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