Grand Jury identifies “serious issues” within Dauphin County Children and Youth Services

On August 1, 2014, Harrisburg police discovered a disabled child – just a few months shy of his 10th birthday – dead in a house. The boy's room located on the hot third floor included only a “television bolted to a television stand” and a "thick coating of feces" smeared on the walls and floors of the room.1 This room where, Jarrod Tutko, Jr. died had the door knob reversed so that “anyone inside the room could not get out of the room once the lock was engaged.”2

On that same day, Jarrod’s sister, who had just had her 11th birthday and previously had been the victim of medical neglect that resulted in a foster care placement, was found in “very bad condition.”

A pediatrician that treated the sister testified before the Grand Jury (GJ) investigating Jarrod’s death that in her 30 years of practicing medicine she had “never seen anything quite like it before.”3 This child, who had long been bed bound in a vegetative state, was discovered with her "eyes matted closed with secretions and dirt."

An autopsy would reveal that Jarrod weighed 16.9 pounds and that "dried, caked and impregnated fecal matter was noted” to the bottom of his feet.4 The physician conducting

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1 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 2.
2 Ibid.
3 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015
4 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 3.
the autopsy determined that Jarrod died “as a result of starvation and child maltreatment syndrome, with complications due to malnutrition and dehydration.”

Thursday, the Dauphin County GJ released at 100+ page report and recommendations.

A long history with the child welfare system crossing county and state lines

The GJ report permits the creation of a timeline tracing the birth of the six Tutko children and the extensive involvement of the family with various child welfare systems.

This involvement resulted, in part, after reports were made by mandated reporters from the education and health care fields. The family intersected with child welfare systems in New Jersey and two Pennsylvania counties (Dauphin and Schuylkill).

Before Kimberly marries Jarrod Tutko, Sr. and gives birth to six children between 2000 and 2011, she has already been recorded as a perpetrator of child abuse. She has her rights terminated to this victim child and also eventually agrees to terminate her parental rights to all four of her children from the relationship that pre-dates her marriage to Jarrod Tutko, Sr.

1993 Schuylkill County names Kimberly as a perpetrator of an indicated child abuse report related to a “second head injury sustained in a short period of time to her then six-month old baby. The mother’s parental rights were 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.”

8/31/2000 Kimberly now married to Jarrod Tutko, Sr. gives birth to a daughter

9/15/2001 Kimberly gives birth to a son.

10/15/2002 A Schuylkill County court hearing is expected related to a petition filed by CYS for removal of the children. CYS was “concerned about the family’s unstable housing situation, the family moving from place to place, and the children not receiving medical care.” The hearing does not occur, because the parents moved to New Jersey.

10/11/2002 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.” CYS officials notified NJ child welfare officials of the open case on the family and that there had been an expected hearing about removing the children from the parents’ care. CYS also reports to NJ officials that the “parents were not following through with their agency’s safety plan and the Tutkos refused to sign

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5 Ibid.
7 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 5.
releases to allow Schuylkill County CYS to review records related to the children.” NJ officials request that the local police department check on the welfare of the children. Law enforcement do a check and report that “the hotel room appeared in order and the children seemed safe.” NJ officials then close the case.8

2002 – 2004 NJ child welfare officials receive “other referrals alleging improper parenting and a failure by both Tutko parents to follow doctors’ instructions concerning proper medical care for the children.”9

8/11/2003 Kimberly gives birth to a daughter

9/27/2004 NJ-DFYS removes the daughter (DOB 8/11/2003) from her parents and she is placed in foster care “due to a failure of the Tutkos to provide proper medical care for their daughter.” DFYS records reveal “Neglect is substantiated. The parents failed to get the baby A.T. 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.”10

10/5/2004 Jarrod Tutko, Jr. was born in New Jersey. NJ child welfare officials request that the hospital ‘place a hold’ on releasing him to his parents, because of “an on-going” investigation involving his sibling born in 2003. 11

10/12/2004 – 10/18/2004 Jarrod is placed in foster care.

7/3/2005 Jarrod is admitted to a New Jersey hospital “as a result of DYFS intervention.” He weighed 13 pounds, 7 ounces and he had been the subject of a report from a home health nurse that was “assisting the family” after the child’s pediatric practice “had negotiated with the insurance company for a nurse to go to the home.”12

7/11/2005 Jarrod Tutko, Jr. is again placed in foster care. During his time in foster care he is diagnosed as “being positive for Fragile X Syndrome.”13

2005 Jarrod’s parents return to Pennsylvania. This time they move to Dauphin County, Pennsylvania.

4/6/2006 Jarrod is returned to his parents.

