



pennsylvania
DEPARTMENT OF HUMAN SERVICES

REPORT ON THE FATALITY OF:

Jarrold Tutko Jr.

Date of Birth: 10/5/2004

Date of Death: 8/1/2014

Date of Oral Report: 8/2/2014

FAMILY KNOWN TO:

Dauphin County Children and Youth Agency

REPORT FINALIZED ON:

March 6, 2015

Unredacted reports are confidential under the provisions of the Child Protective Services Law and cannot be released to the public.

(23 Pa. C.S. Section 6340)

Unauthorized release is prohibited under penalty of law.

(23 Pa. C.S. 6349 (b))

Reason for Review:

Senate Bill 1147, Printer's Number 2159 was signed into law on July 3, 2008. The bill became effective on December 30, 2008 and is known as Act 33 of 2008. As part of Act 33 of 2008, DHS must conduct a review and provide a written report of all cases of suspected child abuse that result in a child fatality or near fatality. This written report must be completed as soon as possible but no later than six months after the date the report was registered with ChildLine for investigation.

Act 33 of 2008 also requires that county children and youth agencies convene a review when a report of child abuse involving a child fatality or near fatality is indicated or when a status determination has not been made regarding the report within 30 days of the oral report to ChildLine. Dauphin County has convened a review team in accordance with Act 33 of 2008 related to this report.

Family Constellation:

<u>Name:</u>	<u>Relationship:</u>	<u>Date of Birth:</u>
[REDACTED]	mother	[REDACTED] 1975
[REDACTED]	father	[REDACTED] 1974
[REDACTED]	sister	[REDACTED] 2000
[REDACTED]	brother	[REDACTED] 2001
Jarrod Tutko (deceased)	victim child	10/05/2004
[REDACTED]	sister	[REDACTED] 2003
[REDACTED]	sister	[REDACTED] 2008
[REDACTED]	sister	[REDACTED] 2011

Notification of Child Fatality:

On August 1, 2014, the Dauphin County Children and Youth Agency (CCYA) [REDACTED] Worker was contacted by the [REDACTED] Police Department regarding the death of a child. The child was found in a bathroom and was in a decomposing state. The [REDACTED] reported that she had smelled an odor and thought it was a dead rat but the [REDACTED] eventually then told her the child had been dead for a couple of days. The [REDACTED] then contacted the police. On August 2, 2014, Dauphin CCYA contacted ChildLine and this was [REDACTED] as a fatality due to [REDACTED].

Summary of DHS Child Fatality Review Activities:

The Central Region Office of Children, Youth and Families (OCYF) obtained and reviewed all current and past case records available pertaining to the [REDACTED] family. Interviews were conducted with the caseworkers [REDACTED] and [REDACTED] and Supervisors [REDACTED] and [REDACTED]. Contact with the county Administrator and Assistant Administrator regarding this case occurred on a regular basis. The Regional office also participated in

the County Act 33 Fatality Review Team meeting on August 29, 2014 and attended an internal Case Review meeting at Dauphin CCYA on October 3, 2014 and attended two interviews of the child's siblings at the [REDACTED].

Children and Youth Involvement prior to Incident:

Dauphin CCYA's first contact with this family occurred on April 24, 2002 when a report was received regarding the [REDACTED] and [REDACTED] 20 month old child at the time. The report stated that the [REDACTED] had given up custody of three of [REDACTED] but gave birth in August 2000 to another child. Schuylkill CCYA was providing protective services to the family despite the [REDACTED] explanation that there was no neglect, endangerment or abuse regarding [REDACTED] 20 month old child. The [REDACTED] was now married and living with [REDACTED]. Dauphin CCYA referred the reporting source to OCYF and Schuylkill CCYA. No additional contact with the family was made at this time by Dauphin CCYA. Case notes do not indicate where the family was living at this time or who the reporting source for this report was. Additionally, there was no indication in case notes that Dauphin CCYA contacted or made a referral to Schuylkill CCYA regarding this referral information.

On July 10, 2006, Dauphin CCYA received a fax from the Division of Youth and Family Services (DYFS) in [REDACTED] regarding this family. DYFS included records of the [REDACTED] family which included the [REDACTED] and [REDACTED]. DYFS expressed concerns that the family was not receiving services like they were in [REDACTED]. The fax did not provide the current location of the family in [REDACTED]. The case history provided documentation that the family was receiving ongoing services in their [REDACTED] home to help with the children's [REDACTED] and [REDACTED]. Records noted that [REDACTED] was not concerned for the safety of the children as services to the family were to be terminated on August 1, 2006. This was an Information Only referral and no follow-up with the family or DYFS was noted by the agency.

On January 9, 2008, a general protective services report was received [REDACTED]. The report expressed concern regarding the [REDACTED] and [REDACTED] three children, [REDACTED]. It was reported that [REDACTED] had poor hygiene, specifically her hands and face were dirty and her hair was not brushed. It was reported that [REDACTED] is hearing impaired and signed to a friend that she was dirty. [REDACTED] used to be "touchy/feely, but now does not like to be touched at all. On this date, [REDACTED] was sick and she was upset that her [REDACTED] had to pick her up from school. [REDACTED] was asked if she had been touched by someone inappropriately and she reported she had been by her [REDACTED], but the details were unclear. The [REDACTED] were notified by [REDACTED] school in November 2007 about [REDACTED] hygiene and appeared upset about it but nothing changed. The [REDACTED] calls [REDACTED] teacher every week and is reportedly intimidating. The [REDACTED] recently quit their jobs to care for the youngest child. [REDACTED] was reportedly fearful of her [REDACTED] and [REDACTED] reported that his [REDACTED] is "scary like a monster" and [REDACTED] acted like a monster. Dauphin CCYA assigned this referral a moderate risk tag and a five day response time. Documentation states that an

assessment was completed on February 8, 2008 but there was no dictation or other documents to review regarding what was done during that assessment period.

