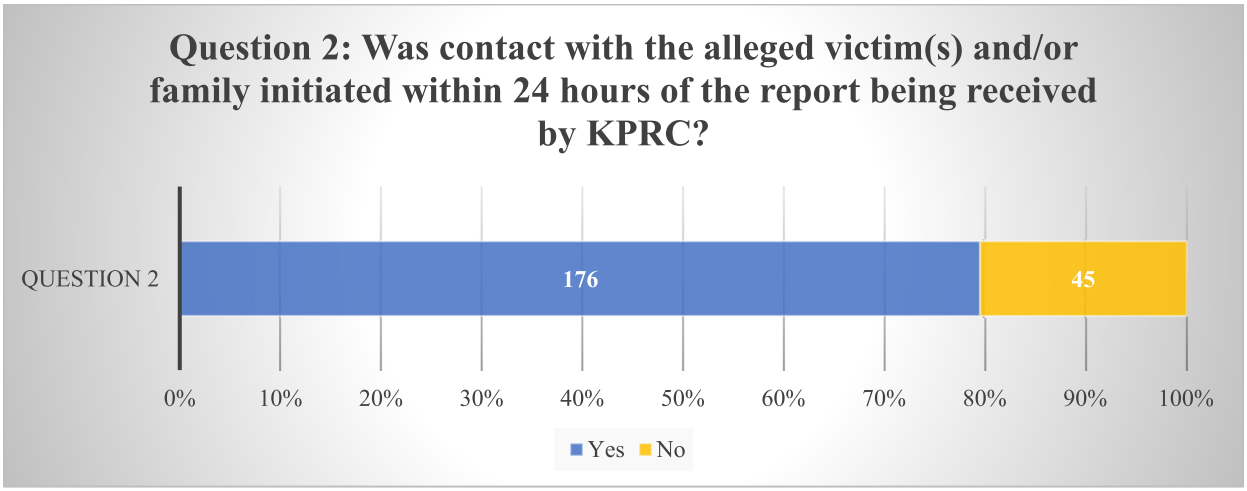
The chart below shows the total number of reviews by region.

Regional



2: Was contact with the alleged victim(s) and/or family initiated within 24 hours of the report being received by KPRC?