7/6/2006 New Jersey child welfare officials make a referral to Dauphin County CYS

9 Ibid.
10 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 7.
“concerning the Tutko children.” NJ officials relate concerns “that the family is not receiving services [in Pennsylvania] like in NJ. Dauphin County records indicate this call “was screened out and not investigated” apparently due to incomplete information about the location of the family.  

1/9/2008 The oldest Tutko child, now 7 years old, is attending Steele Elementary School in Harrisburg. Dauphin County receives a report after staff from the school report that the “child had poor hygiene and is dirty.” Also the child “reported being afraid of her father and that her mother touched her inappropriately.” It is also reported that the father “calls the teacher every week and is intimidating toward the teacher.” Meanwhile another Tutko child now 6 years of age reports that his father “is scary like a monster.”  

2/8/2008 An investigation of the report received on 1/9/2008 by Dauphin County CYS is “completed.” The outcome of this investigation is unknown because “the supporting documents concerning the investigation into this referral were never filed and cannot be located.”  

3/13/2008 Kimberly gives birth to a daughter  

2/3/2010 Dauphin County received a referral concerning the oldest Tutko child who is “hearing impaired and uses sign language.” The child, who was the subject of an earlier report to CYS in January 2008, had a fever the day before and again at school. The father did not respond to a call from the school to pick the child up. The child “stated dad was angry” and said the father had slapped her. The school reports the “child is agitated” and so the school “is afraid to send the child home,” according to the referral notes.  

2/8/2010 The Dauphin County CYS caseworker “made an unannounced visit” to the school and spoke with the child via the teacher providing sign language interpretation. During this interview the child “did not provide any information to the caseworker nor did she disclosed that her father, or anyone else in the house, slapped her.”  

2/12/2010 The Dauphin County CYS caseworker returns to the school and meets with a Tutko sibling. In this “meeting” he denies “any knowledge of his older sister being physically

14 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 11.  
15 Ibid.  
16 Ibid.  
17 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 12.
disciplined.” He does indicate that his younger brother, Jarrod, “sometimes gets smacked on the hands but denied any other physical discipline.”

2/18/2010 The Dauphin County CYS caseworker makes an unannounced visit to the Tutko home. The caseworker observes that the 6-year old child “was confined to a hospital bed” with the mother telling the caseworker the child was “severely brain damaged due to a seizure in 2007.” The caseworker observes that another child exhibits “traits and behaviors that in the caseworker’s past experience” may be consistent with autism. The mother tells the caseworker that Jarrod is at a friend’s house so he is not seen.

5/6/2011 Kimberly gives birth to a daughter.

10/23/2013 Dauphin County CYS receives a report from ChildLine and begins an intake assessment on the Tutko family. The following was included in 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 him up.’ Child denies pain, injury or impairment and could not give specific

18 Ibid.

times when the incidents took place, report be will general protective services.”

10/24/2013 Dauphin County CYS caseworker, who was only recently assigned to take these types of referrals due to “a large volume of referrals, begins an investigation. The caseworker informs the father that all children must be seen. The father carries Jarrod from the third to second floor and the caseworker observes that his head is wet. The father reports that Jarrod “had poured iced tea on his head.”

10/31/2013 The same Dauphin County CYS caseworker who observed Jarrod and the other children on 10/24/2013 interviews the 12-year-old Tutko child at his school. During this interview, the child informs the caseworker that his father “lied” about why Jarrod’s head was wet. The child then tells the caseworker that Jarrod had “poop from his diaper all over himself and his dad tried to wash it up.” The child also tells the caseworker that his dad “doesn’t care about Jarrod Junior anymore.” During the course of the investigation the caseworker learns about:

- Ongoing domestic violence in the home disclosed by at least one child and “confirmed” by the mother. Also the caseworker “observed areas of the home where patch repairs had been made to holes in the wall.” The CYS records also note that “Mrs. Tutko is always following him around antagonizing him and he punches holes in the walls because it’s better than punching a person.”
- The “various disabilities/conditions” of the children.
- Both parents being unemployed.
- The 12-year-old did not have a bedroom and “slept on the couch in the living room.”
- Two of the children, ages 9 (Jarrod) and 10, “were not enrolled in school.”
- Kimberly Tutko “had her rights to other children terminated…..due to abuse/neglect allegations.”
- The family had been “open for services” in New Jersey “due to concerns for medical and educational neglect and homelessness” also several of the children were previously placed in foster care.

