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| IN RE: | : | IN THE COURT OF COMMON PLEAS |
| | : | DAUPHIN COUNTY, PENNSYLVANIA |
| | : | |
| | : | NO. CP-22-MD-1266-2013 |
| THE EIGHTH DAUPHIN COUNTY | : | |
| INVESTIGATING GRAND JURY | : | **NOTICE NUMBER: 08-2013-15** |

ORDER OF COURT

AND NOW, this 3rd day of June, 2015;

IT IS HEREBY ORDERED that **Report Number 3** is accepted and shall be filed as a public record with the Dauphin County Clerk of Court pursuant to 42 Pa. C.S. §4552. The Report may be inspected by any person. After a review of the record, the Court makes a finding that the Report is based upon facts received in the course of the various investigations authorized by this Court and is supported by a preponderance of the evidence. The Clerk of Court is directed to distribute a copy of the Report along with this Order to each on the individuals listed below.

BY THE COURT

WILLIAM T. TULLY J.
SUPERVISING JUDGE

DISTRIBUTION:
Ted Dallas, Secretary, Pennsylvania Department of Human Services
P.O. Box 2675, Harrisburg PA 17105-2675
Michele Brooks, State Senator, Senate Aging and Youth Committee, Majority Chair,
Senate Box 203050, Room: 459 Main Capitol, Harrisburg, PA 17120-3050
Art Haywood, State Senator, Senate Aging and Youth Committee, Minority Chair
Senate Box 203004, Room: 184 Main Capitol, Harrisburg, PA 17120-3004
Katharine M. Watson, State Representative, House Children & Youth Committee, Majority Chair
41A East Wing, PO Box 202144, Harrisburg, PA 17120-2144
Scott Conklin, State Representative, House Children & Youth Committee, Minority Chair
314 Irvis Office Building, PO Box 202077, Harrisburg, PA 17120-2077
Cathy Utz, Department of Human Services, Office of Children, Youth and Families
P.O. Box 2675, Harrisburg PA 17105-2675
Jeff Haste, Dauphin County Commissioner, Chairman
Mike Pries, Dauphin County Commissioner, Vice Chairman
George P. Hartwick, III, Dauphin County Commissioner, Secretary
Joseph Dougher, Acting Administrator, Dauphin County Children and Youth
Seán M. McCormack, Chief Deputy District Attorney (2)
Clerk of Courts

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| IN RE: | : IN THE COURT OF COMMON PLEAS<br>: DAUPHIN COUNTY, PENNSYLVANIA<br>: |
| | : NO. CP-22-MD-1266-2013 |
| THE EIGHTH DAUPHIN COUNTY<br>INVESTIGATING GRAND JURY | :<br>: **NOTICE NUMBER: 08-2013-15** |

ORDER OF COURT

AND NOW, this 2nd day of June, 2015;

IT IS HEREBY ORDERED that Report No. 3 is accepted. This Report shall be sealed and no person shall disclose a return of the Report except when necessary for issuance and execution of process, or as otherwise directed or permitted by order of the supervising judge.

BY THE COURT

WILLIAM T. TULLY J.
SUPERVISING JUDGE

Distribution:

SMM - 6/2/15 Seán M. McCormack, Chief Deputy District Attorney (C-4 copies)

Commonwealth of Pennsylvania

# THE EIGHTH DAUPHIN COUNTY INVESTIGATING GRAND JURY

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| IN RE: | : IN THE COURT OF COMMON PLEAS OF DAUPHIN COUNTY, PENNSYLVANIA |
| | : NO. CP-22-MD-1266-2013 |
| THE EIGHTH DAUPHIN COUNTY INVESTIGATING GRAND JURY | : **NOTICE NUMBER: 08-2013-15** |

TO THE HONORABLE WILLIAM T. TULLY, SUPERVISING JUDGE:

REPORT NO. 3

We, the Eighth Dauphin County Investigating Grand Jury, duly charged to inquire into offenses against the criminal laws of the Commonwealth, have obtained knowledge of such matters from witnesses sworn by the Court and testifying before us. We make the following findings of fact upon proof by a preponderance of the evidence and issue these recommendations for legislative, executive or administrative action in the public interest. So finding by unanimous concurrence, we do hereby make this Report to the Court.

Bonnie Wampler

Foreperson –
Eighth Dauphin County
Investigating Grand Jury

DATED: 5/28, 2015

## INTRODUCTION

We, the members of the Eighth Dauphin County Investigating Grand Jury, having received evidence pertaining to matters occurring in Dauphin County, Pennsylvania, pursuant to Notice of Submission of Investigation 08-2013-15, do hereby make the following findings of fact and recommendations.

## Section I.

## Findings of fact

### I. The death of Jarrod Tutko, Jr.

On August 1, 2014, at 10:35 P.M., Harrisburg Bureau of Police officers responded to 2119 Green Street, in the City of Harrisburg for the report of a deceased child. Upon arriving at the home, Kimberly Tutko told officers that her husband, Jarrod Tutko, Sr., had told her that their nine-year old son, Jarrod Tutko, Jr. (DOB: 10/5/2004), has been dead for days. Officers searched the home and found Jarrod Tutko, Jr.'s decomposing body on the floor of the second floor bathroom.

Jarrod Tutko, Sr. indicated to the police that he last saw Jarrod Tutko, Jr., alive on Sunday, July 27, 2014, in the front bedroom on the third floor of the residence. He did not check in on his son again until he discovered his son dead on Tuesday, July 29, 2014. He then proceeded to hide his son's death from his wife by pretending to check in on Jarrod Tutko, Jr., throughout the remainder of the week.

Jarrod Tutko, Sr., told the police he moved his son's body from the third floor bedroom to the second floor bathroom on August 1, 2014, after he told his wife, Kimberly Tutko, that Jarrod Tutko, Jr. was dead.

Police found the door of the front bedroom on the third floor closed. There was a towel or blanket at the base of the door and moth balls scattered in the hallway outside the room. Inside the room, police officers observed that the only furniture in the room was a television bolted to a television stand. A thick coating of feces was smeared on the walls and floor of the room. Behind the television stand was a pile of dried feces. The inside door knob and light switch were both covered in smeared feces. The light in the room was inoperable. Located in the middle of the floor was a stuffed rabbit toy and a blanket, both covered in feces. Flies swarmed throughout the room. The door knobs were 'reversed,' that is, the door knob locked from the hallway so that anyone inside the room could not get out of the room once the lock was engaged.

Dr. Wayne K. Ross, a board certified forensic pathologist, performed the autopsy on August 5, 2014. Prior to the autopsy, Jarrod Tutko, Jr.'s remains were taken to the Penn State Hershey Medical Center for a 'full body scan.' Radiologist, Dr. Danielle Boal, examined the x-rays and observed no obvious fractures. Dr. Boal also note a 'lack of body fat.' At the time of the autopsy, Jarrod Tutko, Jr., was measured at 42 inches tall and weighed 16.9 lbs. Dr. Ross confirmed a lack of body fat throughout Jarrod Tutko, Jr.'s body, consistent with starvation. Dr. Ross noted signs of dehydration and malnutrition. At the autopsy, dried, caked and impregnated

fecal matter was noted to the bottom of the child's feet, along with blue carpet fibers. The child's hands and fingernails were also observed to have fecal matter on them. At the conclusion of the autopsy, Dr. Ross rendered the opinion that the child died as a result of starvation and child maltreatment syndrome, with complications due to malnutrition and dehydration. He declared the manner of death as homicide.

The Dauphin County Coroner's Office also consulted with Andrew T. Stewart, DMD, MAGD, ABGD, a forensic dentist, who examined Jarrod Tutko, Jr.'s teeth. His examination noted that the child had "multiple abscessed teeth." His examination further noted the following:

> *"Caries in tooth number H had caused an abscess which fenestrated the bone. Caries in teeth numbers S and T exposed their pulp chambers to the oral environment. These are painful conditions. Based on my findings, it appears that this child was neglected dentally, and was in considerable pain."*

Given the severely neglected state of Jarrod Tutko, Jr.'s teeth noted at the autopsy, investigators attempted to track down any and all of his dental records. To date, investigators have been unable to locate any dental records for Jarrod Tutko, Jr. The child never received any dental care.

Kimberly and Jarrod Tutko, Sr., were both responsible for the care and welfare of their son Jarrod Tutko, Jr. Each parent was aware that Jarrod Junior was kept locked in a feces smeared room without lights where he was forced to sleep on a feces covered bare floor. At the time of his death, starvation and a prolonged period of child maltreatment left Jarrod Tutko, Jr., dehydrated and without any body fat. Jarrod Tutko, Jr., weighed barely 11 pounds more at his death at the age of 9

years than he did at his birth. The failure of Kimberly and Jarrod Tutko, Sr., to provide for even the most basic needs of their son demonstrates their extreme indifference to the value of Jarrod Tutko, Jr.'s life.

## II. Tutko family history with the child welfare system

During the course of its review of the facts leading up to the death of Jarrod Tutko, Jr., the grand jury examined the history of the Tutko family and their involvement with the child welfare systems in Pennsylvania and New Jersey.

### A. Schuylkill County

Schuylkill Children & Youth Services (Schuylkill County CYS) records indicate that there is an "indicated finding of abuse" against Kimberly Tutko dating to 1993 involving her oldest child from a previous relationship. The "indicated finding of abuse" was the result of a second head injury sustained in a short period of time to her then six-month old baby. Her parental rights to that child were later terminated. Records and testimony also indicate that, for unrelated reasons, Kimberly Tutko would later agree to the termination of her parental rights for the remainder of her children from her former relationship.

After her prior relationship ended, Kimberly Tutko married Jarrod Tutko, Sr. While still living in Pennsylvania, Kimberly Tutko gave birth to B.T. (female-DOB 8/31/2000) and A.N.T. (male-DOB 9/15/2001). On October 15, 2002, records indicate that there was a court hearing scheduled in

Schuylkill County involving the Tutkos and Schuylkill County CYS. Schuylkill County CYS intended to seek the removal of B.T. and A.N.T. (male) from the Tutko's care due to concerns for the welfare of the children. Schuylkill County CYS caseworkers were concerned about the family's unstable housing situation, the family moving from place to place, and the children not receiving medical care. The hearing never took place as Kimberly and Jarrod Tutko, Sr., moved out of the state prior to the hearing date. Schuylkill County CYS closed out their proceedings against Kimberly and Jarrod Tutko as a result of the Tutkos moving to the State of New Jersey.

Dauphin County CYS records note that in November 2013, Jarrod Tutko, Sr., revealed to one of their caseworkers that the reason the family moved to New Jersey in 2002 was because ***"...his lawyer had advised them at the time to pack their bags and move as the Agency (Schuylkill County CYS) was going to place the children."***

## B. The Youth and Family Services Division of the New Jersey Department of Human Services (NJ-DYFS)

The Youth and Family Services Division of the New Jersey Department of Human Services (NJ-DYFS) became aware of the Tutko family as the result of a referral by Schuylkill County CYS. On October 11, 2002, case workers from Schuylkill County CYS notified NJ-DYFS that there was an open case in Pennsylvania with the Tutko family and a hearing was

scheduled to occur on October 15, 2002, concerning the possible removal of B.T. (female-DOB 8/31/2000) and A.N.T. (male-DOB 9/15/2001). The NJ-DYFS report further indicates that Schuylkill County CYS was concerned that the parents were not following through with their agency's safety plan and the Tutkos refused to sign releases to allow Schuylkill County CYS to review records related to the children. They also reported that Kimberly Tutko already had her parental to her older children from a previous relationship rights terminated. NJ-DYFS contacted the local police department to check on the welfare of the Tutko children. The Tutko's were staying in a hotel at the time of this report. When police officers checked on the Tutko family, the hotel room appeared in order and the children seemed safe. This referral was ultimately closed out by NJ-DYFS authorities. However, NJ-DYFS caseworkers received over the next few years other referrals alleging improper parenting and a failure by both Tutko parents to follow doctors' instructions concerning proper medical care for the children.

Jarrod Tutko, Jr. was born on October 5, 2004, at the Shore Memorial Hospital in Somers Point, New Jersey. Shore Memorial Hospital records show that NJ-DYFS requested that hospital staff 'place a hold' on releasing Jarrod Tutko, Jr., to his parents' care after his birth because of an ongoing NJ-DYFS investigation into Kimberly and Jarrod Tutko, Sr. This investigation concerned Jarrod Tutko, Jr.'s female sibling A.R.T. (DOB: 8/11/2003) and resulted in a **substantiated report of medical neglect**. On

September 27, 2004, NJ-DFYS caseworkers had removed A.R.T. from her parents and placed her in foster care due to a failure of the Tutkos to provide proper medical care for their daughter. NJ-DYFS records indicate the following:

> ***"Neglect is substantiated. The parents failed to get the baby [A.T. (female)] the proper follow up care after hospitalization for seizure disorder. This necessitated another emergency room visit. Parents neglected to follow prescribed medication after first hospitalization."***

NJ-DYFS Records show that after A.R.T. (female) was released from the hospital in July 2004, Jarrod Tutko, Sr., decreased the dosage of her medication against the recommendation of the pediatrician. Despite medical instructions to schedule follow up visits with the doctors, Kimberly Tutko and Jarrod Tutko, Sr., never brought A.R.T. (female) for follow up visits.

After a second hospitalization in September 2004, again the Tutkos were instructed to take A.R.T. (female) to her doctors for critical follow up appointments. When the Tutkos failed to follow the doctor's recommendations, NJ-DYFS caseworkers removed A.R.T. (female) from Kimberly and Jarrod Tutko's custody and care. As a result of their improper care and follow up with medical appointments for A.R.T. (female), Jarrod Tutko, Jr., was also placed in foster care upon his release from the hospital. Jarrod Tutko, Jr., remained in foster care from October 12, 2004, until October 18, 2004.

After being returned to his parents, Jarrod Junior remained in the care of his parents for approximately nine months until July 3, 2005. On June 21, 2005, Jarrod Tutko, Jr., was once again the subject of a NJ-DYFS investigation. A home health nurse assisting the family became concerned with Jarrod Tutko, Jr.'s, lack of weight gain. The nurse was concerned that the parents were not accurately feeding the now nine-month old child. NJ-DYFS case records note the following:

> *"7/3/2005- Caller states that Jarrod has a history of losing weight and developmental delays. He has been a patient of Dr. Dahodwala since 6/2/2005. His previous pediatrician, Medford Kids, had a problem of non-compliance and the parent's not following dr's orders. Dr. negotiated with insurance company for a nurse to go to the home. On Thursday, 6/30/05, Jarrod weighed 14 lbs. 2 oz. (he was 5 lbs. 15 oz. at birth). On 7/1 the nurse again reported Jarrod lost weight. Today the nurse advised the doctor that Jarrod is 13 lbs+. Jarrod should be gaining 1 oz. per day. Dr. Dahodwala called the father today and advised that Jarrod needs to be admitted to the hospital today. Father said that he does not have a car. Dr. suggested he call an ambulance. Father said no and hung up the phone."*

Records from Shore Memorial Hospital in New Jersey note that Jarrod Tutko, Jr., was admitted to the hospital in July 3, 2005, as a result of "DYFS intervention." He was admitted to the hospital weighing 13 lbs. 7 oz. By his discharge on July 11, 2005, he gained over a pound and weighed 14 lbs. 11 oz. NJ-DYFS records indicate that Jarrod Tutko, Jr., upon his release from the hospital, was again placed in foster care on July 11, 2005. He remained in foster care until April 6, 2006.

While in foster care, in August 2005, Jarrod Tutko, Jr., was diagnosed as being positive for **Fragile X Syndrome**. His weight at this time was noted to be 17 lbs. 10 oz. According to the National Institutes of Health, Fragile X syndrome is the most common form of inherited developmental disability. Malnutrition is not a common condition associated with Fragile X syndrome.

## C. Dauphin County Social Services for Children and Youth

In 2005 the Tutko family moved from New Jersey to Dauphin County, Pennsylvania. During her interview on August 2, 2014, with Detective Rodney Shoeman of the Harrisburg Police, Kimberly Tutko indicated that she and her husband moved the family to the Harrisburg area sometime in 2005. If this is correct, it appears the Tutko family moved to Harrisburg while Jarrod Tutko, Jr., was still in foster care in New Jersey. NJ-DYFS records indicate that Jarrod Tutko, Jr., was returned to Kimberly and Jarrod Tutko, Sr., on April 6 2006.

### April 24, 2002

Prior to 2006, Dauphin County Social Services for Children and Youth (Dauphin County-CYS) records only list one prior contact with the Tutko family and Dauphin County-CYS. That contact was on **April 24, 2002**. This

report appears to be the result of a phone call made by Kimberly Tutko complaining about the involvement of Schuylkill County CYS with her family.

**July 7, 2006**

Not long after Jarrod Tutko, Jr., was returned to Kimberly and Jarrod Tutko, Sr., NJ-DYFS made a referral to Dauphin County-CYS concerning the Tutko children. On **July 7, 2006**, a NJ-DYFS caseworker contacted Dauphin County CYS to report that NJ-DYFS caseworkers were ***"concerned that the family is not receiving services [in Pennsylvania] like they were receiving in New Jersey."*** This referral was "screened out" and not investigated.[1] Testimony taken by the grand jury indicates that Dauphin County-CYS "screened out" this referral due to incomplete information concerning the location of the family.