Statewide

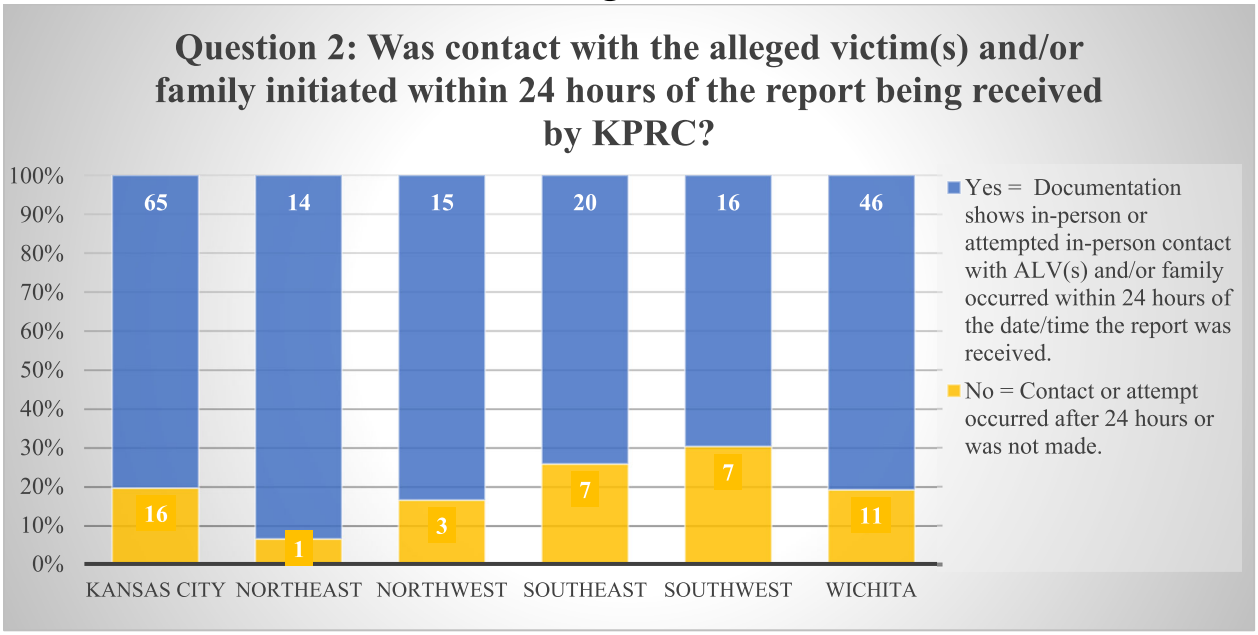


In 2025, DCF reviewed 221 of approximately 500 reports assigned with a 24-hour response time in July 2025. Of the 221 applicable events, 80% (n=176) had contact that was initiated timely with the alleged victim(s) and/or family. Of the 45 "No" responses that did not meet HB2075 requirements, the rationales clustered into a few clear and connected patterns, with some falling into multiple categories:

- **10 of 45 (22%)** showed gaps in documentation, with either no available documentation or insufficient detail to show contact or reasonable efforts within 24 hours.
- **20 of 45 (44%)** had delays in contact. Some cases had an initial attempt within the first 24 hours, while others showed the first attempt occurring after the window. One case missed the requirement by only three minutes; others documented first contact in mid-to-late August on a July report.
- **15 of 45 (33%)** (a subset of the above 20) had only one documented attempt in the first 24 hours, either a phone call or a single in-person attempt, with no second attempt documented, meaning they did not meet the policy expectation of reasonable efforts.
- **6 of 45 (13%)** involved clear access barriers, such as youth/families who were unable to be located, out of state, or away on trips.

The chart below shows the breakdown from FY2022 to FY2026 by region. Further analysis can be found on page 5, with the context of the length of delay considered.

Regional

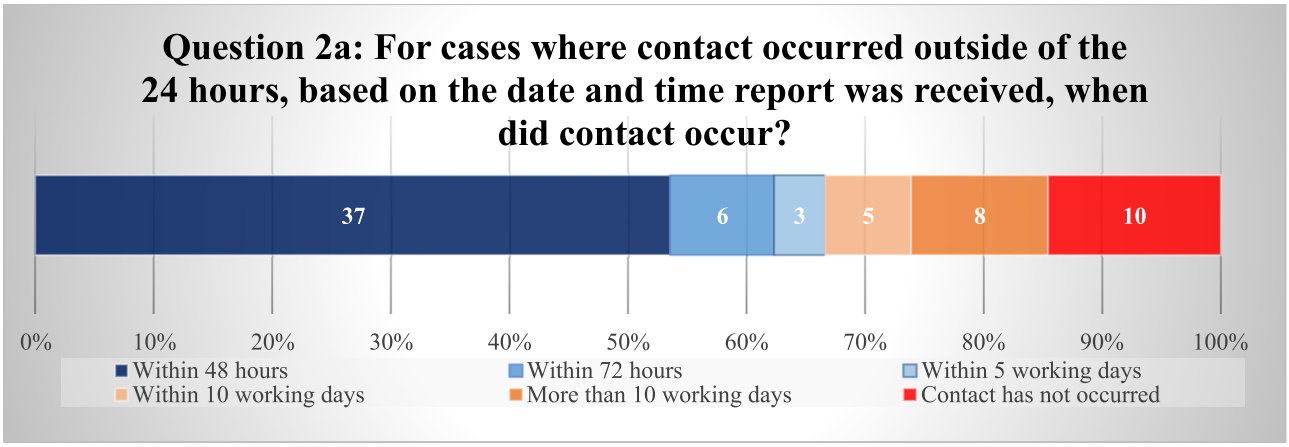


2a: For cases where contact occurred outside of the 24 hours, based on the date and time report was received, when did contact occur?

Of the 221 cases reviewed in 2025, 69 had contact that occurred outside the 24-hour window. For 24 of these cases, reasonable efforts were still made within the first 24 hours, so they received a "Yes" for Question 2. Question 2a looks specifically at when contact occurred once outside the 24-hour timeframe. As shown in the chart below, **54% (37 of 69)** had contact within **48 hours** of the report date and time. Another **9% (6 of 69)** had contact within **72 hours** and an additional **4% (3 of 69)** had contact within **5 working days**.

Additional categories, within 10 working days, more than 10 working days, and contact has not occurred/not documented, are reflected in the chart below.