November 2013 The Dauphin County CYS caseworker asks the parents to sign medical release forms. The father “became upset” and subsequently CYS never

20 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 15.
21 Ibid.
22 Ibid.
23 Ibid.
24 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 16.
receives consent to the child’s medical records. The caseworker acknowledged with the Grand Jury that the parents became more “uncooperative” as time went on. This led to an “emergency triage” meeting of CYS officials and through this process 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 in that way build a relationship with the family to cooperate and further assess those things.” In further testimony to the Grand Jury, the caseworker revealed she felt that the family was “probably a 9” on a scale of how “serious a situation.” As a result of this “triage” meeting, the plan identified was to:

- “Try to get the medical releases signed.”
- Have the two school-age children “not attending school be enrolled in school.”
- Follow up with Schuylkill County CYS and New Jersey child protection officials.
- Outreach to law enforcement “concerning any reports of domestic violence.”
- Assign a new caseworker, who was male and from a rural background who might be able to “get better cooperation from the Tutkos.”

The new caseworker, according to grand jury testimony, “had a significantly different impression of the seriousness” of the situation. This new caseworker did not have a “strong level of concern.” The Grand Jury report notes that the initial caseworker accompanied the new Dauphin County CYS worker on a visit to the Tutko home and wrote a “comprehensive transfer summary” that cited the prior child welfare involvement and lack of cooperation of the parents. The new CYS caseworker and supervisor did conduct home visits, but they never went beyond the first floor of the house. They also continued to meet resistance from the parents about medical release forms, which were never received. Also not followed up on was whether the two children, including Jarrod, not

attending school had become enrolled. 28

12/20/2013 Dauphin County CYS closes the case.

1/21/2014 ChildLine receives a child abuse report and subsequent CY 47 (the required written report following an oral report) from Hershey Medical Center. The CY-47 contained the following information about the child born in 2003:

"The child was admitted January 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."29

The “screening” caseworker at Dauphin County CYS testified that he gave the referral to his supervisor, who then labeled it an “information only” call “thereby screening out the referral.” This caseworker testified that he would have access to prior reports about the family also that by screening it out the report “would not be assessed” and thus no CYS worker would go out to the home.30

This January 21, 2014 screened out referral was the last call made to Dauphin County CYS “until the August 1, 2014 discovery of Jarrod Junior’s death.”31

Caseworker experience and training faulted

While the GJ was convened around the fatality of Jarrod and near-fatality of his sister, it discovered a “pattern” that revealed a “substantial deficiency in the training of the caseworkers assigned to assess the safety and welfare of children with serious and/or complex medical conditions and cases of prolonged neglect.”

As the GJ was wrapping up its work, another infant came to their attention. The infant died

28 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 22.
29 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 23.
30 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 25.
31 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 29.
on May 8th “under circumstances that suggest
the baby was malnourished.” The infant’s
twin was also reported with her situation
recorded as a near-fatality “for dehydration
and malnutrition.” The 5-month old infant
that died weighed 4.4 pounds and Dauphin
County CYS “was involved on and off with this
family for approximately 12 years.”

The caseworker assigned to the twins before
the fatality and near-fatality had visited the
home two days before the infant’s death. The
CYS involvement with the family was related
to an older sibling.

When asked by the GJ how she could be in the
home and have seen the infant and not notice
the “deteriorated condition” of the twins, 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.”

The GJ acknowledged it was too early in the
case to “render an opinion” about this CYS
caseworker’s “responsibility” in the infant’s
death. The GJ cited a pediatrician who
regularly works with Dauphin County CYS
and her reporting that many caseworkers are
“not appropriately trained to conduct proper
safety assessments of children with special
needs.”

The GJ stipulated that the cases reviewed,
beyond the Tutko case, revealed a “pattern of
decision making on the part of the Dauphin
County CYS administration.”

Citing the work and 2012 recommendations
of the Task Force on Child Protection, the GJ
determined that “many of their
recommendations concerning training have
yet to be met.”

Among the Task Force’s recommendations
referenced by the GJ:

- 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 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.