**January 9, 2008**

The Tutko family next came to the attention of Dauphin County-CYS on **January 9, 2008**. The agency received a report from staff at the Steele Elementary School in Harrisburg. The report concerned B.T., the oldest Tutko daughter, who was seven years old at the time of the report.

> *The report indicated that the child has had poor hygiene and is dirty. Child reported being afraid of her father and that her mother touched her 'inappropriately'. The child's teacher reports that Jarrod Tutko, Sr.*

[1] *Screened out* is a category used by Dauphin County-CYS that indicated the agency, for any number of reasons, made a decision not to further investigate the referred report.

*calls the teacher every week and is intimidating towards the teacher. A.N.T. (male-DOB 9/15/2001) reported that his father is "scary like a monster".*

According to CYS records, this referral was opened for investigation and that an investigation was completed on February 8, 2008. The grand jury learned through the testimony of Dauphin County CYS Assistant Administrator Kirsten Johnson[2] that the supporting documents concerning the investigation into this referral were never filed and cannot be located. Therefore, the results of this investigation are not known.

**February 3, 2010**

On **February 3, 2010**, Dauphin County CYS again received a referral concerning D.T. from staff at Steele Elementary School. The referral notes indicate the following:

*2/3/2010, 12 PM, [Phone call] from [referral source] who states that the child, [D.T.], is hearing impaired and uses sign language. The child had a fever yesterday. The school called the father to pick up the child and there was no response. The child still has a fever today. The child stated dad was angry. The child stated "slap" when the school asked if the dad did anything to her. The child is agitated and the school is afraid to send the child home…*

[2] At the time of her testimony Kirsten Johnson held the position of Assistant Administrator. Organizationally, she reported directly to Administrator Peter Vriens and was the second highest person in the agency. A number of witnesses testified before the grand jury that Ms. Johnson was the person they saw as actually responsible for the day to day running of the agency. Since the time of her testimony, Kirsten Johnson has been reassigned and currently holds the position of Director at the agency. Administrator Peter Vriens retired on March 2, 2015. At the time of this report the agency is currently being administered by Joseph Dougher as the Acting Administrator while the Dauphin County Commissioners search for a permanent replacement for Peter Vriens. The position of Assistant Administrator is currently vacant.

Dauphin County CYS records indicate that this referral was investigated by the agency. A caseworker was assigned to investigate the referral. The caseworker made an unannounced visit to D.T. at her school on February 8, 2010. The caseworker spoke to D.T. A teacher was present to provide sign language interpretation while the caseworker spoke with D.T. During the visit, D.T. did not provide any information to the caseworker nor did she disclose that her father, or anyone else in the house, slapped her.

The caseworker made a follow-up visit to the school on February 12, 2010, to meet with D.T.'s sibling, A.N.T. During his meeting with the caseworker, A.N.T. denied any knowledge of his older sister being physically disciplined. He did state that his younger brother, Jarrod, sometimes gets smacked on the hands but denied any other physical discipline.

On February 18, 2010, the caseworker made an announced visit to the Tutko home. During this visit, the caseworker observed B.T. and A.R.T. A.R.T. was confined to a hospital bed in the home and Kimberly Tutko told the caseworker that A.R.T. was severely brain damaged due to a seizure in 2007. The caseworker observed that B.T. exhibited traits and behaviors that in the caseworker's past experience she had seen with other children that were autistic. She suggested to Kimberly Tutko that she might want to have B.T. examined by a doctor for autism. During this visit, Kimberly Tutko explained the situation of D.T.'s fever which prompted the staff at Steele Elementary School to make a referral to CYS. She told the caseworker that

although D.T. had a fever the day before, she felt D.T. was fine the next day and sent her to school. She stated that she even took D.T.'s temperature that morning and it was normal.

The caseworker noted in her report that prior to closing out her investigation she still needed to observe Jarrod Tutko, Jr. According to the report, Kimberly Tutko advised the caseworker during the February 18, 2010, visit that Jarrod Junior was over at a friend's house playing. There is no indication in the report that the caseworker observed all of the rooms in the home during this visit. A scheduled follow up visit to the home was conducted on February 19, 2010. A different caseworker observed Jarrod Junior during that visit. The caseworker noted he *"appeared to be well groomed and appropriately dressed. Child appears to be slightly MR (mentally retarded). No concerns noted in the home."* The investigation into the February 3, 2010, report was therefore closed.

It is unclear from Dauphin County-CYS records whether the caseworkers investigating this referral had access to and/or reviewed previous referrals to the agency concerning the Tutko children. Nor do the records indicate if the caseworker was aware of the previous *substantiated/indicated* child abuse/neglect reports that were investigated previously in Schuylkill County and New Jersey.

**December 9, 2010**

Another report concerning D.T. was received by Dauphin County-CYS on **December 9, 2010.** *"Referral source reports that the child has been dirtier all this year and last year. Referral source [reports] child wears the same clothes for days on end. Child is hearing impaired."* Dauphin County-CYS records indicated that this referral was not investigated. The referral was classified as "information only" and the record indicates the caseworker receiving the referral "gave referral to supervisor." No further records concerning this referral exist. Again, it is unclear from the records if the caseworker receiving this referral accessed or reviewed previous referrals to the agency concerning the Tutko children. Nor do the records indicate if the caseworker was aware of the previous *substantiated/indicated* child abuse/neglect reports that were investigated previously in Schuylkill County and New Jersey.

**October 23, 2013**

**October 23, 2013**, a report was received by Pennsylvania's child abuse hotline, CHILDLINE. As a result of the report, Dauphin County CYS began an intake assessment of the Tutko family. The following information was provided on the ChildLine Referral:

> *[Child] told [referral source] he witnesses ongoing [domestic violence] in the home between [mother] and [father]. [Child] told*

*[referral source] he is often involved in parent's arguments and is expected to choose sides. [Child] states when siding with [mother], [father] hits, yells, curses and gets into [child's] personal space. [Child] states his [father] picks fights with [child] and takes his anger out on [child], [unknown] details and [unknown] timeframe. [Child] states on 10/21/13 he wanted to run away from home because of all the fighting. [Child] states when [father] found out [child] wanted to run away, [father] 'went off on him,' no details provided, [child] states he is afraid to talk to anyone about what happens at home because he is afraid [father] will 'beat up on him.' [Child] denies pain, injury or impairment and could not give specific times when the incidents took place, report will be [general protective services].*

Caseworker #1 testified before the grand jury and outlined the investigation she conducted starting on October 24, 2013.[3] Dauphin County-CYS records indicate, and Caseworker #1 testified, that she told the Tutkos that she needed to see all of the children in the home. As a result of this request, Jarrod Tutko, Sr., then went up to the third floor of the home and, after about 15 minutes, carried Jarrod Tutko, Jr., down to the second floor. When Caseworker #1 observed that Jarrod Junior's head was wet, Jarrod Tutko, Sr. told her that his son had poured iced tea on his head.

During a subsequent visit with A.N.T. (male), 12 years of age at the time, at his school on October 31, 2013, A.N.T. advised Caseworker #1 that his father had lied about why Jarrod Junior's head was wet. According to

[3] Caseworker #1 was assigned to work on this referral even though this type of case was outside the scope of her job duties. Caseworker #1 was assigned as a Quality Assurance Specialist. A referral such as the October 23, 2013, Tutko referral would normally be investigated by someone assigned to the agency's Intake Unit. Due to a large volume of referrals that the Intake Unit had handled in the weeks prior, a decision was made by the Dauphin County-CYS to assign all new referrals (over approximately a 2 week period) to caseworkers assigned in other units within the agency.

Dauphin County-CYS records, A.N.T. told her that Jarrod Junior ***"had poop from his diaper all over himself and his dad tried to wash it up."*** He also said, ***"His dad doesn't care about Jarrod Junior anymore."***

Caseworker #1 testified her investigation involved allegations reported by A.N.T. involving ongoing domestic violence in the home. During the course of her investigation the various disabilities/conditions of the Tutko children were learned by Caseworker #1. Through the investigation she also learned the following additional information:

1. Both Jarrod Tutko, Sr., and Kimberly Tutko were unemployed and stayed home to take care of the children.
2. A.N.T. did not have a bed or a bedroom. A.N.T. slept on the couch in the living room.
3. A.N.T. reported that his father punched holes in the wall during the domestic arguments. Caseworker #1 observed areas of the home where patch repairs had been made to holes in the wall. Caseworker #1 confirmed with Kimberly Tutko that her husband had in the past punched holes in the walls when he was upset. Jarrod Tutko, Sr., confirmed to Caseworker #1 that he did punch holes in the wall previously. According to Dauphin County-CYS records, *"Mrs. Tutko is always following him around antagonizing him and he punches holes in the walls because it's better than punching a person."*

4. A.N.T. reported that his father breaks cells phones during the arguments. Dauphin County-CYS records indicate that Kimberly Tutko confirmed that Jarrod Tutko, Sr., has broken cell phones;
5. A.N.T. reported that his mother would call him upstairs during arguments with his father. While Kimberly Tutko denied this to the caseworker, Jarrod Tutko, Sr., confirmed that she always calls A.N.T. up when they are fighting.
6. A.R.T. (female-age 10) and Jarrod Tutko, Jr. (age 9) were not enrolled in school.
7. Kimberly Tutko had her rights to other children terminated and then adopted through Schuylkill County-CYS in the past due to abuse/neglect allegations.
8. The Tutko family was open for services in New Jersey due to concerns for medical and educational neglect and homelessness. A.R.T. and Jarrod Tutko, Jr., were both previously placed into foster care in New Jersey. Three of the reports in New Jersey were substantiated for medical neglect.
9. During an in home visit of the Tutko home on November 1, 2013, Caseworker #1 requested Mr. and Mrs. Tutko to sign medical releases to allow the caseworker to obtain the medical records for the children and to speak with the medical service

providers. ***"Mrs. Tutko became upset and asked what the consents are needed for and said that's how things get mixed up. Mrs. Tutko further stated she takes the kids to the emergency room when they are sick. Mrs. Tutko threw the consents and continued to yell and asked if she needed to get a lawyer."*** During the course of this investigation, neither Tutko parent would consent to give caseworkers from Dauphin County-CYS access to their children's medical records.

Through her investigation, Caseworker #1 became concerned about the situation in the Tutko home. During her testimony before the grand jury Caseworker #1 explained her concerns:

**Question:** And overall – the family became more and more – I don't know if hostile is the proper word but uncooperative as you were dealing with them as time went on, am I correct?

**Caseworker #1:** *Correct.*

**Question:** They were not happy about you being part of their lives?

**Caseworker #1:** *Correct.*

**Question:** Okay. And - - and at some point in time, there was I think - - you correct me if the term is wrong - - was a triage done or some type of meeting at your agency?

**Caseworker #1:** *An emergency triage.*

**Question:** What's an emergency triage?

**Caseworker #1:** *It's when we have a situation that comes up at Children and Youth that is maybe more serious and we have an all-staff email that goes out or an announcement that there's an emergency triage and staff come up as well as administration to talk about the situation and plan for the next steps.*

**Question:** What - - during this particular meeting, what were the plans for the next steps with this family?

**Caseworker #1:** *The plans for the next steps were to open the family for voluntary protective services due to the ongoing domestic violence, the special needs of the children, the family's history, attempt to try to in that way build a relationship with the family to cooperate and further assess those things.*

**Question:** On a scale of 1 to 10 how serious of a situation did you think this family was presenting as you were involved with them up to the point you stopped being involved with the family given the stuff that you were learning about them?

**Caseworker #1:** *I was very concerned. Probably a 9.*

**Question:** Okay. What - - And, I don't mean to put you on the spot, but what - - what would you like to see happen with this particular

family with your agency? For example, if you were to continue on with the family, what were you looking to see happen?

**Caseworker #1:** *I was looking to - - because Mr. and Mrs. Tutko were telling me one thing about their kids' medical issues, I was looking to get the medical records to be able to further assess the truthfulness as to what they're saying. I had also requested the Tutkos to get the children enrolled in school. They had identified [A.N.T.] as a problem and that he was making things up and causing issues, so I suggested the Tutkos look into family based services and at the same time the agency provide protective services to monitor the home environment.*

As a result of the emergency triage meeting a plan was developed to continue working with the family, try to get the medical releases signed, have the two children of school age not attending school enrolled in school, follow up with Schuylkill County-CYS and NJ-DYFS for more information concerning their contacts with the Tutkos, and follow up with law enforcement concerning any reports of domestic violence. It was also decided that another caseworker would be assigned to take the case over from Caseworker #1. That decision was made because it was felt that a male caseworker coming from a rural community background similar to Mr. and Mrs. Tutko might be able to get better cooperation from the Tutkos.

According to testimony from Kirsten Johnson, the new caseworker assigned to the Tutko family in November 2013, ***"had a significantly different impression"*** of the seriousness of the situation concerning the Tutko family than Caseworker #1. She testified that during her agency's internal review after Jarrod Tutko's death, Dauphin County-CYS identified this as an issue:

> *"There were also concerns about the transfer of the case and the fact that from one worker's assessment to another worker's assessment there were significant changes, and that one worker had a very strong level of concern and that the next worker did not, and that there never appeared to be a dialogue between those workers or between those supervisors about why there was such a discrepancy between what it is that we're seeing and how do we resolve that. That did not occur."*

It should be noted that Caseworker #1 accompanied the new caseworker on at least one occasion to the Tutko home during the transition period and she wrote a comprehensive "transfer summary" report which outlined the family history with both Schuylkill County-CYS and NJ-DYFS, the lack of cooperation from the family concerning the signing of medical releases, the failure of the family to enroll A.R.T. and Jarrod Junior in school, and information corroborating A.N.T.'s report about domestic violence in the home. The transfer summary also included the information, discussed previously in this report, whereby Jarrod Tutko, Sr., admitted the reason the family moved to New Jersey was to avoid the Schuylkill County-CYS court

hearing where CYS had indicated to the family its desire to seek custody of D.T. and A.N.T.

Despite the red flags identified by Caseworker #1, the new caseworker assigned to the Tutko family and his supervisor (Supervisor #1) did not follow up to ensure the identified children were actually enrolled in school. The new caseworker (Caseworker #2) was also unable to get Mr. and Mrs. Tutko to sign medical releases so the agency could do an independent review and assessment of the children's medical care.

The Supervisor #1 and Caseworker #2 did follow up with visits to the Tutko home. They did see the children while conducting those home visits. They also met with D.T. at her school. During one visit to the Tutko home, the issue of medical releases was again brought up by the supervisor. Kimberly Tutko again refused to sign medical releases but did consent to allow the supervisor permission to look at binders Kimberly Tutko had compiled concerning her children's medical care. Neither Supervisor #1 nor the Caseworker #2 examined the third floor of the Tutko home. Supervisor #1 testified that she did not go above the first floor of the Tutko home and the Caseworker #2 was unaware that the home had a third floor.

Without ever getting the Tutkos to sign medical releases for the children and therefore unable to confirm the information shared by the parents concerning their children's medical welfare and treatment, the agency closed out the family's case on December 20, 2013. No attempt was made to

confirm with the Harrisburg School District to see if the family was following up on the agency's request to have A.R.T. and Jarrod Junior enrolled in school.

**January 21, 2014**

**January 21, 2014,** a call was received from Hershey Medical Center concerned for the safety of A.R.T. (female). The following information was contained in the ChildLine referral (CY47 form):

> *"The [child-A.R.T.] was admitted on 1/17/2014. The [child] was unkempt with dirty not trimmed finger nails. The [child] is bed bound and cannot take care of herself. The [child] is admitted and is transported by ambulance and taken home by ambulance. The family has no transportation and multiple children at home. The family does not visit the [child] when the [child] is admitted. The [referral source] said the family can take the bus to visit the [child]. The [child] is not verbal. The [child] has a lot of medical needs and was not admitted due to neglect. The [child] was admitted due to rapid heart rate and fever. [Referral Source] said the nurses (Elite Staffing) that were past in the home are refusing to take the case as 'the family was uncooperative.' The [Referral Source] said the family does not know the report is being made since the family did not visit the [child]. [Referral Source] has arranged for Central PA Nurses to take care of the [child] at home.*

The following additional information was contained in the CYS records after the agency received the ChildLine report;

> *"[Referral Source] reported that when the child was being discharged the ambulance contacted the parents to talk to the parents about the child coming home. [Referral Source] stated that the parents started to change their stories saying the child could not be discharged home as they did not have supplies to care for her.*

*[Referral Source] stated they were able to verify that the family had the supplies for the children. [Referral Source] stated that the parents then said they couldn't care for the child if she was coming home on oxygen (child has been on oxygen previously) as her doctor from St. Christopher said it was not allowed. [Referral Source] stated the hospital followed up with the doctor at St. Christopher who is following [A.R.T.] for pulmonology and he stated the child can be sent home with oxygen. [Referral Source] stated that the hospital confronted the parents with this information and they said to send the child home.*

Caseworker #3 testified that in January 2014 he was assigned as a "Screening Caseworker" at Dauphin County CYS. He explained his responsibility was to take phone calls from the community about possible abuse or neglect of children. Reports of child abuse or neglect also come to a screener through reports from the state-wide child abuse hotline-ChildLine. The ChildLine reports are typically sent to a county CYS agency via an electronic document.

