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

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.

every six weeks that we do not receive referrals.

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 (DPW5) 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 deadlinecritical 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 training⁶ 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 School⁷ 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.