The report also spoke about ChildFirst, which has been championed by Dauphin
County Chief Deputy District Attorney Sean
McCormack. ChildFirst has developed in
Pennsylvania through the leadership of the
Pennsylvania Children and Youth Solicitors

32 Eighth Dauphin County Grand Jury Presentment
#1, Notice Number 08-2013-15 unsealed June 4,
2015, page 54.
33 Ibid.
34 Eighth Dauphin County Grand Jury Presentment
#1, Notice Number 08-2013-15 unsealed June 4,
2015, page 55.
35 Ibid.
36 Eighth Dauphin County Grand Jury Presentment
#1, Notice Number 08-2013-15 unsealed June 4,
2015, page 56.
37 Eighth Dauphin County Grand Jury Presentment
#1, Notice Number 08-2013-15 unsealed June 4,
2015, page 82.
38 http://www.childprotection.state.pa.us/
39 http://www.childfirstpa.com/
Association (PCYSA). PCYSA have worked “collaboratively with the Pennsylvania District Attorneys Association (PDAA).”

ChildFirst provides “certified forensic interview training programs in cases of child abuse and to assist those participants and interviewers in defending their interviews and work product in court.” It provides county-based multidisciplinary teams with five days of “intensive and rigorous” training that includes “a critiqued mock forensic interview for every participant” followed by a “written, proctored examination.”

ChildFirst has been supported with approximately $250,000 of federal funding PA receives as part of its Children’s Justice Act (CJA) grant.

The GJ outlined some specific recommendations on the training front:

1. Recognizing that CPS and GPS investigations “do not occur in a vacuum” instead they are “intertwined and comingled with law enforcement investigations,” the GJ recommended training that promotes “joint investigations and cohesive approaches.”

2. Personalized hands-on training should be implemented statewide.

3. Support for ChildFirst and other similar MDIT type trainings, including by continued direction of federal Children’s Justice Act (CJA) to this training.

4. Establish a Child Protection Training Center that includes “mock courtrooms, interview rooms, and a mock house for child abuse investigations.” This center is envisioned as the “center of the state’s mandated training for child welfare caseworkers.” The GJ recognized the cost and suggests “exploration of both public and private funding to make this facilitate a reality.”

5. Statewide implementation of a safety training for new caseworkers. This would be mandated upon hire and “would encompass areas where the caseworker’s personal safety may be at risk.”

6. The GJ minimally recognized the PA Child Welfare Training Resource Center and its mission to train the child welfare workforce. The GJ saw the need for changes so that training is “more hands-on” and training must be regularly updated.

7. Identification of one caseworker in each county “to receive specialized training on working with, assessing, and ensuring the safety of medically needy children.”

Despite a state law requiring a team investigation and the presence of a high quality CAC, investigations are disjointed and child safety jeopardized

The GJ report cites a number of cases that illustrate the “breakdown of coordination between law enforcement and CYS.”

One involved the death of a 6-month old infant and an “inexperienced caseworker.” The report notes that state law establishing multidisciplinary investigative teams (MDITs) “requires the sharing of information by the members.”

During the autopsy it was revealed that the baby had suffered rib fractures several weeks before the infant’s death. The parents were considered potential suspects.

40 http://www.childfirstpa.com/?page_id=13
41 http://www.childfirstpa.com/?page_id=13
42 http://www.pacwrc.pitt.edu/
43 Ibid.
44 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 56.
The detective on the case “explained how important interviews were in child fatality investigations” to this “inexperienced” caseworker.\textsuperscript{45} The CYS worker included information about the rib fractures in paperwork that was filed and thus tipped the parents off before the detective interviewed the parents. The detective then asked the caseworker and CYS supervisors “to coordinate the investigation and future investigative steps.”\textsuperscript{46}

Before law enforcement had the opportunity to interview the parents, the CYS caseworker “met with the suspected parent and conducted a two hour interview with said parent.”\textsuperscript{47} This interview was not recorded, police were not present and the parent did not have an attorney present. Later when police sought to interview the parent, “the parent arrived at the police station with his attorney” and when the interview turned to the earlier injuries “the attorney ended the interview.”\textsuperscript{48} At this time, no criminal charges have been filed in the case.