Caseworker #3 was the caseworker who received the January 21, 2014, referral referenced above from ChildLine. He indicated that he gave the referral to his supervisor (Supervisor #2). He further testified that Supervisor #2 classified the referral as "information only," thereby screening out the referral. Caseworker #3 testified that in his position as a screener he would have access to prior reports and information gathered by Dauphin County-CYS in previous referrals concerning the child and/or family that was the subject of a new referral.

**Question:** You said some of the things you do as a screener, what you do is that you try to do a little research on the family; is that correct?

**Caseworker #3:** *Yeah. We try to gather as much information on the family to see if we ever had involvement; look up any criminal things with the family, as much information as we can find.*

**Question:** Did you do that in this case?

**Caseworker #3:** *I cannot remember what I did.*

Caseworker #3 continued his testimony and described what he did next with the January 21, 2014 referral...

**Question:** So you do the screening and you said that this information is given to the screening supervisor; is that correct?

**Caseworker #3:** *Correct.* **...**

**Question: ...** What determination was made with the call?

**Caseworker #3:** *The referral was made information only, meaning that it would not be assessed.*

**Question:** When you say not assessed, you mean no one would be sent out to the home to check on this status, this child?

**Caseworker #3:** *Correct.*

**Question:** And you said that was information - - you provided whatever information you had, you provided to [Supervisor #2] and she was the one who made the decision to make it information only?

**Caseworker #3:** *Correct.*

**Question:** And then what do you do with the call then?

**Caseworker #3:** *Then what happens is we had to enter dictation as information only so we can track. That is our way that we track all the calls that we receive that are information only.*

**Question:** No one would be sent into the home to check and see whether the nursing, Central Pennsylvania Nurses actually did move in- actually did work with the family; is that correct?

**Caseworker #3:** *Correct.*

**Question:** Do you give any feedback then? Do you call the reporting source to say, 'We've marked this as information only; we are not doing anything further with it'?

**Caseworker #3:** *We sometimes do. Sometimes we do not.*

**Question:** Do you have a specific recollection whether you did that in this case with this child?

**Caseworker #3:** *If I would have, I would have documented it, so I'm guessing I did not reach out to them.*

Later in his testimony, Caseworker #3 testified concerning the training he received as a screener and his expectation of his supervisor's role in the process...

**Question:** What type of training does someone that is doing screening receive?

**Caseworker #3:** *Screening is a newer thing that the county had gotten when I was first a screener, that we had. We got trained on different things: What kind of questions to ask; specifically make sure it is important to get demographic information, where they live, but just kind of ask as many questions you can think of that are going on with the family. We did not do any out-of-house training like some people have to do. It was kind of in-house and things like that.*

**Question:** Now, how about, - - that is information you are trying to gain off the phone. How about, was there any training as to how much time you should spend researching it when you

have other calls coming in and those sort of things? Was there any policy?

**Caseworker #3:** *No. It was never said how much time you had to do. I mean, if you have the time then go ahead, but again, if there is a large volume of calls, we are trying to get the referrals out, so if they need to respond, then they can get out to the workers and be responded to. It kind of depends on what the situation is.*

**Question:** So but when you get the calls, is every call then referred to the supervisor or only certain ones?

**Caseworker #3:** *Not every call. We receive a lot of calls that people may have questions about where they can go for certain things. So for some calls, we don't document and make referral for everything, but if it is a referral with concerns of the family, that would get forwarded -- typed in the referral and passed along.*

**Question:** Is there an expectation from your position as a screener that the next level up, the supervisor, is going to go into the -- let's say you didn't have a chance to go through and read all the dictation from the previous two months, three months, would you expect that is what your supervisor is going to be doing before they make the final call?

**Caseworker #3:** *Yes.*

**Question:** Do you know - - You may not know. When the report says that Hershey Medical Center is reporting back that the family [referring to the Tutko family] says they are not able to care for the child at this time, do you know what they meant by that?

**Caseworker #3:** *No, I do not.*

The January 21, 2014, referral was the last referral Dauphin County-CYS received concerning the Tutko family until the August 1, 2014, discovery of Jarrod Junior's death.

## III. A.R.T. (DOB: 8/11/2003)

During its investigation, the grand jury also heard testimony concerning the medical condition of Jarrod Tutko, Jr.'s, female sibling, A.R.T. (DOB: 8/11/2003). As discussed above in our discussion of the Tutko family's involvement with NJ-DYFS, A.R.T. was born a year prior to Jarrod Junior. It was the medical neglect of A.R.T. by Kimberly Tutko and Jarrod Tutko, Sr., that not only resulted in a substantiated report of medical neglect, but also resulted in Jarrod Junior initially being placed into foster care upon his birth.

On August 1, 2014, Kimberly Tutko called 911 to report the death of her son, Jarrod. Law enforcement and Dauphin County CYS caseworkers

responding to the Tutko home quickly became concerned about the wellbeing of the other children in the home. A decision was made to take custody of the surviving Tutko children. There was a particular concern about A.R.T. since she was confined to a hospital bed due to her medical condition. She was in a vegetative state and required 24 hour care. It was noted at the scene that her heart rate was slow and her body temperature was below normal. She was ultimately taken to Penn State Hershey Medical Center.

Dr. Lori Frasier, the head of Hershey Medical Center's Child Protection Team, testified to the following concerning A.R.T.'s condition:

**Question:** And can you give the grand jury an idea of the state -- the medical state and the physical condition that Arianna was in when she arrived at Hershey Medical Center?

**Dr. Frasier:** *In August?*

**Question:** Yes, in August of last year.

**Dr. Frasier:** *Right after Jarrod was found -- Arianna, first of all, is a completely dependent child. She's ten years old and she suffered -- she was at the time, she suffered from a severe brain injury that she ended up being very dependent on for all of her care. So she's fed through a tube in her stomach. She has to be turned and bathed and wears diapers. She really doesn't do very much for herself.*

*She was found in the home, the Tutko home, and she was taken to Pinnacle first where she was found to be in very bad condition, so she was transported very quickly to Hershey for higher level of care.*

*She was -- her heart rate was very low. Her respiratory rate was very low. Her blood pressure was very low. It looked like she was going into shock that would have killed her.*

*She was resuscitated and admitted to Hershey. She was found to be incredibly dirty, so in ways that I don't think -- I've been a pediatrician for, like, 30 years. I've never seen anything quite like it before. She had wax from her ears that were coming out onto her face. Her eyes were matted closed with secretions and dirt. She couldn't open them. She had thick, filthy scales in the creases and all over her body. She had thick scales in her hair. She was absolutely looked like she had not been bathed in a long, long time or any kind of routine care. Her diaper area was clean, so somebody was changing her diaper, but the rest of her was really bad.*

*She had been at Hershey previously and we had some weights on her. She lost about 15 pounds since the year before. Remember, she doesn't eat orally or anything like*

*that. She requires somebody to feed her formula through a hole that goes directly into her stomach.*

*So she was -- her weight was significantly down. She's very twisted, so as part of her disability, her spine has become progressively twisted, which presses on one of her lungs. So she -- when I went to see her the first time, the nurses had cleaned her up significantly. And it took about six baths for her to get to the point where you could tolerate the odor around her. So I believe, in my opinion, she was very close to death and she was extremely poorly cared for.*

## IV. Dauphin County Children & Youth

During the course of our investigation into the death of Jarrod Tutko, Jr., the grand jury became aware of serious issues within the Dauphin County CYS Agency.

### A. The Restructure

In March 2014, Dauphin County CYS began a restructuring process. Prior to the restructure, the agency was divided into three divisions: ***in-take, in-home protective services*** and ***permanency***. Each division was headed up by a separate director. Under the previous structure, new referrals of child abuse and neglect being received by Dauphin County CYS were handled by the ***in-take*** division. The

***in-take*** division was further divided up into an in-take unit, Child Protective Services (CPS) unit(s) and General Protective Services (GPS) unit(s). The ***in-take*** division overall was responsible for the investigation of child abuse and neglect claims. Depending upon the severity of the abuse allegation and the type of abuse alleged, allegations were classified as either a GPS investigation or a CPS investigation. Those respective units would then investigate the cases assigned to them.

After an investigation by the ***in-take*** division where it was determined there were enough child welfare concerns, *ongoing services* will be provided to the family. If the children were safe, in other words they did not need to be removed from the home, then the family's case was assigned to the ***in-home services*** division. The ***in-home service*** caseworkers develop a plan of services for the family and set goals for the family to achieve. ***In-home service*** caseworkers would then provide services to the family on a six-month interval basis. Every six months the family's service plan was reviewed to determine if the family's case would be closed out or try to authorize six more months of service and continue working towards the goals for the family.

The ***permanency*** division handled cases where children were removed from the home and foster care situations. ***Permanency*** caseworkers worked with the children, the foster family as well as the biological family. They are typically working towards the reunification of the child with their biological family. In certain cases they are working towards the termination of parental rights when it is not in the child's best interest to return to their biological family.

The restructuring of the agency took effect on March 10, 2014. Under the new organizational structure, the agency was focused around seven teams of caseworkers. Six of the teams were located at the agency's offices in Harrisburg. The seventh team was located in the Dauphin County CYS satellite office in upper Dauphin County. The agency did away with dedicated intake, in-home protective, and permanency units. The caseworkers from those units were then each spread out and assigned into one of the seven new teams created by the agency. Each team was assigned two supervisors. Instead of three separate divisions, each team, in theory, would handle a percentage of all of the types of cases handled by the agency. Under the new structure, the team is assigned to handle an intake, in-home services and permanency caseload. Some caseworkers handled all three types of cases at the same time.

It was believed that the agency, under the three division model did not have enough communication between the divisions. The children and families receiving services from Dauphin County CYS often found themselves being shuffled to new caseworkers each time their case moved to the next division in the process. It was felt that the team structure would help the agency provide more stability and continuity if a child's case was assigned to one team. In the future, if a new case was referred to the agency involving a family previously involved with the agency, it would be assigned to the same team.

The agency also created a RED team. The term RED stands for *Review*, *Evaluate* and *Direct*. The RED team meets every morning to review the new child

abuse referrals received by the agency. Attending this meeting are the team supervisors, the agency directors and other agency staff as needed. During a RED team meeting, the child abuse allegation is reviewed. Any prior history the agency had with the child or family is evaluated. The group discuss the next steps that should be taken with the allegation and it is assigned to a team for investigation. The original plan was that each team located in the Harrisburg office would rotate for a week as the designated team to be assigned cases as a result of the RED team meeting. For one week, a team would be assigned new intake cases and then would not receive another case for five weeks. On the sixth week they would be back on RED team status.

### B. The impact of the restructure on Dauphin County CYS

The theories that went into the planned restructure at Dauphin County CYS were quickly tested when the new organizational structure went into place. No sooner did the new structure go into effect when problems began to arise. The planned six week team rotation plan proved unworkable in the face of incoming child abuse allegations. Issues concerning the lack of caseworker/supervisor training in preparation for the transition quickly surfaced. This problem was compounded by the dissolution of the agency's dedicated CPS and GPS units. The grand jury found that caseworkers and supervisors were unprepared to operate without a centralized CPS unit tasked with investigating child abuse allegations.

The grand jury learned that during the planning stages of the agency's reorganization the administrators of the agency did not seek input from the supervisor in charge of the CPS unit. Said supervisor, Michele Rush, had 21 years of experience as both a caseworker and supervisor with child abuse investigations. She testified that over the course of her career with the agency she has investigated over 2000 cases and supervised the investigation of over 4000 cases. She was never consulted by the administrators planning the reorganization as to the issues that the lack of a dedicated CPS unit would present across the agency. The supervisor of the CPS unit learned of the dissolution of the unit the same day as everyone else in the agency when the administration formally announced the reorganization to the agency staff on February 4, 2014.

**Question:** ...How much input did they take from you or ask you as they put this [the restructure] together?

**Michele Rush:** *None.*

**Question:** When did you find out about what the restructuring was going to be?

**Michele Rush:** *February 4th, sitting on the other side of that room in front of a hundred people on the other side of this building. Yeah.*

**Question:** So you found out when everyone else found out?

**Michele Rush:** *Yes.*

**Question:** So- and, from February 4th to March 10th, that was the transition period to put this new structure into place?

**Michele Rush:** *Correct.*

The transition period into the new organizational structure was accomplished within 34 days. For the most part, the caseworkers and supervisors across Dauphin County CYS' new 'team focused' structure were neither prepared, nor trained, to handle their new roles concerning the investigation of child abuse allegations. It appears that there was a plan to have the caseworkers formerly assigned to the CPS unit continue to be assigned CPS cases. A number of factors derailed this plan. First, the grand jury heard testimony from a number of current and former caseworkers that the manner in which the changes at the agency were executed caused considerable discontent and severely affected staff morale. This resulted in a significant number of caseworkers leaving the agency. In particular, a number of key caseworkers from the fully trained former CPS unit left the agency as a direct result of the restructure and their dissatisfaction with a perceived lack of concern by Administrator Peter Vriens and Assistant Administrator Kirsten Johnson that the restructure, in the view of the caseworkers, was not working. Their departure left the agency, by the end of 2014, with only one caseworker with both the training and experience necessary to properly conduct CPS investigations at the fulltime caseworker level.[4]

[4] Several other former members of the fully trained CPS unit continued to be employed by the agency but were not in positions that resulted in their being assigned to complete CPS investigations.

The grand jury heard testimony from employees of Dauphin County CYS from various positions within the agency, to include upper management, midlevel supervisors and line level caseworkers. While Assistant Administrator Kirsten Johnson and Director Jenna Shickley testified about the positive aspects of the restructure, the testimony of witnesses from the supervisor and caseworker levels painted a much different picture. Almost all the witnesses agreed that there were some positive improvements that could have resulted from the restructure, however, the manner in which the restructure was implemented not only negated those positive results, the changes actually resulted in Dauphin County CYS being less responsive to the needs of the children they serve.

Caseworker #4 testified concerning the situation at Dauphin County CYS for line level caseworkers after the restructure. Prior to the restructure, Caseworker #4 worked in a specialized unit that worked primarily with foster families. She did not have any experience or training investigating CPS/GPS cases. Caseworker #4 described that caseworkers were told that under the new structure each team of caseworkers and supervisors would be on RED team for one week. That is, during the RED team week, the designated team would be assigned all the new child abuse investigative referrals that came into the agency that week. After their turn as the RED team, the team would then have five weeks to complete their investigations before they would be designated the RED team again.

**Question:** So originally from what you're saying is when the plan is presented to you, your team is really going to be on one week and then you'll have five weeks that you'll be doing all your follow up...?

**Caseworker #4:** *Exactly. That was—in theory that was what was presented at the meeting. Very quickly when we made the change, it was found that that wouldn't work and it was suggested that we have two teams on RED team and we rotate every three weeks. And so we tried that. I think initially that was tried if I recall correctly, but that very quickly didn't work. And within just a very short amount of time, I'd say a couple of weeks after we made the transition, we were told everybody is going to be getting referrals and we were going to have one week every six weeks that we do not receive referrals.*

Caseworker #4 was then asked about the caseload assigned to her:

**Caseworker #4:** *So I can't really recall how many I had. I mean, it was, like, four and then six and, you know it just kind of increased from there.*

*At one point we had one of the workers on our team was in an auto accident and was out on medical leave, for a while*

*she was placed on desk duty and could not do any referrals in the field.*

*Very soon after that another team member of our team was hospitalized and is also still on desk duty from that.*

*And so, that left two intake workers that was me and [another caseworker] who was a newly hired intern. And we were receiving all of the GPS and CPS referrals that were coming in for our team.*

*And we got--both of us got very overwhelmed. I probably had up to, like, 23 at one time.*

*I went on vacation in October-- my daughter had to have some surgery so I went down to stay with her for a week-- and it was a planned vacation and while I was away I was assigned about five new cases while I was out on vacation.*

*And other people did the initial responses to those cases and then I came back to try and pick them up in the middle. At the same time I had all the work from the previous cases that I had to catch up on.*

*And Form 48 is due for Department of Public Welfare (DPW[5]) that had to be turned in, so that's kind of immediate.*

[5] The Department of Welfare (DPW) is now known as the Department of Human Services (DHS).

*And then all these new cases coming in that had to have immediate responses.*

*So I found everything is just immediate. It is deadline-critical type work. And everything that comes in is just immediate, immediate, immediate because we deal with crises.*

*And it got to be very overwhelming. There was just no way to handle it. But I think the most I had was about 23. I know my coworker [the newly hired intern] had 30 at one time.*

**Question:** Speaking from your own perspective, did you feel ready to be taking on that type of caseload and those cases from where you started to the transition?