Statewide

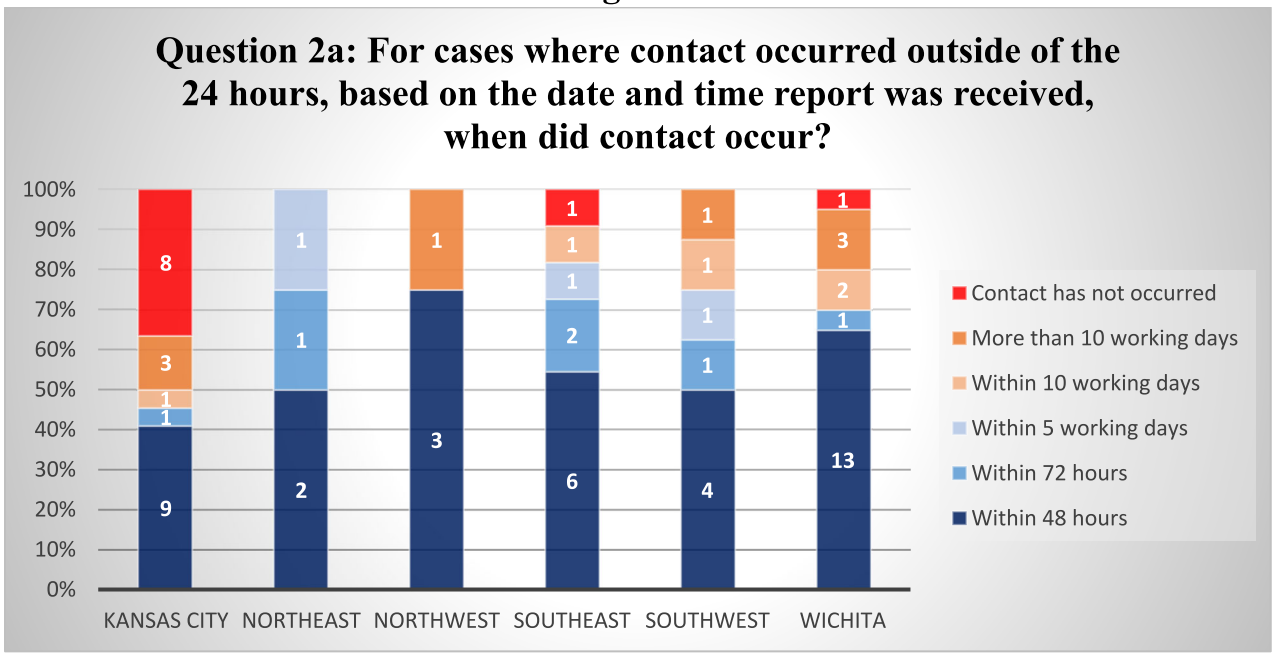


The chart below shows regional variation in when contact occurred for cases outside the 24-hour window. Because Kansas City (**81 cases**) and Wichita (**57 cases**) had the highest number of HB2075-assigned reports, they also proportionally had higher numbers of responses outside the 48-hour window, although we can see from the Question 2 Region Chart that both regions respectively performed at around 80% for contact occurring within 48 hours.

Both regions did have several cases where contact occurred within 48 hours, with the proportional breakdown showing important variation. Kansas City had 9 of the 22 cases (**41%**) where contact occurred **within 48 hours** and had a higher number of extended delays, including 3 cases (**14%**) with contact occurring **more than 10 working days** later and 8 cases (**36%**) where contact had not yet occurred or had not been documented as of the date of review. Wichita showed more timely patterns overall, with 13 of 20 cases (**65%**) where there was a response **within 48 hours** and only 1 (**5%**) where **contact had not yet occurred or been documented** as of the date of review.

For the Northeast Region, 4 cases had contact outside of the 24-hour window, with only 1 case where reasonable efforts were not met (per question 2 responses). All 4 cases had contact within five working days, showing delays but no extended gaps. In the Northwest Region, 3 of the 4 cases had contact within 48 hours, while 1 case reflected a longer delay of 10 or more working days. **Southeast** and **Southwest** Regions, whose overall Question 2 performance was **74%** and **70%** respectively, show more variation. **Southeast** had 9 of their 11 (**82%)** delayed cases where contact occurred (6 within 48 hours, 2 within 72 hours, and 1 within 5 days) **within 5 working days**, while **Southwest** had 6 of their 8 (**75%**) delayed cases delayed where contact occurred within 5 working days. These patterns suggest that while most delays in these regions were relatively short, both regions experienced delays that contributed to their overall lower performance on timely contact.