In another incident, another police department testified about a child sexual abuse investigation involving a 4-year-old child with the alleged perpetrator being the father. When police began investigating the alleged sexual abuse after serving a PFA, they discovered that CYS “had already investigated the claim in February 2014 and had closed the case.”\textsuperscript{49}

Law enforcement learned the worker had interviewed the child and determined the report to be unfounded.\textsuperscript{50} Law enforcement “questioned” Dauphin County CYS about why the child was not taken to the Pinnacle Health Children’s Resource Center, the local children’s advocacy center (CAC), and why police were not notified.

By way of understanding of the Child Protective Services Law (CPSL)\textsuperscript{51}, the expectations for MDITs extend well beyond “sharing of information,” as cited in the GJ report.

Since the 1990s, Pennsylvania law has required joint investigations of suspected child abuse that also involved a possible crime against a child.

The CPSL requires that this MDIT legally operate with a jointly developed protocol intended to avoid “duplication of fact-finding efforts and interviews to minimize the trauma to the child.” The MDIT is convened by the district attorney. The MDIT is expected “to coordinate child abuse investigations” between CYS and law enforcement. It must, “at a minimum,” include a health care provider, county caseworker and law enforcement official. The DA and CYS agency “shall develop a protocol” for convening the MDIT “for any case of child abuse by a perpetrator involving crimes against children.”

A challenge in getting a case to the MDIT is how the report to ChildLine and/or the CYS agency is classified (e.g., GPS or CPS). Consider that many of the reports in the Tutko case were termed GPS, which is put forth as PA’s differential response (less focus on investigation than assessment). Even the

\begin{itemize}
  \item \textsuperscript{45} Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 57.
  \item \textsuperscript{46} Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 58.
  \item \textsuperscript{47} Ibid.
  \item \textsuperscript{48} Ibid.
  \item \textsuperscript{49} Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 59.
  \item \textsuperscript{50} Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 60.
  \item \textsuperscript{51} http://www.legis.state.pa.us/WU01/LI/LI/CT/PDF/23/23.PDF
\end{itemize}
reports on the Tutko family involving domestic violence got put in the GPS bucket.

Another element of the CPSL that may provide some confusion in practice and invite potential missteps is the fact that Section 6368 requires the county CYS agency to “immediately commence an investigation” in response to reports of child abuse.52 This section also requires that the “investigation shall include interviews with all subjects of the report, including the alleged perpetrator.” The CPSL permits the interviews to be “reasonably delayed” for a number of reasons, including if it would “threaten the safety of a victim or significantly interfere with the conduct of a criminal investigation.”

The GJ report concluded that the caseworker in the child sexual abuse case cited above was unfamiliar with the MDIT 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.”53 The GJ was clearly alarmed by the fact that the action of the caseworker had been approved by his supervisor, who did not “recognize that this case was not properly investigated.”54 The GJ outlined a number of other cases that troubled them including a physical abuse case where again the CYS caseworker interviewed the “young child subject.”55 The report notes that the case called for an “interview conducted by a child interview specialist” at the CAC, especially since the mother's boyfriend had previously been convicted of endangerment.56 The CYS caseworker never scheduled an interview at the CAC and the supervisor later agreed with the decision to “close out the investigation as unfounded.”57

The GJ points out that “two months later in January 2015, C.A. was rushed to the hospital with serious life threatening injuries.”58 The CYS supervisor was disciplined and the caseworker was also expected to be disciplined “but resigned ... before said discipline could be given to her.”59

Recommendations from the GJ, on this front, include60:

- “Ensure caseworkers conduct investigation in accordance with the Dauphin County Child Abuse Investigative Protocol and in adherence with MDIT principles.”
- Ensure all supervisors are “properly trained” about how to conduct a child abuse investigation “in coordination with law enforcement” so that they can provide “informed and knowledgeable supervision to caseworkers.”
- CYS and law enforcement should commit to “developing a cross training program to promote greater understanding of each discipline’s roles and responsibilities.”

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52 http://www.legis.state.pa.us/WU01/LI/LI/CT/PDF/23/23.PDF
54 Ibid.
55 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 83.
56 Ibid.
57 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 84.
58 Ibid.
59 Ibid.
60 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, pages 114-116.
- 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.” (NOTE: Act 176 of 2014 requires cross-directional sharing of information between CYS and medical professionals).

- Develop better “lines of communication to help foster greater understanding” (NOTE: again Act 176 of 2014 should aid in enhancing communication, also a health care provider is a required member of the MDIT)

- Hershey Medical Center’s Child Protection team should “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.”

It is an instructive part of the GJ’s report. It provides a lens into the organizational dynamics and the unrelenting pressures on the CYS agency.