**Caseworker #4:** *No.*

**Question:** Did you ever reach out to anyone or anything like that to say, hey, you know, what kind of training are they going to give us? Anything along those lines?

**Caseworker #4:** *I had been, you know, told that it was just going to be on the job training. So we were told that if we have a question--we were going to be given cases, if we had a question go to our supervisors or we could go to Michele Rush.*

*And it was difficult because Michele was always busy. All of a sudden she has 80 some caseworkers, you know. And so it was difficult. You know, my supervisors tried. They were supportive, but I think we were just all so overwhelmed.*

Caseworker #4 described the atmosphere at the agency following the restructure:

*...So we're just so overwhelmed with casework, with referrals. And we often work late hours. I average about 10 hours a day. I do-- I started to come in on Sunday afternoons. I work five to six hours on Sunday afternoons doing paperwork because it is quiet and I won't get interrupted so I can get a lot done.*

*They are paying overtime for that now. Prior they were only allowing us flex time for that. But we were accumulating so many hours flex time we really found it very difficult to use those hours and still get our work done.*

*I do know that caseworkers have taken off, they've used flex time to work at home just so they can get their paperwork done. And I do know that caseworkers have called off sick to stay home and do paperwork.*

*Most of my coworkers have a laptop--I haven't graduated to one of those yet mainly because I don't want to take it home with me and work all night like they do--but I do know caseworkers that take their laptops home and leave the office and they go home and they sit on their laptops doing work.*

*I do know that many caseworkers have been in tears--come to work and sat and cried at their desks because they are so overwhelmed with the workload and having trouble sleeping at night because they are so worried about their cases, their caseload.*

The grand jury also heard testimony from former caseworkers. These caseworkers were, prior to the restructure, members of the fully trained CPS unit under Supervisor Michele Rush. Caseworker #5 left the agency in November 2014. She described what they experienced once the CPS unit was disbanded and its workers spread out to the new teams. She quickly became disillusioned by the agency's restructure.

**Question:** What kind of cases did you investigate [in the CPS unit]?

**Caseworker #5:** *Child sexual abuse, serious physical abuse, medical neglect, child deaths, child near fatalities, imminent risk. The bad cases.*

**Question:** Not that somebody can love being involved with-- but how did you find your work?

**Caseworker #5:** ...*I did, I loved that job. I would go back in a heartbeat... Knowing that kids who could trust--would be able to trust me enough to tell me things, and knowing that I could help them have a second chance, I did, I loved that. I saw horrible things but I loved knowing that I could do something for someone...*

**Question:** ...Why did you end up leaving?

**Caseworker #5:** *I didn't agree with the changes that were made in the agency. I felt overburdened. I felt that no one had my back and that I would be thrown under the bus in a heartbeat. I started to doubt my own abilities as a worker... I had administration trusting me with these terrible, horrible, high profile cases but then telling me to do things in ways that I didn't agree with, and changing the ways I have for the past four years that had gotten them to trust me and my abilities. And if I started doubting my abilities then I was--I wasn't doing any good for the families.*

**Supervisor #3** was asked by the grand jury to describe the morale at Dauphin County CYS after the restructure:

*It's-- it's horrible. It is just a complete air of despair. On a daily basis there are workers crying, there are supervisors crying, and not just because of what they have seen or experience, it's just walking*

*into the place where you--you don't see a light at the end of the tunnel You know that the volume, you know, that the referrals aren't going to stop. Workers don't know where to go for direction and support, and they try to go to their supervisors and that's not to knock that the supervisors are not in some way trying to help but the supervisors are in sheer survival mode as well, because they can't meet the requirements that they have to...*

The grand jury heard testimony from multiple witnesses describing how they were trained to conduct CPS investigations by Michele Rush under the former agency structure. New caseworkers assigned to the CPS unit were assigned for their first three months in the CPS unit to review old investigative case files to become familiar with how case are investigated and documented. They were asked to apply what they learned in their basic caseworker CORE training[6] to the old cases. One former caseworker, Caseworker #6, assigned to the CPS unit, who also had previous experience as a caseworker in the Berks County CYS agency testified before the grand jury. She explained to the grand jury that the basic CORE training provided,

[6] Caseworkers are required to attend 120 hours of child welfare specific training within their first six months after being hired. This training is often referred to as the CORE training. The training includes a general overview of the child welfare system in Pennsylvania. Caseworkers are given a basic understanding of both federal and state child welfare related laws. All of the witnesses that testified before the grand jury stated the training, while it provided a good foundation for the work they did as caseworkers, the CORE training, by itself, is not enough training to prepare a caseworker for what they face during a CPS investigation. The witnesses also agreed that it is the responsibility of the county child welfare agency to augment what was learned in the CORE training.

*"a good general overview but it was nothing compared to what you actually face when you go out into the real world."*

During the time a new caseworker was assigned to review old case investigations, they were questioned by the supervisor about ways the investigations could be improved and identify things that were done well. Michele Rush testified that this initial period of training helped her as a supervisor to establish a baseline of the new caseworker's understanding of their duties and responsibilities. This time also helped her get a feel for the caseworkers comfort level dealing with the particular kinds of abuse the CPS unit routinely encountered. She explained to the grand jury, *"So it's a lot of discussion, and there is an ownership by a supervisor. It's not just the health and safety of the children and families that you're working with, you have a responsibility to the workers that you're sending home every night."*

From there the caseworkers were assigned phone duty. During this part of their training they get to interact with people and obtain information from them. They are evaluated on their ability to handle different situations they encountered on the phone. How did they deescalate a person that is extremely irate on the phone? They would also be observed on how they interacted with people who, rather than calling the agency, walked in to report an abuse or complain about an investigation. This allowed the supervisor to assess the caseworker's strengths and weaknesses when dealing with real

people. During this time they might also get to shadow another, more experienced, caseworker in the field.

The next step in the process was to assign the worker 'easy' investigations to start them out. The most common case they would be given during this part of their training was a 'courtesy' investigation. A courtesy investigation is essentially a request by another county or an out-of-state CYS agency for Dauphin County CYS to check on the safety of a child residing in Dauphin County. For example, a child may have been abused in the past in Montgomery County but currently attends the Milton Hershey School[7] in Hershey, Pennsylvania. The Montgomery County CYS agency needs to assess the current safety of that child. Rather than send one of their own caseworkers to Hershey, Montgomery County CYS is likely to ask Dauphin County CYS to send a caseworker to check on the immediate safety of the child. Given that the child is more than likely in a safe environment at the Milton Hershey School, this type of referral is considered relatively routine and easy for a new caseworker to handle.

While the actual assessment of the child's safety may be easy, what the supervisor is evaluating is how the caseworker conducted, as well as how they documented, the assessment. They might do a good job obtaining information from the child but were they also able to get all the information they obtained properly documented in a written report. The courtesy

[7] The Milton Hershey School is a private boarding school located in Dauphin County.

investigations also give the caseworker their first exposure to how abuse may have impacted and affected the child. From this point, the new worker would do more shadowing of experienced caseworkers to see how more complicated cases are handled. Ultimately they begin to be assigned more complicated cases of their own to investigate.

Even Caseworker #6, with 2 ½ years of experience as a caseworker in Berks County, was required to go through the training process when she was assigned into Michele Rush's CPS unit.

**Caseworker #6:** *Well, just the way that I got into the unit, Michele saw something in me that she wanted in her unit and she basically said I want you in my unit.*

*I was a little hesitant because I knew that they would do sexual abuse investigations and just knowing myself, that was something I still wasn't really comfortable with. But she said, don't worry about it. You'll be trained. We'll walk you through it. You can do this.*

*So I got interviewed, I got into the unit. And even with my background with Berks County, I still basically started at the bottom, started with answering phones, screening calls.*

*Then when I finally did get cases, it would be what they call, you know, the easy cases, you know, very simple, cut and dry, straightforward--well, as straightforward an abuse report can be--but very simple cases.*

*I did a lot of shadowing. And again, that was even with my years of experience at Berks County, I had to do a lot of shadowing, a lot of preliminary before I got into the more serious cases.*

*And with my first sexual abuse case, again I had to shadow someone else in order to get more comfortable with doing those kinds of things.*

The witnesses experienced with handling CPS investigations agreed during their testimony that this training process is what prepared them for the often difficult and emotional cases they would encounter while investigating CPS allegations. Unfortunately, after Dauphin County CYS restructured in 2014, caseworkers with little to no experience with CPS investigations, suddenly found themselves handling CPS investigation without the benefit of a proper training program to prepare them to conduct appropriate CPS inquiries. With the time period for the transition being so condensed and the dissolution of the dedicated CPS unit occurring at the same time, the

caseworkers and their supervisors were completely unprepared for the onslaught of CPS cases that began to come into their newly formed teams.

The grand jury found Assistant Administrator Kirsten Johnson's February 25, 2015, testimony explaining the way CPS cases were assigned after the restructure was in direct conflict with the testimony from caseworkers and supervisors. When asked about training for caseworkers, Ms. Johnson stated:

> *"That is part of our efforts with the restructuring that we did was to assure that we had support for caseworkers in the field when they were facing situations that they had not faced previously."*

Concerning the assignment of CPS investigations, Ms. Johnson testified:

> *"When the teams first became functional, all the CPS cases that were assigned to that team were assigned to that experienced CPS worker. That's who received them. We sort of differentiate between our CPS investigations. Some of them are clearly more high risk than others. For example, we might get an abuse allegation because a child has a scratch to their face. The scratch could be because somebody went to block them from walking into the street and mom's ring caught the*

*child's face... It was those types of cases we started to give to the less experienced workers so they could learn the regulatory components of CPS without the high intensity perpetrator interview types of things the stronger ones required."*

Despite Ms. Johnson's claims to the contrary, the grand jury found a number of examples of serious CPS investigations being assigned to caseworkers without CPS experience or the necessary training to conduct CPS investigations. Concerning the assignment of cases, **Supervisor #4** testified, ***"And the cases are distributed just more by supervisors saying, okay, we can handle that. We'll take that one. So it's not about giving a case to somebody who has a particular skill or who has the ability to do that case. It's about whether you have a worker who might have nine cases instead of ten so she can take this one..."*** One case in particular, discussed below,[8] involved the death of a six month old baby. Shortly after the restructure took effect this case was assigned to a caseworker without CPS experience, let alone any experience or training in child death investigations. Predictably, problems arose during that investigation which the police detective assigned to investigate the baby's death attributed directly to the worker's lack of experience and training.

[8] *See*, the Harrisburg Police incident discussed in subsection D on page 56 of this report.

**Supervisor #5** was asked if there were any positives that came out of the restructure:

**Supervisor #5:** *It's hard for me to say if there's positives. I think there are positives. I think that prior to the restructuring the agency functioned in pockets.*

*And by that I mean so you had your GPS division who was really focused solely on themselves. So, like, everybody was a pocket. Your CPS team was a pocket. And then you had your permanency group, protective teams who were pockets. You didn't intermingle if that makes sense.*

*So I think with the change, while it shuffled people around and threw them into jobs essentially that they didn't know, it also created some level of cohesiveness maybe for certain individuals. But they were never truly trained on what they needed to be trained on.*

**Question:** And that kind of leads me to the question, why do you think things were not successful?

**Supervisor #5:** *There wasn't any training. Units were divided. The CPS unit was disbanded. Caseworkers were given cases that they had no idea what they were to be doing.*

*You're moving permanency people into a role they've never done casework before.*

**Question:** Is there any person or persons that you feel were responsible for the troubles that the agency has gone through over the past year?

**Supervisor #5:** *Well, I believe that the idea of the restructure was that of Kirsten Johnson and she is the one who pushed for this change.*

## C. Training of caseworkers and supervisors

Three years after the **PA Task Force on Child Protection**[9] issued their findings, the grand jury finds many of their recommendations concerning training have yet to be met. In their final report, the PA Task Force on Child Protection made the following recommendations concerning caseworker training:

- *Minimum experience and training requirements for children and youth caseworkers should be increased to adequately reflect the skills that are necessary to perform the functions and duties of the position, given that caseworkers need to be able to engage families to identify their needs and assist in providing the appropriate services to meet those needs. Caseworkers often go into hostile, chaotic environments where they need to*

[9] The PA Task Force on Child Protection was formed in response to the Gerald 'Jerry' Sandusky case.

*ameliorate the emergent circumstances before they can focus on the root cause of the problem.*

- *Efforts should be made to decrease high staff turnover rates and retain qualified caseworkers.*
- *Training should be improved for supervisors of children and youth caseworkers.*
- *The structure and characteristics of a county agency should be analyzed, with consideration given to demographics and caseload…*
- *In general, training by Child First and others emphasizes the cognitive differences between children and adults and the difficulty which children have in conforming themselves to the requirements of adult legal proceedings…*

As will be broken down in more detail in *subsection F* below, the grand jury heard testimony concerning other Dauphin County CYS cases in addition to the Tutko case. During the testimony, a pattern emerged revealing a substantial deficiency in the training of caseworkers assigned to assess the safety and welfare of children with serious and/or complex medical conditions and cases of prolonged neglect. **Even as this report was being finalized, it came to our attention that a five-month-old baby, (L.H.), died on May 8, 2015, in Harrisburg, Dauphin County, under circumstances that suggest the baby was malnourished.** That child's twin sister was hospitalized the same day, and her medical condition was registered at ChildLine as a near

fatality for dehydration and malnutrition. When L.H. died, at five months of age, she weighed only 4.4 pounds. Dauphin County CYS was involved on and off with this family for approximately twelve years.

On May 6, 2015, two days prior to her death, a caseworker from Dauphin County CYS was in her home and observed her and her twin sister. That same caseworker had also been in the home a week prior, on April 30, 2015. Much like the situation in the case of Jarrod Tutko, L.H. and her twin sister were not the focus of the Dauphin County CYS inquiry. Their investigation involved an older sibling. Nevertheless, the caseworker was in the home and saw L.H. two days before L.H.'s death.

After L.H. died, the caseworker was asked how she didn't notice the deteriorated condition of L.H. and her twin sister. The caseworker responded that she did not have children of her own and she felt that she did not have enough training concerning the developmental stages of children to adequately process what she observed. As this case is still in the early stages of investigation, the grand jury is not prepared to render an opinion concerning the Dauphin County CYS caseworker's responsibility in L.H.'s death. However, this is yet another case that illustrates the point that caseworkers and supervisors need better, practical hands on training to prepare them for these situations. Kathryn Crowell, MD, from The Penn State University Hershey Medical Center Child Protection Team testified, that in her experience working with Dauphin County CYS caseworkers on many of the

cases discussed in this report, caseworkers are not appropriately trained to conduct proper safety assessments of children with special medical needs.

**D. A breakdown of coordination between law enforcement and CYS:**

Without trained and experienced CPS caseworkers, the agency began to assign investigations to caseworkers who did not have the benefit of the same level of training and supervision that previously existed at the agency. The lack of experience quickly began to effect the coordination of CPS investigations with law enforcement. The grand jury heard testimony from law enforcement officers who described how the agency's assignment of caseworkers unfamiliar with CPS investigations detrimentally affected law enforcement investigations.

**Harrisburg Police incident:**

Detective Joseph Zimmerman described a situation where he was investigating an allegation involving the death of a six month old infant. Detective Zimmerman, who was accustomed to working with caseworkers on other child death investigations, suddenly found himself working with Caseworker #7 who had no prior CPS investigative experience, let alone experience investigating a child death case. The assignment of this inexperienced caseworker resulted in an uncoordinated investigation and detrimentally affected the direction of the investigation.

The coordination of a child abuse investigation requires the sharing of information by the members of the Multi-Disciplinary Investigative Team (MDIT). In this case, Det. Zimmerman, as was his practice, shared information with the assigned caseworker that was gathered during the autopsy of the deceased baby. Radiological survey of the baby's body determined that the baby suffered two rib fractures approximately two to three weeks prior to the baby's death. The parents of the baby were considered potential suspects in their baby's death. Det. Zimmerman further explained how important interviews were in child fatality investigations. Many times the examination of the deceased child reveals multiple injuries that were caused over a period of days, weeks or sometimes months. This widens the suspect pool to anyone caring for the child over that time period. Interviews with all of the care takers become extremely critical in these cases to identify the perpetrator.

Det. Zimmerman explained the importance of information management and how investigators time the disclosure of certain information during interviews of suspects. The controlled disclosure of critical information gives the police investigator the opportunity to observe the interviewee's responses and reactions when confronted with the information. Under the right circumstances, a properly planned and conducted interview can and will lead to a confession.

In this particular case, without notifying Det. Zimmerman, Children and Youth included information concerning the rib fractures in paperwork they filed in their proceedings. This resulted in the parents of the deceased baby learning about the rib fractures prematurely during the investigation and prior to Det. Zimmerman interviewing the parents.

As a result of this disclosure, Det. Zimmerman met with Caseworker #7 and his supervisors from Children & Youth to coordinate the investigation and future investigative steps. Det. Zimmerman left the meeting with the understanding that the Caseworker #7 would allow the police the first opportunity to conduct a comprehensive interview with the parent suspected of causing the death of the baby. He later learned that Caseworker #7, after the date of the meeting, instead of allowing the police the first opportunity to interview the parent, met with the suspected parent and conducted a two hour interview with said parent. The interview was not recorded and the police were not present during the interview. The suspect parent did not have an attorney present during his interview with Caseworker #7.