Regional



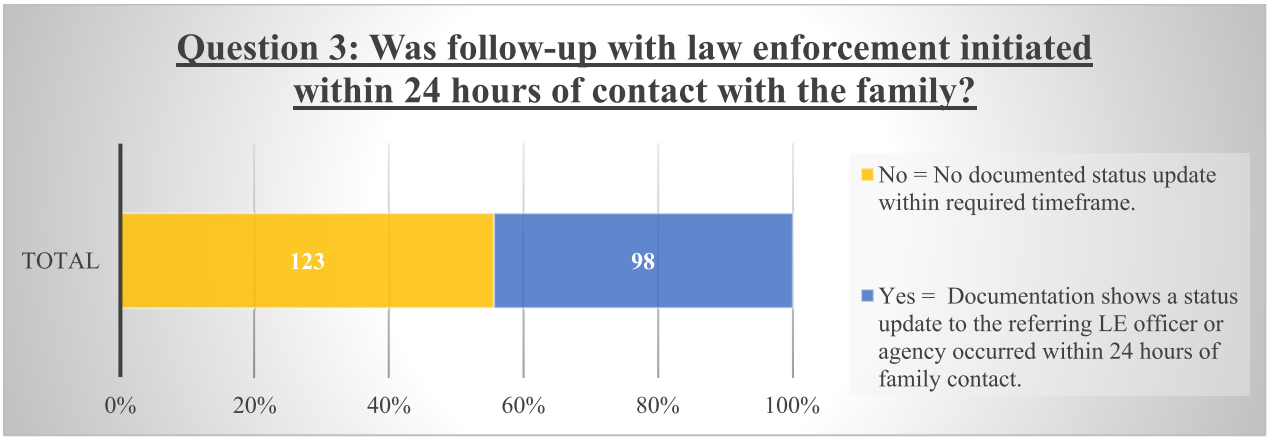
3: Was follow-up with law enforcement initiated within 24 hours of contact with the family?

Question 3, which evaluates whether staff provided a status update to the referring law enforcement officer within 24 hours of contact with the family, 123 cases (**56%)** were marked "No" indicating that there was no contact with law enforcement within 24 hours of contact with the family. This translates to performance for this question being at **44%** overall, 98 "Yes" responses out of 221 cases reviewed. As with Question 2, the rationales clustered into clear patterns:

- **60 of 123 (49%) had missing or insufficient documentation** about follow-up with law enforcement. In these events, the review could not confirm whether law enforcement was contacted or what information was shared because KIDS notes, attachments, or emails were not present or did not clearly provide date and time or details of the follow up.
- **41 of 123 (33%) reflected delays in follow-up**. Documentation showed that updates or notifications to law enforcement occurred more than 24 hours after contact with the family and/or alleged victim, sometimes several days or weeks later.
  17 of 123 (14%) documented LE contact within the expected timeframe, but the email, log entry, or 1010 did not include one or more elements required by policy (for example, the allegations being investigated, or a clear immediate safety determination), meaning they did not fully meet HB2075 expectations.
- **5 of 123 (4%) involved special circumstances where compliance could not be verified,** such as law enforcement being contacted prior to family and/or alleged victim contact with no follow-up afterward, or documentation referring to encrypted or unsupported attachments that reviewers could not open to confirm whether a complete, timely status update occurred.

The chart on the following page breaks down Question 3 performance by region.