It is, however, ironic that it takes so much space in a GJ report focused on a chronic pattern of reports to the agency and eventual death and near-death of children in a family that occurred before the restructuring was envisioned or took effect.

Originally the CYS agency had three divisions in-take, in-home protective services and permanency before a restructuring occurred in March 2014. The in-take unit was divided into the Child Protective Services (CPS) and General Protective Services (GPS) units. GPS cases in Pennsylvania have historically been framed as “neglect” cases.

After dismantling the divisions, the county created seven teams that included caseworkers and supervisors. These teams were expected to handle all types of cases. As envisioned this team approach was expected to reduce the number of times a family had to deal with a new caseworker and provide more stability to children out-of-home placement. Also, if a family worked with a team and then the case was closed, but opened again at a later team the concept was they would be served by the same team.

Also created was a Review, Evaluate and Direct (RED) team that met daily “to review the new child abuse referrals received by the agency,” including any prior history the family had with the agency.62

The GJ report acknowledges that the “theories” behind the restructuring were “quickly tested.” Chief among the challenges was that the agency was operating “without a

### County’s restructuring collides with change in state laws and “torrential increase in referrals”

The GJ outlined a number of criminal charges against the parents, but also had its eyes opened to “serious issues” within the Dauphin County Children and Youth Services (CYS) Agency.61

A significant amount of the GJ report is focused on the 2014 restructuring of the CYS agency.

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61 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 32.

62 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 35.
centralized CPS unit tasked with investigating child abuse allegations.”

The GJ heard testimony from caseworkers and supervisors that reported the new organizational structure “was accomplished within 34 days” and few felt “prepared or trained to handle their new roles.”

A number of seasoned staff departed the agency with the perception that there was “a lack of concern” about the implications of the restructuring by the then CYS Administrator, Peter Vriens and his Assistant Administrator, Kirsten Johnson.

This restructuring was happening at the same time the agency was receiving more reports. In addition to the chart below prepared from review of PA’s Annual Child Abuse reports, the GJ report informs that the county’s referrals have “increased 128% over 2014.”

The increased reports occurs as staff are leaving the agency because of the restructuring of the agency. This creates a “crisis situation of dealing with a torrential increase in referrals while having to replace departing caseworkers with newly hired untrained caseworkers.”

The GJ report is filled with what seems more like a workplace grievance document than a document providing the foundation for criminal charges against the parents.

Highlights of the challenging workplace dynamics include:

- “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 was hospitalized and is also still on desk duty from that.”
- We were receiving all of the GPS and CPS referrals that were coming in for our team.....both of us got overwhelmed. I probably had up to, like 23 at one time.”

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63 Ibid.
64 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 37.
65 Ibid.
66 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 96.
67 Ibid.
68 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 40.
69 Ibid.
• “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.”

• We were 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...doing paperwork. They are paying overtime for that now...prior they were only allowing us flex time for that.”

• “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.”

• “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 I started doubting my abilities then I was – I wasn’t doing any good for the families.”

• A former caseworker, who also had experience in Berks County, talked about the 120 hours of required CORE training citing it as a “good general overview but it was nothing compared to what you actually face when you go out into the real world.”

The GJ report underscores that with the restructuring, “caseworkers with little to no experience with CPS investigations, suddenly found themselves handling CPS investigations. They did so without the benefit of a proper training program to prepare them to conduct appropriate CPS inquires.”

The GJ report scrutinizes the prior leadership of the agency and the assignment of cases. The Assistant Administrator’s testimony was found to be in conflict with that of caseworkers and supervisors about the qualifications of those investigating reports.

The GJ cites a case involving the death of a 6-month old baby soon after the restructuring in 2014. The case was assigned to a caseworker “without CPS experience, let alone any experience or training in child death investigations.” Problems in the investigation were attributed by law enforcement to the “worker’s lack of experience and training.”