When Detective Zimmerman was able to meet with the suspected parent, the parent arrived at the police station with his attorney. When the interview turned to specifics about the injuries the baby suffered two to three weeks prior to the baby's death, the attorney ended the interview.

As of the date of this report, no charges have been filed in this case against anyone.

**Lower Paxton Police incident:**

Det. Autumn Lupey testified that a child sexual abuse investigation was discovered by the Lower Paxton Police Department when the department was asked to serve a Protection From Abuse (PFA) order. The order outlined allegations of sexual abuse involving a four year old girl. Her father was purported to be the alleged perpetrator of the abuse. Det. Lupey testified that the Lower Paxton Police Department found out about the allegations when a protection from abuse order was served on their office sometime in late March/early April. After reviewing the allegations in the PFA, the Lower Paxton Police opened up a criminal investigation into the allegations. Det. Lupey quickly learned that Dauphin County CYS had already investigated the claim in February 2014 and had closed the case.

The same caseworker assigned to Detective Zimmerman's homicide investigation was assigned to this allegation for CYS. Det. Lupey spoke with Caseworker #7 about the CYS investigation and learned that he responded to the allegation and interviewed the four year old victim. Not surprisingly, the four year old child did not disclose any abuse to Caseworker #7. He also informed Det. Lupey that no Children's Resource

Center[10] (CRC) appointment was ever scheduled to interview the child. As a result, the case was determined to be unfounded. No referral was ever made to law enforcement in this case. Det. Lupey questioned the failure of Dauphin County CYS to notify law enforcement about the allegations and the failure to schedule an appointment at the Children's Resource Center.

Det. Lupey explained to the grand jury the purpose of a minimal facts interview of a child and the difference between that type of interview and a forensic interview of a child performed at the Children's Resource Center. The theory behind a minimal facts interview is that the child is not to be interviewed at all by a first responder unless absolutely necessary. The information is first and foremost supposed to be gathered from family members and others to whom the child has disclosed abuse. As for there being a requirement that the child must be interviewed, the Child Protective Services Law (CPSL) requires that the child be seen and that the child's safety be assured. Nothing in the law or regulations requires the child to be interviewed at that point in the investigation.

Children should, whenever possible, be interviewed by a child interview specialist. This is especially true for very young children such

[10] The Pinnacle Health Children's Resource Center (CRC) is a nationally accredited Child Advocacy Center located on North 3rd Street, Harrisburg, Pennsylvania. Children suspected of being abused are interviewed at the CRC by trained child interview specialist. While at the center, the children also receive a medical examination performed by medical personnel specifically trained in the area of child abuse. The interviews at the CRC are video recorded.

as the four year old in this case. There was no good reason why this child was not scheduled to be interviewed at the Children's Resource Center. Det. Lupey noted during her testimony that when the police found out about the allegations they did schedule an interview at the Children's Resource Center which resulted in the child disclosing information that identified a second potential victim and lead to the filing criminal charges. Ultimately the accused perpetrator committed suicide prior to any court proceeding in this case.

This allegation, pursuant to a protocol developed between the Dauphin County District Attorney's Office and Dauphin County CYS, should have been reported to law enforcement right away[11]. There is no requirement that Dauphin County CYS must first establish the validity of the allegation before it is reported to the police.

The conclusion reached by the grand jury was that the Caseworker #7's unfamiliarity with the Dauphin County Child Abuse Protocol and his inexperience in coordinating investigations with law enforcement resulted in a situation where a child abuse allegation was prematurely closed by the agency and thereby potentially endangered the child victim. What is of greater concern to the grand jury was the fact that Caseworker #7's supervisor approved the closure of this case and did not recognize that

[11] 23 Pa.C.S.A. § 6365 (c), requires counties to develop a protocol to coordinate the investigation of allegations of child abuse by law enforcement and the county CYS agency.

this case was not properly investigated. Furthermore, the supervisor did not ensure that the caseworker notified the police of the existence of the allegation.

## E. CY-48s and the 60 day time limit to complete investigations

During this investigation, the grand jury learned about the paperwork caseworkers are required to submit to ChildLine when a CPS investigation is completed. Caseworkers are required to submit to ChildLine a form known as a CY-48.[12] On this form caseworkers are required to include their determination concerning the validity of the child abuse allegation they investigated. Essentially there are three possible outcomes of an investigation. The caseworker can list that the allegation is ***unfounded***, ***indicated*** or ***founded***. An ***unfounded*** report is a conclusion made by the caseworker that there is not enough evidence to support the allegation. It could also signify that legally the allegation does not meet the legal criteria necessary under the Child Protective Services Law (CPSL) to be listed as either founded or indicated.[13] An ***indicated*** report signifies that the caseworker found substantial evidence to support the child abuse allegation. A ***founded*** report denotes that a judge, in a court proceeding, determined the allegation is true.

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[12] 55 Pa. Code § 3490.67

[13] For example, an eleven year old that sexually molests his 9 year old neighbor would not fit the definition of perpetrator under the CPSL. Therefore, because of his age, the 11 year old in this example cannot be determined to have committed child abuse under the CPSL.

Pennsylvania State Public Welfare Regulations require a CY-48 to be submitted to ChildLine within thirty calendar days from the initial report. If the investigation is of such a nature that it requires more than thirty days to complete, the agency is allowed an additional thirty days to complete their investigation. However, the agency is required to submit the CY-48 no later than sixty calendar days[14] after receiving the initial child abuse report. A failure to submit the report within sixty days will result in ChildLine automatically listing the investigation as unfounded (55 Pa. Code § 3490.69):

**Reports not received within 60-calendar days**

*When the CY-48 form is not filed with ChildLine within 60-calendar days of receipt of the report by ChildLine, the report shall be unfounded.*

There is one other category that the state permits a Children and Youth Agency to list on the CY-48. That category is known as *pending.*[15] ***Pending*** is allowed in situations where, for example, the police have made an arrest or the law enforcement investigation is still not complete. As a result, the agency determination is pending the

[14] Sixty calendar days include weekends and holidays. Practically speaking, sixty calendar days work out to be approximately 43 work days for the case worker to complete the investigation. Similarly, the preference for thirty calendar days constitutes approximately 22 work days.
[15] 55 Pa. Code § 3490.67

completion of the criminal and/or juvenile court proceedings. However, even when an agency lists an investigation as *pending*, they must still submit the CY-48 to ChildLine within the required sixty days. A failure to do so will result in the report automatically being determined to be *unfounded.* The grand jury also learned, although *pending* is a legitimate investigatory classification, the use of the *pending* category is frowned upon by the Pennsylvania Department of Human Services. In the past, Dauphin County CYS has been criticized by the DHS for over reliance on the *pending* category.

When the Dauphin County CYS restructure took place in 2014, many, if not most, caseworkers and their supervisors were unfamiliar with the submission of the CY-48 form. Many were also not prepared to deal with the strict time lines for the completion of a child abuse investigation and the submission of CY-48s as required by state regulations. With the stress of new job duties and requirements suddenly thrust upon them, caseworkers and supervisors alike struggled with the timelines required for the submission of the CY-48 form. The grand jury obtained multiple emails which were exchanged between senior management and the supervisors at Dauphin County CYS that demonstrate the agency, under the new organizational structure, was struggling with submitting CY-48 forms in a timely fashion. As far back as May 2014, there were email discussions

making senior management aware of the critical situation with the CY-48 forms.

On August 5, 2014, the agency received a phone call from representatives from ChildLine inquiring about three CY-48 forms that were submitted to ChildLine beyond the sixty day limit. One of the late reports was determined by the agency to be unfounded and therefore the consequences of the late report were negligible. However, two of the late reports submitted to ChildLine were child abuse reports that the investigating caseworker determined to be *indicated* reports of child abuse. As a result, two Dauphin County CYS *indicated* reports of child abuse were in jeopardy of being administratively listed as unfounded by ChildLine.

The ramifications of an indicated report administratively being listed as *unfounded* at ChildLine are serious and far reaching. First and foremost, as a consequence of this negligence, the alleged perpetrator of the investigated child abuse allegation is not listed on the state wide database of child abusers. This is the same database used by employers, Boy/Girl Scouts, schools and other child related organizations to obtain child abuse clearances for their employees and volunteers. Despite the fact that the agency determined that there was substantial evidence of child abuse committed by the perpetrator, that

person can potentially[16] [17] pass a child abuse background check when seeking employment or volunteering in positions that will put the person in contact with children.

The administrative *unfounded* registration at ChildLine could place the child victim of the abuse investigation back into in potentially dangerous situations with the alleged perpetrator. Even if the child does remain safe, there is still an emotional impact to the child and his or her family when they learn that the allegation of abuse was determined to be *unfounded* because of an administrative failure to submit in a form on time.

When the August 5, 2014, call from ChildLine was received by Dauphin County CYS, Supervisor #6 made handwritten notes of her conversation with the ChildLine representative. She listed the number ChildLine assigned to the investigation as well as the date each CY-48 was due and the date each one was received by ChildLine. Supervisor #6 then brought the information and her handwritten note concerning the late CY-48 reports to the attention of the Director of Operations,

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[16] We use the term *potentially* here because the grand jury recognizes there will be situations where law enforcement conducts a parallel criminal investigation and makes an arrest. The arrest and any resulting conviction should show up on the criminal records check during a child abuse background check. However, the grand jury also recognizes there are situations where the only investigation is the CYS investigation. In those cases in particular, there is no law enforcement safety net to prevent an indicated perpetrator of child abuse from evading a proper child abuse background check.

[17] Luckily, in this case, the Pennsylvania State Police conducted a concurrent investigation and criminal charges are currently pending against A.M.'s perpetrator. However, until A.M.'s perpetrator is convicted in criminal court, that perpetrator's name will not appear on the state wide child abuse database.

Jenna Shickley. Supervisor #6 left her handwritten note with Jenna Shickley at the conclusion of their meeting.

Ms. Shickley proceeded to add her own notations to Supervisor #6's written notes. Ms. Shickley added information to include the agency's investigative determination listed on the delinquent CY-48s and the type of child abuse allegation the agency investigated. In her own handwriting, Ms. Shickley wrote that two of the three late CY-48 reports were *indicated* reports. One was an investigation of sexual abuse, the other was an allegation of physical abuse. The remaining late CY-48 was an unfounded report of physical abuse.

Ms. Shickley later asked Michele Rush to contact ChildLine to provide the agency's response to ChildLine's inquiries concerning the late CY-48 reports. She then handed the handwritten notes created by Supervisor #6, and further supplemented by Ms. Shickley, to Ms. Rush. The thought was that since Ms. Rush had a long term working relationship with the authorities at ChildLine, she might be able to persuade them to accept the *indicated* CY-48 reports despite their late submission. Ms. Rush then proceeded to call ChildLine. Ultimately, ChildLine agreed to accept the two late *indicated* CY-48 reports. They accepted the *indicated* reports because the caseworkers that conducted those investigations had submitted to their supervisors their

determinations within the sixty day time limit. The *unfounded* report remained late and was marked as such by ChildLine.

On the same day Ms. Rush called to ChildLine to discuss the untimely CY-48 forms, two more CY-48 forms were submitted late by Dauphin County CYS to ChildLine. One report was indicated, the other was unfounded. Ms. Rush had previously been advised by one of her former CPS caseworkers, Caseworker #5, that the caseworker was very concerned that an indicated CY-48 that she submitted to her supervisors was on the verge of being submitted to ChildLine late. Knowing the importance of the report, Caseworker #5 made efforts to ensure her supervisors reviewed and submitted the CY-48 report on time. During this investigation, the grand jury obtained an email sent by Caseworker #5 to one of her supervisors concerning the pending CY-48 form she feared was about to be submitted late. The email, retrieved by Det. Sgt. Todd Johnson of the District Attorney's Criminal Investigations Division, revealed that the information sent by Caseworker #5's email was forwarded by her supervisor to Jenna Shickley. Despite Caseworker #5's efforts, the CY-48 was still submitted late to ChildLine.

**Question:** Did you have any of your cases that you know "I'm done the investigation, I've submitted the paperwork to

my supervisors," and that paperwork was not sent in on time?

**Caseworker #5:** *Yes.*

**Question:** What kind of case was that?

**Caseworker#5:** *A four year old who was sexually abused by his grandfather.*

**Question:** And that was something that was 'indicated' or 'unfounded'?

**Caseworker #5:** *I 'indicated' that.*

**Question:** Okay. So you felt that there was evidence that that four year old had indeed been sexually abused?

**Caseworker #5:** Yes.

**Question:** And, When did you find [out that the report was submitted late]?

**Caseworker #5:** *Two days after it was due.*

**Question:** ... Did you submit it to your supervisor on time?

**Caseworker #5:** *Yes.*

**Question:** Do you know if your supervisor submitted it to whomever she was supposed to submit it to on time?

**Caseworker #5:** *She did not.*

**Question:** Okay. Which supervisor would you have been responsible to submit it to? Because I know you had two supervisors, did you submit it to both?

**Caseworker #5:** *I submitted it to both because I, unfortunately, didn't trust that one of them would do it so I, as a backup to myself, I would submit to both.*

**Question:** Okay. So two supervisors were responsible then to make sure that it left their desk to get to the next place?

**Caseworker #5:** *Yes.*

Caseworker #5 was then asked how she felt when she found out the CY-48 form for this case was submitted late.

**Caseworker #5:** *I called Michele crying, wondering how I was going to explain to the family that I believed their son but there was going to be no record of it and that he wouldn't be held accountable if it got turned into an unfounded. I had no idea how to approach that with that family when this whole time they trusted me, and we had a good working relationship, for me to then come back and say I thought I had enough. And I put it in writing and for unforeseen circumstances it's no longer*

*indicated. I didn't know how to have that conversation.*

Ultimately, Caseworker #5 did not have to have that conversation as ChildLine agreed to accept that indicated report in the same manner they accepted the two late July 2014 reports.[18] Since Caseworker #5 did her due diligence to get the investigation finished on time and submitted it to her supervisors in a timely fashion, ChildLine agreed to accept the indicated report despite the fact the report arrived late. This would be the last *indicated* CY-48 report ChildLine accepted late. In December 2014, when yet another *indicated* report was submitted late by the Dauphin County CYS, ChildLine administratively listed that report as unfounded.

On February 25, 2015, both Kirsten Johnson and Jenna Shickley testified before the grand jury. Ms. Johnson and Ms. Shickley were both asked directly about the situation concerning the late submission of CY-48 forms to ChildLine by Dauphin County CYS. Prior to appearing before the grand jury, Dauphin County CYS, and Ms. Johnson in particular, were served a subpoena requesting any and all records regarding late CY-48 submissions by the agency to ChildLine,

[18] Despite the fact ChildLine accepted the three late CY-48 *indicated* reports of child abuse, the Department of Human Services (DHS) cited Dauphin County CYS for the late submission of the two unfounded reports. When a CYS agency is cited by DHS, a formal document called a L.I.S. is sent to the agency. The agency is then required to submit in writing to DHS the steps the agency will implement to rectify to situation that caused the delinquent reports of the CY-48 reports to ChildLine. Administrator Peter Vriens replied to the L.I.S. in this instance and then shared the document via email with his senior agency supervisors.

regardless whether ChildLine ultimately accepted the report despite its late submission.

Documents returned to the grand jury pursuant to our subpoena requesting information about late CY-48 forms acknowledged only one *indicated* report was submitted late to ChildLine by Dauphin County CYS. That indicated report was submitted late to ChildLine in December 2014. In her testimony on February 25, 2015, Jenna Shickley admitted that she was responsible for the late submission of the December 2014 *indicated* report concerning a child named A.M. Both Jenna Shickley and Kirsten Johnson denied any knowledge of the two July 2014 indicated reports sent late to ChildLine or the August 2014 report about which Caseworker #5 was so concerned.

**Question:** And as it relates to CY-48s, the CY-48 is the form number sent to ChildLine; is that correct?

**Ms. Johnson:** *That is correct.*

**Question:** All right. So if there are any cases in addition to the one involving [A.M.], that is something that you should be aware of that; is that correct?

**Ms. Johnson:** *If there were late submissions?*

**Question:** Yes.

**Ms. Johnson:** *Yes.*

**Question:** And you're indicating that you are not aware of any other late submissions or anything like that?

**Ms. Johnson:** *I am not aware of any other late submissions of any indicated reports. No, I am not.*

Jenna Shickley was also questioned concerning the late submission of CY-48 reports in July 2014:

**Question:** ...With your agency from January 2013 through February 2015, through today, other than [A.M.'s case], are you aware of any other situations where reports were sent late to ChildLine from your agency?

**Ms. Shickley:** *Yes.*

**Question:** Okay. How many more reports?

**Ms. Shickley:** *I think it was two.*

**Question:** Okay?

**Ms. Shickley:** *I'm not positive.*

**Question:** And when I'm talking about reports being sent late, I'm talking about ones that would have been indicated?

**Ms. Shickley:** *Oh, no, there are none.*

**Question:** There are none that were indicated sent late?

**Ms. Shickley:** *That I'm -- none that I'm aware of.*

**Question:** Okay. So the ones that you're saying that there were two potentially, what are you talking about with that? Let me ask you this?