Statewide



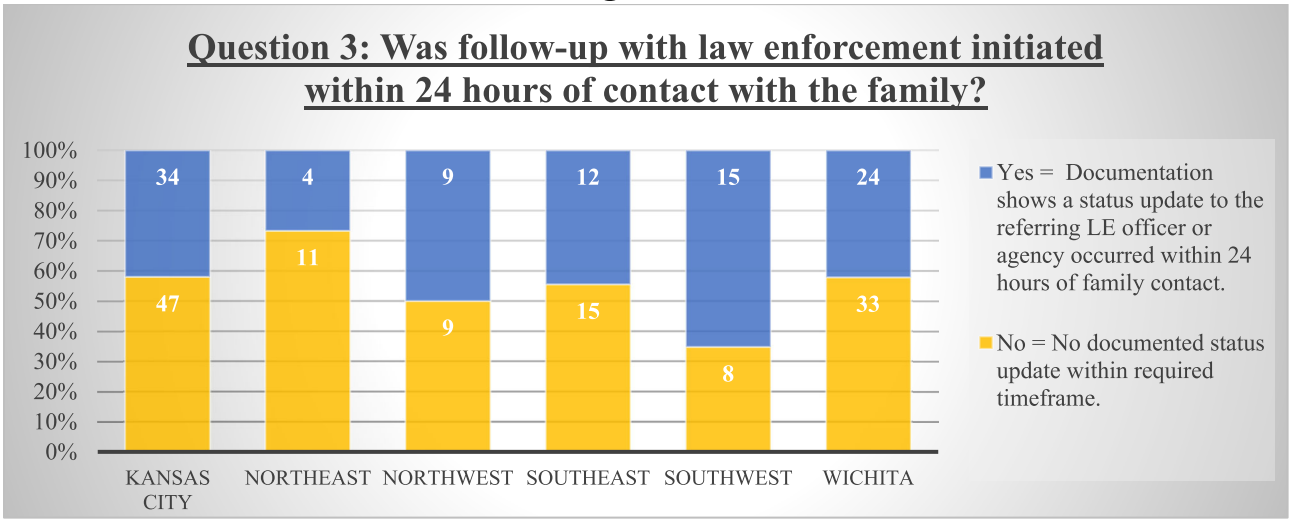
Across regions, performance on Question 3 shows variation in how consistently follow-up with law enforcement is documented within 24 hours of contact with the family. **Northeast** had the highest percentage of "No" responses (**11 of 15**), indicating significant documentation and/or

process challenges in meeting HB2075 follow-up expectations. **Kansas City** and **Wichita** also had high numbers of "No" responses, **47** and **33** respectively, which highlights opportunities for standardizing expectations, workflow, and documentation practices.

Southwest stands out as the strongest performer, with **8 "No" responses out of 23** reviewed events. This region's consistency may be connected to the standardized form their team developed early on and adopted across staff, a promising practice that may be useful to explore or adapt statewide as part of the agency's larger improvement strategy.

Northwest and **Southeast** fall in the middle of the distribution, with **9** and **15** "No" responses respectively. Their patterns reflect similar themes to the larger dataset: follow-up often occurred, but documentation did not always clearly verify whether required elements were communicated or whether it occurred within the 24-hour window.

Regional



Review Findings

The findings of this review reflect both meaningful strengths and clear opportunities to strengthen the statewide response to HB 2075 requirements. Across regions, staff demonstrated consistent effort to engage families, complete safety assessments, and communicate with law enforcement. At the same time, the review revealed patterns that point to system-level challenges, particularly around documentation clarity, timing of follow-up, and consistent use of required elements in policy. These patterns are not isolated to any single region; rather, they highlight the need for aligned processes, clearer expectations, and shared tools that support staff in meeting the intent of the law.

Late in the review, an important complicating factor emerged that warrants further examination. HB 2075 was designed to provide an alternative path to police protective custody by ensuring timely notification to DCF when law enforcement identifies a child who may be a victim of abuse or neglect and requires swift follow-up. However, **38** of the police reports reviewed reflected incidents that occurred well before the DCF report date, starting at two weeks and increasing to more than a year prior, with no indication that the referral was connected to

immediate safety concerns or PPC considerations. In reviewing these cases, law enforcement often noted they would not be assigning a detective, and the report appeared to function as an informational referral rather than an urgent safety matter. While additional analysis is underway, this raises important questions about how the law is being interpreted and how this reflects in practice across jurisdictions, and how these delayed referrals might impact both the intent of HB 2075, and the workload placed on PRC and field staff.

At the same time, there is a meaningful bright spot when looking at aggregate statewide data. Comparing July to September Police Protective Custody (PPC) events from SFY2025 to SFY2026, Kansas saw a 13% decrease in police protective custody cases (from 683 to 593). While PPC trends are influenced by many factors, this early shift may reflect increased use of the HB 2075 referral pathway as an alternative to immediate removal when safety allows. Continued monitoring will help determine whether this pattern strengthens over time and how it intersects with the documentation and timeliness challenges identified in this review.

Taken together, the data tell a story of a system earnestly working to meet new statutory expectations while navigating real-world complexity. The insights from this review offer a clear path forward: continued collaboration with regional teams, strengthening documentation tools and expectations, engaging law enforcement partners to clarify shared understanding, and refining statewide processes to ensure that HB 2075 achieves its purpose, supporting child safety while minimizing unnecessary system involvement. This work will require shared ownership, curiosity, and thoughtful action.