At one point a supervisor testifying before the GJ was asked to name the “person or persons that you feel were responsible for the troubles that the agency had gone through over the past year.” Assistant Administrator

70 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 41.
71 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 42.
72 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 43.
73 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 44.
74 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 46.
75 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 49.
76 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 51.
77 Ibid.
Later in the report, the GJ writes, “Ultimately the blame for these deficiencies must rest with the administrators and directors of the Dauphin County Children & Youth Services specifically naming Kirsten Johnson, Jenna Shickly, former Administrator Peter Vriens and Directors Rick Bukmanic and Dave Mattern. All are cited as having been “part of the senior leadership of the agency” at the time."79

The GJ recommended the following:80

- Examination of the issue of high caseworker caseloads and “determine if current staffing levels are adequate to handle the increase in referrals the agency is experiencing.”
- CYS administrators should “closely monitor caseworker caseloads to ensure each caseworker is able to handle the caseload they are assigned.”
- The PA Department of Human Services (DHS) should “study the issue of high caseloads in light of recent changes to the mandated reporter law and make recommendations to improve the situation.”

Finally, the GJ recommended that a “dedicated CPS investigative unit be reestablished at the agency and to “commit long term to maintaining, supporting and training a viable fully staffed CPS unit.”81

78 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 53.
80 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 119.
81 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 114.
82 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 64.
83 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 65.
“Despite the fact that the agency determined that there was substantial evidence of child abuse committed by the perpetrator, that person can potentially pass a child abuse background check when seeking employment or volunteering in positions that will put the person in contact with children.”

The GJ recommended that the legislature review the sixty day investigative time limit and “eliminate the time limit altogether.”

“Serious concerns” but no criminal charges for CYS employees

In the end the GJ concluded that while it had “serious concerns with the manner in which Dauphin County CYS handled the October 23, 2013 and January 21, 2014 child abuse referrals” they did not find that any “actions, or for that matter inactions” of CYS employees met the criteria to recommend criminal charges.

The GJ then outlines what is needed to “substantiate a charge of Endangering the Welfare of a Child” reminding that actions or inactions “must be made knowingly.” There is a three prong test:

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 threat 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 be reasonably be expected to protect the child’s welfare.

The GJ found that the employees at Dauphin County CYS involved in the October 2013 investigation met the first prong of the standard. The GJ, however, also found that the employees were “not aware that Jarrod Junior was in circumstances” so the 2nd prong was not satisfied. They also determined that “whatever missteps were taken during the October 23, 2013, referral investigation, their conduct during the investigation did not rise to the level where they” met the 3rd standard.

The GJ observed that caseworkers saw the first two floors of the house that “were clean and appeared organized.” The report notes that the parents “refused to sign medical releases,” but did show binders that the family compiled about “medical treatment their children were receiving.” The GJ also says that even the caseworker that had “serious concerns about what she observed in the Tutko home” did not ultimately “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.”

“Serious deficiencies with the investigations and the safety assessments” are cited.

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84 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 66.
85 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 121.
86 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 91.
87 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 92.
89 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 93.
90 Ibid.
91 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 94.
92 Ibid.
“throughout the agency’s years of contact” with the family.93

The CJ turns its focuses on the “pattern” of the agency “to screen out referrals without doing at least a minimal review of the report being made to the agency.”94

They return to the fact that three of the six referrals received between 2008 and 2014 “were either screened out or designated as information only.”95

The GJ cited the screen out in 2006 from NJ where that’s state child welfare workers expressed concerns that the family was not receiving services similar to those delivered when the family was in NJ. “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.”96

Noted as “of particular concern” was the screen out of the January 2014 referral from staff at Hershey Medical Center. Here the GJ reinforces that by this time the agency “had considerable amount of information concerning the Tutko family history,” including earlier reports from the Harrisburg School District “concerning neglect and potential domestic violence in the home.”97

“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.”98

The GJ expresses understanding about the “volume of reports” facing the agency and how the significant increase impacts the ability to “do full and complete assessment of every referral.”99 Still the GJ underscored that their findings reveal something more “symptomatic” than “high volume and caseload constraints.”100

Not to be diminished is the “repeated examples of missing documentation, incomplete reports, and lack of supervisory documentation” in cases well beyond the Tutko family.101

The GJ cites “insufficient training” for caseworkers and supervisors and the “complex issues” particularly the children’s medical conditions. The report also returns to the fact that the agency and the community’s children have been well served by the CAC and other medical professionals in Central PA. And yet all indications are that pursuit of expert consultation from medical professionals wasn’t “even contemplated.”102

93 Ibid.
94 Ibid.
95 Ibid.
96 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 95.
97 Ibid.
98 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 96.
99 Ibid.
100 Ibid.
101 Ibid.
102 Eighth Dauphin County Grand Jury Presentment #1, Notice Number 08-2013-15 unsealed June 4, 2015, page 98.