**Ms. Shickley:** *They were unfounded.*

**Question:** And when were they - - when were those two sent in late?

**Ms. Shickley:** *It was right around the beginning of our - - of March of last year. And I don't - - I don't recall the exact time frame, but it was right around that time.*

**Question:** Okay. Are you aware of two individual reports in July of 2014 that were sent to ChildLine late?

**Ms. Shickley:** *No.*

**Question:** And are you aware of reports from roughly around the July of 2014 that were, although they were received late by ChildLine, that ChildLine accepted them anyway, despite the fact that they were late? Are you aware of any of those?

**Ms. Shickley:** *No.*

At the time of Ms. Shickley's testimony, the grand jury was unaware of the handwritten notes taken by Supervisor #6 and supplemented by

Ms. Shickley. Ms. Shickley's testimony, overall left an impression that the issue of late CY-48 reports was essentially no more an issue than in other years.

On February 27, 2015, Michele Rush testified before the grand jury pursuant to a subpoena issued on February 26, 2015. It was during Ms. Rush's testimony that the grand jury first learned about the handwritten notes.

> **Ms. Rush:** ...*We received notice from the state - - it actually went to my director, Jenna Shickley, that these three reports were overdue. She had written everything down for me and provided everything to me in writing. Child -- the director of ChildLine had requested that I give them a call back. I called them back, it would have been the first week in August...*

Ms. Rush then continued with her testimony and discussed in more detail the handwritten note.

**Question:** And Jenna knew that?

**Ms. Rush:** *Jenna provided me with the phone message in writing with each ChildLine number and whether it was indicated and unfounded and the date it should have been received and the date it was actually received. So I got it in writing.*

**Question:** And is that in her handwriting?

**Ms. Rush:** *Yes.*

Ms. Rush later testified to the following concerning her conversation with officials at ChildLine and to whom at Dauphin County CYS she reported back the results of her conversation:

*So based off the conversation, what I was told is that because the two of them were indicated and because the dates on the bottom of the 48 were within the time frame even though they didn't come to me within the time frame, that they would be accepted as timely by the state because they were indicated and the impact that it would have on these children.*

*So I passed the information along to Rick, Jenna, Kirsten and Peter. Kirsten asked me how I was able to*

*make that happen and I explained it wasn't what I made happen, it was the relationship and the work that we've produced throughout all these years that caused them to question what is going on now that this is not happening. And because they were indicated and they impact a child they accepted them as timely.*

The grand jury proceeded to subpoena records from ChildLine regarding the CY-48 reports that were listed on the handwritten notes prepared by Supervisor #6 and supplemented by Jenna Shickley and Michele Rush. A review of the records obtained from ChildLine confirms that three *indicated* reports, in addition to the December 2014 case involving A.M., were sent to ChildLine beyond the sixty calendar day time limit. As discussed above, ChildLine accepted those reports despite the lateness of the report. The records also reveal, confirming the reason ChildLine provided for accepting the late report, that the caseworkers completed their investigations and submitted the reports to their supervisors at Dauphin County CYS before the sixty day due date.

On May 26, 2015, Jenna Shickley and Kirsten Johnson were recalled to testify. Once again they were questioned concerning the late submission to ChildLine of indicated CY-48 reports during 2014.

Both Ms. Johnson and Ms. Shickley continued to deny knowledge of the delinquent submission of indicated CY-48 reports to ChildLine. Ms. Shickley was shown a copy of the handwritten notes compiled by Supervisor #6. Ms. Shickley admitted that her handwriting was included on those notes. She also admitted that she added in her own handwriting to the notes that two of the three late submissions to ChildLine were *indicated* reports. Despite being shown her own notes, Ms. Shickley testified that she could not recall discussing those cases with either Supervisor #6 or Michele Rush. She also indicated that she had no memory of Michele Rush reporting back to her that ChildLine had agreed to accept the *indicated* reports despite the fact they were submitted beyond the sixty day limit.

After reviewing all of the testimony and evidence presented to us concerning Dauphin County CYS' late submission of CY-48 reports, we find that Ms. Shickley's testimony denying knowledge of the late reports not to be credible. Notes written by her own hand prove she had knowledge of at least two of the three reports in question. The handwritten note directly conflicts with both her February 25, 2015, and May 26, 2015, testimonies.

Ms. Shickley admitted during her testimony of May 26, 2015, that the late submission to ChildLine of an *indicated* report is an alarming situation for the agency. She testified concerning her own late

submission of A.M.'s indicated report in December 2014 was a traumatic event for her. She described the emotions of having to notify A.M.'s family, the investigating state trooper and the District Attorney's Office of her mistake. Her testimony echoed the testimony of Caseworker #5, who described the emotions she experienced when back in August 2014 when she believed she would have to make similar notifications in her case when her supervisors failed to forward her report in a timely fashion.

Given the number of witnesses that testified to the importance of the timely submission of CY-48 reports, and the dire consequences of failing to submit a report on time, the grand jury does not believe that the two *indicated* reports in July 2014 and one indicated report in August 2014 went unnoticed by Ms. Shickley. Especially since there is direct proof that she was made aware of the situation. To claim that she has no memory of the event and any subsequent information is simply not believable.

Ms. Johnson also claims to have no knowledge of the late CY-48 reports in question. The grand jury also finds her testimony to be suspect. The grand jury acknowledges there is no direct link to Ms. Johnson and the handwritten notes. Nor did the grand jury find any emails to, or from, Ms. Johnson specifically referencing the late indicated CY-48 reports. However, we did hear testimony from Ms. Rush that she advised her superiors of the situation. The grand jury found the testimony of Michele Rush to be credible.

When she testified, Ms. Rush provided the grand jury with documents and emails to back up her testimony. Additionally, various witnesses, including Jenna Shickley, noted during their testimony that a L.I.S. citation[19] concerning the late submission to ChildLine of the two unfounded reports, was shared by Peter Vriens with his senior staff.

The grand jury also reviewed an email sent by Ms. Johnson in September 2014 announcing changes in Dauphin County CYS' procedures concerning the submission of CY-48 reports. Ms. Johnson, during her May 26, 2015, testimony, explained that it was noted by senior management at the agency that since Michele Rush was not the chain of command of the team supervisors, Ms. Rush was having a difficult time getting the supervisors to accept her advice concerning the CY-48 reports. Therefore, the supervisors, starting on October 1, 2014, were required to submit the reports directly to Jenna Shickley. Ms. Shickley would then submit the reports to ChildLine. The timing of these changes seems more than just coincidental.

## F. Other specific CYS cases reviewed by the grand jury

During the course of our investigation into the death of Jarrod Tutko, Jr., the grand jury became aware of other cases where Dauphin County CYS was

[19] Licensing/Approval/Registration Inspection Summary- this is a citation issued by the Department of Human Services to a county CYS agency requiring the county agency to provide a plan of action to correct the cited infraction, in this case the late submission of CY-48s.

actively involved with a child and/or the child's family when later the child or a sibling became the victim of a serious injury, medical neglect or death. **Just days before this report was finalized, the grand jury became aware of the tragic May 8, 2015, death of five-month-old L.H.** The correlation between Dauphin County CYS interaction with L.H.'s family is eerily similar to the Tutko case. Dauphin County CYS was involved with L.H.'s family for approximately 12 years. Issues of neglect, dirty children and unstable homes frame the history of this family's contact with Dauphin County CYS. While the family cooperated with the most recent CYS investigation, their cooperation was conditional. They refused to allow the caseworker to photograph all of their children and more importantly, in light of the Tutko case, would not allow the caseworker to view the entire home. Given the Dauphin County CYS history with this family, red flags should have been raised immediately and a more thorough examination of the home and children should have resulted. Two days later, an emaciated[20] five month old baby girl, lay dead in the same morgue as Jarrod Tutko, Jr., had nine months earlier.

The grand jury believes the number of these incidents reflects a serious situation which needs to be addressed in this report. In particular, the grand jury found that caseworkers working on complex cases involving medical neglect are often not properly trained to understand the nature of the situation they are assessing. Our review of these cases just as importantly shows a pattern of poor

[20] L.H. weighed 4.4 pounds at the time of her death.

decision making on the part of the Dauphin County CYS administration. The grand jury reviewed the following CYS cases in addition to investigating Jarrod Tutko, Jr.'s death:

- ***In the matter of S. P.:*** This was a medical neglect case. S.P. was nine years old when she was rushed to Hershey Medical Center. When she was admitted to the hospital she was in a deplorable state. She had no subcutaneous fat on her body, she was severely malnourished and dehydrated and her body was covered with lice. What is shocking about this case was that a caseworker from Dauphin County CYS was regularly meeting with this family and providing services in the home during the timeframe the child was suffering from malnutrition. Dauphin County CYS was involved with S.P. and her family for many years. During their contact with S.P.'s parents the agency encountered many instances where the family failed to follow through with the agency's requests. Like Jarrod Tutko, Jr., S.P. was not enrolled in school. Enrollment in school for children with special needs is critical not only for educational purposes but schools also provide the physical/health needs of these children. Dauphin County CYS allowed the deteriorating situation involving S.P. and her siblings to go on well beyond reasonable efforts to get the family to voluntarily comply with the agency's requests. Dauphin County CYS should have legally intervened in S.P.'s case much sooner.

- ***In the matter of J.M.:*** J.M.'s is another example of a case that demonstrates the need for improved training for caseworkers so caseworkers will recognize the situations they are observing as they interact with families. In this case, J.M. was admitted to the hospital with multiple fractures to many parts of his body. In essence, he was literally a broken child. Skeletal scans of his body showed that many of his fractures were months old and had healed improperly. Because of the angle that the fractures healed, their presence was obvious. Dauphin County CYS caseworkers were involved with this family during the time period J.M. was being abused. Caseworkers did not notice his severe injuries despite holding the child. Nor did they recognize his delays in reaching developmental milestones.
- ***In the matter of C.A.:*** This case came into the agency as a reported physical abuse of C.A.'s older sibling. Caseworker #8 was assigned to investigate this case. Much like the actions of Caseworker #7 in the case described by Det. Lupey above, the Caseworker #8 conducted her own interview of the young child subject of the reported physical abuse. Given the child's age and the caseworker's lack of training on how to interview very young children, an interview conducted by a child interview specialist at the Children's Resource Center was warranted in this situation. Additionally, it was noted that the boyfriend of the children's mother had been convicted in the past of endangering the

welfare of children. A detective from the Harrisburg Police Department requested that Caseworker #8 arrange for the child to be interviewed at the Children's Resource Center. The requested interview was never scheduled by Caseworker #8. Caseworker #8's supervisors instructed her to take some additional steps in the case but essentially agreed with Caseworker #8's decision to close out the investigation as *unfounded*. Caseworker #8 never followed up on the case as she was instructed by her supervisors. Two months later in January 2015, C.A. was rushed to the hospital with serious life threatening injuries. After C.A's admission to the hospital, Dauphin County CYS disciplined Caseworker #8's supervisors for their failure to ensure that she followed through on their instructions to her concerning the case. Caseworker #8 was also in line for disciplinary action but resigned from Dauphin County CYS before said discipline could be given to her.

- ***In the matter of K.C.:*** This is case of medical neglect by parents of a child with complex medical issues. Dr. Crowell testified that she was concerned that the family was not properly following up with medical care and missing important scheduled medical appointments necessary for K.C.'s care. Dr. Crowell felt the caseworker assigned to the case was not as concerned as she was about the situation. K.C. missed ten straight days of critical medication which resulted in his losing weight. Ultimately, Dr. Crowell considered the situation serious

enough to reach out to someone at the Department of Human Services to report the situation.

- ***In the matter of J. B.:*** This was yet another case of medical neglect referred to the agency by Hershey Medical Center in 2014. The same caseworker assigned to K.C.'s case was assigned this case. Dr. Crowell testified that she had serious concerns that the caseworker was not following through with this child's case. The family missed approximately thirteen doctor appointments. Doctors at Hershey Medical Center noticed that prescriptions written by them were not being filled. The child continued to lose weight.

A review of other cases cause the grand jury to question the decision making of Dauphin County CYS to the highest levels of the agency. Two situations in particular illustrate this point:

- ***In the matter of C.R. and D.R.:*** C.R. and D.R. came into the custody of Dauphin County CYS after they were abandoned along with two other siblings by their mother. The two sisters were place with a foster family. They appeared to be doing well with this family and since their mother eventually agreed to relinquish her parental rights, the foster family volunteered to adopt the sister. This family had already adopted two other children prior to fostering the sisters.

Every year foster parents are required to be recertified as foster parents. The foster parents in this case were required to recertify in November 2012. In addition to recertification, foster parents are also required to notify the agency of any changes concerning issues that might disqualify them as foster parents.

In July 2012, the foster father was arrested for sexually assaulting an adult female acquaintance. Among other charges, he was charged with Aggravated Indecent Assault which is graded as a felony of the second degree punishable up to ten years in prison. Neither the foster father nor the foster mother made the agency aware of his criminal charges. On October 1, 2012, the agency sent the family a letter notifying them that it was time to recertify. On October 31, 2012, the foster mom finally notified the agency of the pending charges.

The failure by the foster mother to make the agency aware of her husband's pending charges was a violation. Instead of immediately removing the children, which was advocated by the agency solicitor, the children's guardian ad litem and others at the agency, a series meetings were held at the agency over the next few days to discuss their options. The caseworkers working directly with the family felt it would be detrimental to remove the children and disrupted them once again given their history. The top administrators at the agency

attended the meeting including Peter Vreins, Kirsten Johnson, Jenna Shickley and Rick Vukmantic.

On October 31, 2012, a call was placed to representatives from the Department of Human Services (DHS) to solicit their advice. Dauphin County CYS was advised that DHS felt the children should be removed from the home but ultimately the decision was Dauphin County's to make. While still debating a final decision in this matter, the agency approved the foster mother's recertification despite her failure to report her husband's arrest. A safety plan was developed leaving the children with the foster family and removing the foster father from the home. However, he was not completely out of the picture. He was allowed to come to the home each day to work on the family's farm. A third party was designated to supervise any contact he had with the children.

Almost immediately the foster mother complained to the agency that the arrangement was putting a strain on her relationship with her husband. At the same time she began to discuss the option of seeking to adopt the children alone. Although, she was considering adopting the children alone, she was not considering divorcing her husband at this time.

Due to the strain of relationship with her husband, the foster mother requested the safety plan be changed to allow her to supervise her

husband's contact with the children without the need for a third party being present. Despite the charges still pending against the foster father, and the foster mother's initial failure to report the charges, the agency not only entertained the idea, they actually agreed with the plan.

On June 13, 2013, the foster father pleaded guilty to indecent assault. The agency was informed of his guilty plea on June 17, 2013. Once again the agency held a series of meetings to discuss the new situation. Kirsten Johnson was present for a meeting held on June 18, 2013 to discuss the situation. Again, despite strong objections from the children's guardian ad litem and legal concerns about the liability the agency was opening itself up to by leaving the children in the home, the consensus was to leave the children in the home and let the foster mother proceed with the adoption. Two days later a decision was made to finally remove the children from the foster home.

The children were ultimately adopted by another family. In the fall of 2013, the girls disclosed to their new family that they had been sexually molested by the original foster father and the foster family's son. While a criminal investigation was conducted into the allegations, the reviewing District Attorney's Office in the county where the foster

parents lived decided not to pursue criminal charges due to the age of the children.[21]

Kirsten Johnson was asked during her May 26, 2015, testimony the decision making she and the agency made in this case to leave the children in this home:

**Question:** I mean, one of the comments in here was after he had plead guilty and the decision was made to leave the children there was, what's changed today that wasn't the same yesterday, as if that the children are still safe in that situation.

Is this a situation that you feel that if they were your children that they should have been left in this type of situation, if someone was making a decision about your children?

**Ms. Johnson:** *No.*

Her answer to that question clearly defined the inappropriateness of the agency's decision to leave these children that foster home.

- ***Caseworker #7's Dominican Republic Trip:*** Finally, the grand jury heard testimony concerning a situation of a child in Dauphin County

[21] The foster family did not reside in Dauphin County.

CYS custody that was being sent to live with family in the Dominican Republic. Caseworker #7 was assigned this case. It was decided that Caseworker #7 would accompany the child to the Dominican Republic to help that child make the transition to his new home. Caseworker #7 however did not speak Spanish so an interpreter would be needed to accompany him during this trip. A decision was made by the agency to contract with an interpreter. The interpreter contracted by the agency was Caseworker #7's fiancé. The agency paid for Caseworker #7 and his fiancé to travel to the Dominican Republic. It was learned that they also brought their infant child with them on this trip.[22] While there is no evidence that there were any inappropriate actions by Caseworker #7 and his fiancé during the trip, the decision by the agency to approve contracting with Caseworker #7's fiancé to provide interpreting services on an international trip has the appearance of impropriety and was ill advised.

[22] The agency did not pay for the child to travel with them.

## Section II.

## Conclusions

### I. The Role of Dauphin County CYS in the Death of Jarrod Tutko, Jr.

While the grand jury has serious concerns with the manner in which Dauphin County CYS handled the October 23, 2013, and January 21, 2014, child abuse referrals, we do not find the actions, or for that matter inactions, by employees of Dauphin County CYS meet the criteria to recommend criminal charges against any employees of Dauphin County CYS as related to the death of Jarrod Tutko, Jr.

The grand jury reviewed the language of the charge of **Endangering the Welfare of Children** (18 Pa.C.S.A. § 4304):

**(a) Offense defined.--**

(1) A parent, guardian or other person supervising the welfare of a child under 18 years of age, or a person that employs or supervises such a person, commits an offense if he knowingly endangers the welfare of the child by violating a duty of care, protection or support.
(2) A person commits an offense if the person, in an official capacity, prevents or interferes with the making of a report of suspected child abuse under 23 Pa.C.S. Ch. 63 (relating to child protective services).
(3) As used in this subsection, the term "person supervising the welfare of a child" means a person other than a parent or guardian that provides care, education, training or control of a child.

To substantiate a charge of Endangering the Welfare of a Child, the actions or inactions of those responsible for the welfare of a child must be made **knowingly**. A *knowing act*, as it relates to endangering the welfare of a child, requires the following:

> "The three-prong standard to determine whether an accused acted knowingly for purposes of endangering the welfare of a child requires that: **(1)** the accused must be aware of his or her duty to protect the child; **(2)** the accused must be aware that the child is in circumstances that could threaten the child's physical or psychological welfare; **and (3)** the accused either must have failed to act or must have taken action so lame or meager that such actions cannot reasonably be expected to protect the child's welfare." *Commonwealth v. Retkofsky, 860 A.2d 1098, 1099-1100, 2004 PA Super 399 (2004).*

While the grand jury finds that the employees of Dauphin County CYS involved in the October 23, 2013, investigation meet the first prong of the standard[23] discussed in *Retkofsky*, we also find that they were not aware that Jarrod Junior was in "circumstances that could threaten the child's physical or psychological welfare." While there were clearly additional steps the caseworkers and supervisor investigating the Tutko home should have taken, the information they did obtain during their investigation did not reveal anything near the level of proof necessary to make them aware, at a criminally culpable level, of Jarrod Tutko, Jr.'s situation. Whatever missteps were taken during the October 23, 2013, referral investigation, their conduct during the investigation did not rise to the level where they "failed to act" or took actions "so lame or meager" that such actions endangered Jarrod Tutko, Jr.'s welfare.

Overall, the first and second floors that the caseworkers and supervisor observed in the Tutko home were clean and appeared organized. The family presented to the supervisor a schedule the Tutko parents allegedly followed outlining their daily routine of care for all of their children, especially those with special needs. While the Tutkos refused to sign medical releases

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[23] The grand jury found that the caseworkers and supervisor from Dauphin County CYS investigating the October 23, 2013, referral do meet the class of "persons supervising the welfare of a child" that can be held criminally responsible under the crime of endangering the welfare of a child (18 Pa.C.S.A. § 4304). While they were not directly involved in the supervision of Jarrod Tutko, Jr., the Pennsylvania Supreme Court recently ruled that the statute refers to the supervision of the child's "welfare" rather than "direct" or "actual" supervision of the child himself. *Commonwealth v. Lynn, --- A.3d ---- (2015).* Using that standard, it is clear that the caseworkers and supervisor had a legal obligation ensure the safety and welfare of Jarrod Tutko, Jr.

to allow Dauphin County CYS access to the medical records of their children, they did allow the supervisor to view the binders the family had complied concerning the medical treatment their children were receiving. Even Caseworker #1, who had serious concerns about the situation she observed in the Tutko home, did not feel there was enough evidence of abuse or danger to the children that would warrant Dauphin County CYS to obtain a court order to force the Tutko parents to cooperate with the investigation.

## II. Conclusions concerning Dauphin County CYS' overall handling of referrals concerning the Tutko children

The grand jury does find evidence of serious deficiencies with the investigations and the safety assessments conducted by Dauphin County CYS throughout the agency's years of contact with the Tutko family.

Starting with the **July 7, 2006**, referral from NJ-DYFS, there is a pattern by the Dauphin County CYS to ***screen out*** referrals without doing at least a minimal review of the report being made to the agency. Three of the six referrals received by the agency between 2008 and 2014 were either *screened out* or designated as *information only*. After receiving the 2006 referral indicating caseworkers from a CYS agency in New Jersey were *"concerned that the family is not receiving services [in Pennsylvania] like they were receiving in New Jersey"*, Dauphin County CYS caseworkers *screened out* the referral without any

investigation or follow-up to determine the extent of the Tutko family's involvement with NJ-DYFS. Even a cursory check should have revealed the fact that Kimberly Tutko had a previous indicated report of abuse and had her parental rights to her older children terminated by Schuylkill County CYS.

Officials from Dauphin County CYS indicated during testimony that the referral from NJ-DYFS did not contain enough information concerning an address for the Tutko family. Often, as was the situation when Kimberly Tutko called the agency in 2002, people call Dauphin County CYS due to the simple fact that state capital is located in Dauphin County. While that may often be the case, the fact is when NJ-DYFS called Dauphin County CYS in 2006, the Tutko family was indeed living in Dauphin County. A more exhaustive search for information concerning the location of the Tutko family was warranted in this instance.

Upon following up with the referral, instead of screening it out, caseworkers would have ascertained the extensive contact NJ-DYFS had with the Tutko family, and further learned the fact that both Jarrod Junior and A.R.T. had been previously taken into foster care due to neglect. This information alone should have warranted at least a safety assessment of the Tutko children. Instead, without any independent investigation of the referral, the referral was treated as information only and closed out.

The screening out of the **January 21, 2014**, referral from Hershey Medical Center is of particular concern. By this time the agency had a considerable amount of information concerning the Tutko family history of indicated abuse

findings in New Jersey and Schuylkill County. In addition, the agency records contained repeated referrals received from the Harrisburg School District concerning neglect and potential domestic violence in the home. To disregard the January 21, 2014, Hershey Medical Center referral without even conducting a safety assessment of the child named in the referral is unconscionable. Even worse, it appears from the records and Caseworker #3's testimony, that this report was completely disregarded and summarily marked ***information only.***

While the grand jury understands the volume of reports[24] received by Dauphin County CYS does not permit the agency to do a full and complete assessment of every referral, the deficiencies the grand jury noted in its review of the agency's contact with the Tutko family are symptomatic of more than just high volume and caseload constraints. We found repeated examples of missing documentation, incomplete reports, and lack of supervisory documentation not only in Dauphin County CYS' Tutko files, but also across the board in other files reviewed by the grand jury during this investigation. The grand jury found that these deficiencies stemmed in large part from a combination of insufficient

[24] As of May 22, 2015, Child Abuse referrals to Dauphin County CYS have increased 128% over 2014 referral numbers. During that time frame the agency lost a substantial number of caseworkers due to turnover. Many caseworkers left the agency in response to the 2014 restructure. The agency is now faced with a crisis situation of dealing with a torrential increase in referrals while having to replace departing caseworkers with newly hired untrained caseworkers. In May, 2015, alone the agency hired 15 new caseworkers and that covers only a portion of the number of positions the agency still needs to fill. The primary reason for the increase in child abuse referrals is a change to Pennsylvania's Mandatory Reporter law that increased the number of persons required to report child abuse. At the same time the law broadened the definition of child abuse. 23 Pa.C.S.A. §

training for caseworkers and supervisors alike for the duties to which they were assigned.

The caseworkers assigned to investigate the October 23, 2013, referral were not prepared or adequately trained to recognize the seriousness of what they encountered when they assessed the safety of the children in the Tutko home. The Tutko family presented the caseworkers with a number of complex issues. First, the majority of the Tutko children had unique and complex medical conditions. A.R.T. was confined to a hospital bed and was reported by the parents to be in a vegetated state. Jarrod Tutko, Jr. reportedly had Fragile X syndrome. D.T. was deaf. A.N.T. reportedly had issues of defiance that were being dealt with through counseling. B.T. exhibited traits and behavior that might indicate that she is autistic. Second, Kimberly and Jarrod Tutko, Sr., were not receptive to Dauphin County CYS conducting an investigation. They refused to sign medical releases and became, at times, verbally hostile with at least one caseworker. Third, in the background of all these issues was the referral concerning potential domestic violence in the Tutko home.

The caseworkers and supervisor handling this investigation admittedly did not have experience dealing with a child presenting with Fragile X syndrome. While Jarrod Tutko, Jr., appeared thin, they did not know how much of that appearance would be due to his condition rather than malnutrition. In examining A.R.T., confined to a hospital bed, they did not know what to look for to ensure she was receiving proper care. Assistant Administrator Johnson testified that the

agency had the ability to consult doctors at the Children's Resource Center and Hershey Medical Center, yet that was never done in this case. Nor is there is any record to indicate that option was even contemplated.

The grand jury found that there were a number of missed opportunities during the agency's investigation of the October 23, 2013, referral.

1. No one from Dauphin County CYS ever inspected the third floor of the Tutko residence. When conducting a safety assessment, they should have insisted on examining all of the living and sleeping areas of the home.
2. When confronted with the complex and serious medical, intellectual and mental health conditions of the Tutko children, the agency should have made additional efforts to obtain child welfare records and medical documentation regarding all of the children in the home.
3. Dauphin County CYS did not make reasonable efforts to confirm information being shared by the parent through collateral contacts.
    a. Given the family history obtained during the investigation, and the information they obtained during their own investigation concerning domestic violence in the home, the agency should have taken steps to obtain court approval to access medical records and speak with the care providers.

b. The agency should have followed up with the Harrisburg School District to ensure that the family was following through with the agency's request to have Jarrod Tutko, Jr., and A.R.T. enrolled. Communication between Dauphin County CYS and the Harrisburg School District might have helped to facilitate the District's processing of the enrollment of Jarrod Junior.

4. The agency called an 'emergency triage' meeting at Caseworker #1's request to discuss the difficulties with, and concerns about, Tutko parents. This meeting resulted in Caseworker #2, and with him Supervisor #1, being assigned the case. At the time the decision was made to close the Tutko case approximately a month later, many of the goals decided upon at the initial 'emergency triage' meeting still had not been met. The Tutkos were still refusing to sign medical releases. Furthermore, there was no independent confirmation to ensure that the family enrolled Jarrod Junior and A.R.T. in school. Given the discrepancies in the assessments between Caseworker #1 and Caseworker #2, a second 'triage' type meeting should have been utilized to reconcile the differences between caseworker assessments.

## III. Conclusions concerning Dauphin County CYS Reorganization

The problem of inexperienced and inadequately trained caseworkers and supervisors was exacerbated by the agency's reorganization in 2014.[25] The grand jury is not in a position to, nor do we have adequate information to, question the reasons behind Dauphin County CYS' decision to restructure. As discussed above[26], some of the goals of the restructure, such as the increased team approach to screen new referrals and improve decision making, were lauded by a number of the witnesses. Where the grand jury finds fault is with the implementation of the restructure. Whatever the plans were for how GPS and CPS cases were going to be investigated quickly fell to the wayside and the responsibility to investigate these cases fell upon caseworkers inexperienced with CPS investigations. Caseworkers were not only unfamiliar with the requirements and rigors of these investigations, but they were also unfamiliar with the process of how to properly conduct a CPS investigation. Their supervisors similarly were unprepared and inexperienced in supervising caseworkers with a CPS caseload. It appears there was no comprehensive plan to train the caseworkers and supervisors for their new roles. Nor does it appear there was much of a real, planned out, transition period. The reality of the

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[25] The reference to inexperience and inadequately trained caseworkers/supervisors as used in this section of the report refers to their lack of training on how to investigate GPS/CPS cases and not necessarily the number of overall years of experience each worker had with the agency.

[26] *See*, **Section I** (*Findings*), **Heading IV** (*Dauphin County Children & Youth*) **subsections A** (*The Restructure*), **B** (*Training of Caseworkers & Supervisors*), **C** (*The impact of the restructure & insufficient training issues on Dauphin County CYS*), **D** (*A breakdown of coordination between law enforcement and CYS*) and **E** (*CY-48s and the 60 day time limit to complete investigations*) for a detailed discussion of the Dauphin County CYS 2014 restructure.

situation was that the restructure took place and almost immediately substantial issues with the new organizational structure appeared. Despite the obvious problems that arose, Dauphin County CYS administration refused to alter their implementation of the restructure plan.

As we discussed above, required paperwork was submitted late to ChildLine and Dauphin County CYS' relationship with law enforcement deteriorated. Caseworkers, in an alarmingly high number of cases missed the signs of abuse that were present right before their eyes. Ultimately all these factors lead the grand jury to the conclusion that the current situation at Dauphin County Children & Youth Services is detrimentally impacting the very children the agency is tasked with protecting.

Kirsten Johnson agreed during her May 26, 2015, testimony that the agency did not properly plan out the transition period between their old and new organizational structure. In particular, they did not anticipate how unprepared the supervisors were for their new roles managing not only the type of cases they were familiar with but also taking on all cases the agency handled. That failure lead the agency down a path it has yet to recover from.

Ultimately, the blame for these deficiencies must rest with the administrators and directors of Dauphin County Children & Youth Services.[27] By failing to put into place an adequate system to review, correct and mitigate the

[27] In addition to Kirsten Johnson and Jenna Shickly, the grand jury notes that former Administrator Peter Vriens and Directors Rick Vukmanic and Dave Mattern, were also part of the senior leadership of the agency during this time period.

problems that the administration knew existed, they have put the agency in a position that most likely has jeopardized Dauphin County Children & Youth Services' state license. We had an opportunity to review as part of our investigation the Department of Human Services' review of Dauphin County Children & Youth Services' handling of the Tutko family referrals discussed above. Many of the same issues we identify in this report concerning the October 2013 and the January 2014 referrals concerning the Tutko children were noted during the state review.

## Section III

## Recommendations

Throughout the course of our investigation, we repeatedly encountered issues along four common themes: insufficient training, lack of coordination and communication between Dauphin County CYS and outside agencies and disciplines, unmanageably high caseloads, and a state regulatory requirement that results in indicated reports of abuse being administratively listed as unfounded if the CY-48 report is not filed with ChildLine within sixty calendar days.

## I. Training

A. The realm of child-welfare is expansive, ranging from investigations of suspected child abuse and neglect, to in-home services, independent living, and permanency. Training on a broad-base does not give a caseworker the necessary knowledge and skills to work in any specific area. The grand jury heard testimony concerning the lack of practical hands on training for caseworkers dealing with a multitude of diverse situations from cases of sexual abuse, domestic violence, physical abuse, complex cases of medical neglect and child homicide investigations. It is also evident through the testimony before the grand jury that CPS and GPS investigations do not occur in a vacuum. They are intertwined and comingled with law enforcement investigations. Trainings that promote joint investigations and cohesive approaches reduce trauma to the child victim and ensures the safety of the child while also ensuring the successful pursuit of criminal charges.

B. The grand jury had the opportunity to hear testimony about an in-house training system that worked and produced skilled, knowledgeable CPS intake caseworkers at Dauphin County CYS.[28] **It is a finding of the grand jury that a caseworker has to have specialized training and knowledge to properly do an investigation. There is a need for this personalized, hands-on training to be implemented state-wide, in each county agency.**

[28] This training program is discussed in detail in this report on pages 45-49.

C. ChildFirst

(1) Testimony of several individuals cited to a specific training, ChildFirst, which took a multidisciplinary approach. It was lauded as not only being helpful, but being directly applicable to the work the caseworker was doing. One caseworker described it as follows:

*One of the trainings that I remember most was the Child First training, a week-long training out in Hershey. And it was with caseworkers, law enforcement, you know, people from the district attorney's office and we were all there.*

*It was somewhat of a classroom-based training. But like I said, it was a week-long training and we actually got to act things out.*

*On one of the days they actually brought in some kids from the Derry Township School District to act for us and, you know, we had to do mock interviews of the kids and we were critiqued on how we did the interviews and how we interacted with the kids.*

*And that's one of the trainings that I've taken over my eight years doing child abuse investigation that stuck with me the most.*

(2) The training has members from the entire multi-disciplinary investigative team (MDIT) train together, and they work through the

process of receiving referrals and interviewing children. The MDIT team includes a caseworker, a police officer and a prosecutor. It provides the opportunity for the team to work together to go through the process, and learn how to work together without interfering with each agency's process. Further, it is a training on putting the child first through the entire process and ensuring that the child is always the priority. There is a demonstrated need for this training and others like it to receive state-support and state-wide implementation.

(3) Previously, ChildFirst in Pennsylvania has been supported through federal Children's Justice Act funds. As a result, the training and related lodging and meals have historically been offered to participants free of charge.

**(4) Recommendation: The grand jury recommends that Pennsylvania support ChildFirst and similar MDIT type trainings with continued Children's Justice Act or other funding to ensure this proven program continues to be available to caseworkers, police officers, Children and Youth solicitors and prosecutors.**

D. Establishment of a Pennsylvania Child Protection Training Center (PaCPTC)

(1) The collective attitude towards training of those that testified before the grand-jury was that it needed to be hands-on and scenario based. During the course of the grand-jury investigation, a training occurred at Harrisburg

Area Community College (HACC) that was attended by caseworkers and supervisors from Dauphin County CYS.[29] That training also contained a safety portion for the caseworkers. Additionally, it provided an opportunity for caseworkers to interact in scenarios. One supervisor felt that this training was exactly what new caseworkers need. She stated:

> *That should be done from the get-go. People should know what you're walking into when you're hired in this field and what you could potentially find when you knock on a door.*
>
> *...there's no clear cut case. But everything that is going to give you hands-on experience is really beneficial to a caseworker.*

(2) The training at HACC went beyond a classroom lecture. Sets were put up for the caseworkers to go in and actors were present for caseworkers to run through scenarios. As caseworkers went through the scenarios, they were able to get feedback on their performance and identify areas for improvement. The training provided a safe situation where the caseworker could learn and practice their skills in a hands-on manner.

(3) This model of training needs to be expanded and implemented to provide applicable, relevant, and useful training to caseworkers. The expansion of

[29] The grand jury notes, to their credit, Dauphin County CYS developed this training in coordination with the Harrisburg Area Community College's Public Safety Center. This training was presented in February 2015.

this model would move beyond sets to the use of a training facility that has specially built areas for hands-on training; such as mock courtrooms, interview rooms, and a mock house for investigations. That facility would make it possible for multiple agencies to set up and perform hands-on scenario trainings across the entire life of a case from initial response and investigation, to forensic interviewing, and court room testimony.

(4) In the realm of child-welfare, the agency would be able to set up scenarios and the new caseworkers would have the ability to work the case and investigation hands-on. Individuals would be in the house and performing roles of the family that the caseworker is investigating. Props could be used in various areas of the house to enhance the investigation and scenario. Caseworkers would get the opportunity to learn how to assess a house as a whole, looking at bedrooms and checking for any safety hazards. This facility would provide a forum for supervisors to evaluate their caseworkers' ability to perform their job functions and adhere to the Child Protective Services Law as well as Federal and State regulations. The controlled environment would allow supervisors to help new caseworkers be exposed to situations they will face in their careers without a concern for the caseworkers safety.

(5) In addition to its use for child welfare caseworkers, the facility could also be utilized to train other members of the multidisciplinary team on child abuse investigations. Law enforcement would be able to train detectives

on investigating child abuse scenarios and evidence collection in a controlled environment.

(6) Other areas of the facility would be used to provide training on forensic interviewing and interrogation. Mock interview rooms would provide space for this training to occur in a realistic environment. Further, with a facility of this type, the interview area could potentially house a Children's Advocacy Center and be an operable interviewing facility. This would prove integration of the training and real-life interviewing of child abuse victims. Utilizing the building for this dual purpose could further justify the cost of building of this facility.

(7) The mock courtrooms would be available for several purposes. Caseworkers and law enforcement are inevitably part of the criminal prosecution, but often are not given training on testifying. Mock courtrooms would provide the opportunity for those individuals to develop courtroom skills. Further, they would provide space for Children and Youth solicitors and prosecutors to receive training in a mock court room. The criminal prosecution and dependency court hearings are an integral part of the multi-disciplinary team, and development of those skills is inherently important to the process.

(8) A training facility of this type would provide an experience that no other training program can. Real-world, scenario based training in settings that depict true to life situations will allow all members of the multi-disciplinary team to obtain the best training available in the child-welfare field. There

is a need for the state to build a facility of this type and use it as a center of mandated child welfare training for the caseworkers within the state.

(9) Recommendation: **The grand jury recommends that Pennsylvania develop a training facility to house mock courtrooms, interview rooms, and a mock house for child abuse investigations. This facility would be the center of the State's mandated training for child welfare caseworkers. Recognizing the cost of such a facility is an issue that must be addressed, the grand jury calls for the exploration of both private and public funding to make this facility a reality. An investment of this type, in properly trained caseworkers, police officers, county children and youth solicitors and prosecutors, is a long term investment in the future of the child protection system for decades to come.**

E. Caseworker Safety Training

**(1) The grand jury recommends that there be state-wide implementation of a safety training for new caseworkers. This training would be mandated to occur when a caseworker is first hired and would encompass areas where the caseworker's personal safety may be at risk.**

F. Modifications to the Training Provided Through Child Welfare Resource Center (CWRC)

**(1) Recommendation: The grand jury recommends that the state make changes to the training programs provided through the CWRC.**

(2) The mandatory 120 hour training program needs to be enhanced to provide a more hands-on, applicable approach.

(3) The trainings offered for caseworkers to meet their required yearly training hours needs to be updated on a regular basis, and tailored to meet the needs that are identified by the county child welfare agencies. The CWRC should be offering a wide variety of training that changes from year to year and encourages caseworkers to continuously increase their knowledge base and skills.

G. Implementation of a State-Wide Database of Available Training

**(1) Recommendation: The grand jury recommends that a state-wide database be developed and maintained to provide county agencies with a central location to identify trainings available in the communities that are relevant and pertinent to the field of child-welfare.**

H. Implementation of a Specialized Training Program for Caseworkers Dealing with Medically Needy Children

**Recommendation: The grand jury recommends that the state-mandate at least one caseworker in each child welfare agency be identified to receive specialized training on working with, assessing, and ensuring the safety of medically needy children.**

## II. Need for improved coordination and communication between Dauphin County CYS and outside agencies and disciplines

A. Coordination between states and other Pennsylvania counties

(1) On two occasions the Tutko family moved their residence to another state. On both occasions, the local CYS agency had extensive history and contact with the Tutko family prior to the family moving. In one instance, Schuylkill County CYS was initiating court proceedings to remove the Tutko children from Kimberly and Jarrod Tutko, Sr. On both of the occasions the Tutko family moved, they were leaving a jurisdiction where the local CYS agency had determined child abuse or neglect claims perpetrated by the Tutko parents were substantiated/indicated. In fact, Jarrod Tutko, Sr., later admitted the family moved to avoid proceeding being brought against them in Schuylkill County Court, when the Tutko

family left Schuylkill County for the State of New Jersey. On both occasions when the Tutko family moved their residence out of state, the CYS agency from the state the Tutko family were departing from reached out to the receiving state to express serious concerns for the welfare of the Tutko children. Finally, on both occasions, the CYS agency receiving the referral from the out of state CYS agency conducted minimal to no investigation concerning the welfare of the Tutko children.

(2) <u>Recommendations:</u>

**(a) The grand jury calls on federal, state and local officials to examine how cases are transferred between states to ensure that the welfare of children in contact with social services in one state do not fall through the cracks in another state simply because of a line on a map.**

**(b) The grand jury calls on Dauphin County CYS and CYS agencies across the state to examine how they receive and screen referrals between county CYS agencies.[30]**

[30] During the course of our investigation, the grand jury learned that there have been improvements in sharing information between agencies with Pennsylvania's new Child Welfare Information System (CWIS). It is now easier for agencies to review prior family contacts with other county CYS agencies. This was a particular issue identified by the grand jury in the Tutko case. Dauphin County CYS was not able to obtain a clear history from Schuylkill County CYS. In particular, Dauphin County CYS received incomplete information from Schuylkill County CYS concerning the reasons for Schuylkill County CYS seeking termination of Kimberly Tutko's parental rights from her previous relationship.

B. Coordination and communication between Dauphin County CYS and law enforcement

(1) The grand jury heard examples of extremely successful child abuse investigative outcomes obtained through cooperative investigations based on Multi-disciplinary Investigative Team (MDIT) principles between Dauphin County CYS and law enforcement. Unfortunately, we also heard testimony providing examples of how poorly coordinated investigations between Dauphin County CYS and law enforcement negatively impacted not only the investigations but also potentially endangered children.

(2) The grand jury understands that a primary reason behind the administration's plan to restructure Dauphin County CYS in 2014 was a desire to improve communication within the agency. Testimony provided to the grand jury suggested that prior to 2014 the agency's former structure resulted the agency's three divisions becoming somewhat isolated to themselves and an impediment to providing cohesive services to the families the agency served. Despite the laudable purpose behind the organizational changes, the grand jury is convinced the dissolution of the agency's dedicated CPS unit was a mistake. To properly conduct child abuse investigations caseworkers require specialized training and skills. The Dauphin County CYS' attempts to spread these investigations across the agency had disastrous results. The agency is still struggling to deal with the ramifications of this decision

(3) Recommendations:

(a) The grand jury calls on Dauphin County CYS to reestablish a dedicated CPS investigative unit within the agency.[31] Additionally, in reestablishing a CPS unit the grand jury calls on Dauphin County CYS to commit long term to maintaining, supporting and training a viable fully staffed CPS unit.

(b) The grand jury calls on the administration at Dauphin County CYS to ensure their caseworkers conduct investigations in accordance with the Dauphin County Child Abuse Investigative Protocol and in adherence with MDIT principles.

(c) Dauphin County CYS calls on Dauphin County CYS to ensure all of its supervisors are properly trained themselves on how to conduct a child abuse investigation in coordination with law enforcement so that they are prepared to provide informed and knowledgeable supervision to the caseworkers they are assigned to supervise.

(d) The grand jury calls on Dauphin County CYS and law enforcement to commit themselves to developing a cross training program to promote greater understanding of each discipline's

[31] Since the grand jury began its investigation, we received information that it is the intention of Dauphin County CYS to reinstitute this specialized unit. We agree with their intent to reestablish this unit.

**roles and responsibilities.**

C. Coordination and communication with the medical community

(1) Investigating the death of Jarrod Tutko, Jr., the grand jury reviewed the January 21, 2014, referral to Dauphin County CYS from Hershey medical Center concerning A.R.T. Despite staff from Hershey Medical Center providing Dauphin County CYS with detailed information outlining the hospital staff's concerns for the welfare of A.R.T., Dauphin County CYS screened out and closed this referral without any investigation. The agency did not even consult with Hershey Medical Center staff before closing out the referral. Testimony provided to the grand jury revealed an unexpected level of dismissiveness of Hershey Medical Center referrals by Dauphin County CYS. The grand jury also discovered a certain level of animosity by Dauphin County CYS towards the staff at Hershey Medical Center's Child Protection Team. Some of this distrust seems to have been caused by a lack of understanding of each discipline's perspectives when dealing with the same family.

(2) **Recommendations:**

**(a) The grand jury calls on Dauphin County CYS to establish formal policies and standards on how referrals from Hershey Medical Center, and the greater medical community in general, will be**

**handled. At a minimum, caseworkers in this type of referral should be required to communicate and collaborate with medical referral sources to determine the nature and extent of the neglect or abuse reported.**

**(b) The grand jury calls on Dauphin County CYS to reach out to the medical professionals practicing in Dauphin County, in particular and the medical staffs of Hershey Medical Center's Child Protection Team and the Pinnacle Health System, to develop better lines of communication to help foster greater understanding between their employees at all levels.**

**(c) As training is an overriding concern of the grand jury, we call on Dauphin County CYS and the medical staff of Hershey Medical Center's Child Protection Team to develop a cross training program to ensure that caseworkers and medical professionals alike have a clear understanding of each other's roles, responsibilities and, in some cases, legal limitations.**

D. Coordination and communication between Dauphin County CYS with Dauphin County school districts

(1) Children spend a significant amount of time at school. As a result, teachers and school employees are our front line protectors in recognizing

and reporting child abuse. Jarrod Tutko, Jr., was of school age. Dauphin County CYS caseworkers properly identified that he was not enrolled in school. Despite recognizing the need to have him enrolled in school, caseworkers did not coordinate their efforts to get Jarrod Junior enrolled in school with the Harrisburg School District. Testimony before the grand jury showed the lack of communication between Dauphin County CYS and a local school district in Jarrod Junior's case was not an isolated incident. The grand jury heard testimony explaining how important it is for children like Jarrod, A.R.T. and S.P. to be enrolled in school. In addition to providing educational services, school can also provide therapeutic services to the children to deal with their physical disabilities as well. The grand jury believes a failure by Dauphin County CYS to communicate with local school districts to coordinate school based services for the children they encounter is a missed opportunity to provide an additional layer of safety to those children.

(2) <u>Recommendations</u>:

**(a) The grand jury recommends that Dauphin County CYS caseworkers follow up directly with local school districts when they encounter children of school age that have not been enrolled in school to ensure they actually become enrolled.**

(b) **The grand jury recommends all Dauphin County school districts designate a staff member to serve as liaison to Dauphin County**

**CYS. Likewise, the grand jury calls on Dauphin County CYS to designate a staff member(s) to serve as a formal liaison with school districts. The grand jury believes the formal designation of a liaison person to coordinate communication between the agency and the school districts will help to better foster relationships between Dauphin County CYS and the school districts.**

## III. Caseworker caseload ratios

A. Throughout the course of our investigation, the grand jury was greatly concerned by the volume of cases individual caseworkers are responsible to handle. The grand jury found these caseloads in many instances to be unmanageable. The grand jury recognizes there are many factors that go into this situation and that there is no simple fix to this problem. In Dauphin County, the problem of caseloads was amplified by caseworker turnover due to the agency's 2014 restructure. However, the grand jury recognizes that employee turnover is a constant issue at CYS agencies even in the best of times. To make matters worse, due to changes in the mandated reporter laws, Dauphin County CYS has seen an increase in referral to the agency at levels above 120% over this time last year. The grand jury also heard

testimony that explained that the issue of high caseloads and caseworker turnover are not just Dauphin County issues. They are statewide issues.

(1) Recommendations:

**(a) The grand jury calls on Dauphin County officials to examine the issue of high caseworker caseloads and determine if current staffing levels are adequate to handle the increase in referrals the agency is experiencing.**

**(b) The grand jury calls on the administrators and supervisors at Dauphin County CYS to closely monitor caseworker caseloads, to ensure each caseworker is able to handle the caseload they are assigned.**

**(c) The grand jury calls on the Pennsylvania Department of Human Services to study the issue of high caseloads in light of recent changes to the mandated reporter law and make recommendations on how to improve this situation.**

## IV. Sixty calendar day time limit for child abuse investigations

A. The grand jury heard testimony from caseworkers explaining the state requirement that CPS investigations be completed within sixty calendar days. When weekends are subtracted from the sixty days, there remain approximately forty-three days to complete an investigation. While many

states have time limits established for child abuse investigations to be conducted by their child welfare agencies, there does not appear to be a national consensus as to the number of days required to complete an investigation. The sixty calendar day time limit in Pennsylvania does not appear to be tied to any particular study concerning an appropriate amount of time that it takes to properly investigate a child abuse allegation. In the grand jury's opinion, the time limit, as set, appears arbitrary and in many case is detrimental to a complete and thorough investigation.

B. In line with our comments concerning caseworker caseloads, with a reasonable caseload a caseworker might be able to conduct a complete and thorough investigation in forty-three days but when you have a caseworker handling upwards of twenty to twenty-five investigations simultaneously, the forty-three day working days a caseworker has to complete their investigation becomes unworkable. Law enforcement officers assigned the same investigation have no corresponding legal time limits on their ability to complete their portion of the investigation. While many CPS investigations can and are completed well within the sixty days, the grand jury heard examples of many complex investigations that clearly require more than sixty days to complete.

C. The sixty calendar day requirement to complete a CPS investigation is written into the Child Protection Services Law (CPSL).[32] A further reading of the

[32] 23 Pa.C.S.A. § 6368 (n)(1)

CPSL indicates that the agency is actually encouraged to complete the investigation within thirty calendar days and must provide adequate reasons for going over the thirty days if they cannot meet that standard. As discussed above, the grand jury recognizes that an agency can designate an investigation as pending, but testimony received by the grand jury indicated that the use of this designation has in the past has resulted in Dauphin County CYS receiving negative feedback from DHS for the use of this category.

D. In addition to the sixty day time limit to complete an investigation, state regulations governing the county children and youth agencies require each county agency to submit the results of their investigation to ChildLine on a CY-48 form within sixty days. If the county children and youth agency does not submit the CY-48 report within sixty days, the regulation requires ChildLine to list the investigated child abuse allegation as unfounded. This requirement to list an delinquent CY-48 report as unfounded is only contained in regulations not required by law.

E. <u>Recommendations</u>:

**(1) The grand jury calls on the legislature to review the sixty day investigative time limit currently required by law and consider eliminating the time limit altogether.**

**(2) The grand jury calls on the Pennsylvania Department of Human Services to review and consider revising the regulation contained in**

55 Pa. Code § 3490.69 (Reports not received within 60-calendar days) to remove the automatic unfounded listing of a CY-48 report that is received by ChildLine beyond the sixty day time limit. The grand jury strongly believes children are endangered by a failure of a substantiated child abuse allegation to appear on the statewide child abuse database simply because the late filing of paperwork. The goals of this regulation, to ensure that an agency conducts a timely investigation, can be accomplished through other regulatory measures and the county's annual licensure review. The current system punishes victims and rewards child abusers.