On February 3, 2010, a general protective services report was received by Dauphin CCYA regarding [REDACTED]. It was reported that the child had a [REDACTED] the previous day and when the [REDACTED] was called to pick up the child, he did not respond to the call. On the day of the report, the child still had a [REDACTED] and she reported that her [REDACTED] was angry. The child stated "slap" when asked if the [REDACTED] did anything to her. The child was reportedly agitated and the [REDACTED] was afraid to send the child home. Dauphin CCYA assigned a moderate risk tag on this case and a five day response time. On February 8, 2010, [REDACTED] was visited at her school by Dauphin CCYA caseworker. It was noted that the caseworker attempted to speak to the child with the assistance of [REDACTED] but the child did not provide any information. The child would only answer "yes" or "no" and her hands were hidden under the table. There was no disclosure that her [REDACTED] or anyone in the house slapped her. On February 10, 2010, [REDACTED] was visited at his school by a Dauphin CCYA caseworker. It was noted that [REDACTED] appeared well adjusted and was both appropriate and respectful to the caseworker. [REDACTED] appeared to have a slight cognitive delay but had a very positive and enthusiastic disposition. [REDACTED] noted no concerns to the caseworker and denied having any knowledge of [REDACTED] being physically disciplined. [REDACTED] stated that his younger brother, [REDACTED], sometimes gets smacked on the hands but denied any other physical discipline. [REDACTED] reported that he gets along well with his [REDACTED]. On February 16, 2010, it was noted that a Safety Assessment was completed but a copy was not part of Dauphin CCYA's file. On February 18, 2010, an announced home visit was made. The mother and two sisters, [REDACTED], were present for the visit. The [REDACTED] reported that [REDACTED] was born [REDACTED] but can [REDACTED] somewhat when she wears her [REDACTED] is severely [REDACTED] and in 2007, a [REDACTED] put her into a [REDACTED]. Jarrod Jr. is [REDACTED] with [REDACTED]. During the visit, the caseworker noted that [REDACTED] was covering her ears, rocking and flapping her hands often. The caseworker discussed these behaviors with [REDACTED] and suggested that she speak with the [REDACTED] about looking at [REDACTED]. The caseworker expressed to the [REDACTED] that she was not an expert in the field, but that she had worked with several [REDACTED] children and [REDACTED] behaviors were similar to those found with [REDACTED] children. The [REDACTED] reported that she was going to have [REDACTED] seen by a [REDACTED] because all of her other children, with the exception of [REDACTED] have some type of [REDACTED]. The [REDACTED] also discussed how she and the [REDACTED] are trained to do [REDACTED] with [REDACTED] and they have a rigorous schedule of [REDACTED] and care for her. In regard to the [REDACTED] not coming to pick [REDACTED] up [REDACTED] when she had a [REDACTED], the [REDACTED] reported to the caseworker that the [REDACTED] had called a cab but the cab never arrived. The [REDACTED] told [REDACTED] to send [REDACTED] home on the bus. The [REDACTED] reported that [REDACTED] was given a cold towel to put on her forehead, [REDACTED], orange juice and soup that evening. The next day, [REDACTED] did not have [REDACTED] and was pleading to go to school because she likes school so much. The [REDACTED] allowed [REDACTED] to go to school and that is when she got a [REDACTED] again. The [REDACTED] called for a cab and picked the child up from school. The caseworker noted that neither [REDACTED] works due to the continuous care required for [REDACTED] and they [REDACTED]

██████████. No safety concerns were noted in the home. The home was clean and ██████████ appeared well cared for. ██████████ looked well fed and no bed sores were noted by the caseworker. Jarrod Jr. was not present during the visit as he was spending time with a friend who is ██████████. It was reported that Jarrod Jr. and this friend seem to relate well to each other and liked to "hang out." On February 19, 2010, an announced home visit was made. Present for the visit were the ██████████ and Jarrod Jr. The caseworker conducted a visual assessment of Jarrod Jr. and it was noted that he appeared well groomed and appropriately dressed. Jarrod Jr. appeared slightly ██████████ and there were no concerns with the home environment. Dauphin CCYA completed their assessment on February 22, 2010 and it was noted that a Safety Assessment and closing/decision letter were completed on that date but copies of these documents were not in the agency file.

On December 9, 2010, a general protective services report was received ██████████. The report stated that ██████████ has been coming to school dirty. It was reported that the child wears the same clothes for days and is ██████████. Dauphin CCYA's documentation noted that there were no safety threats or allegations of child abuse or neglect regarding this referral. It was given an Information Only status and no further action by the agency was noted.

On October 23, 2013, the county received a general protective services report regarding the family alleging domestic violence between the parents and inappropriate disciplining of the 12 year brother. During the investigation, the various ██████████ of the children were learned. The ██████████ and ██████████ were unemployed and stayed home to take care of the children's extensive needs. The ██████████ has ██████████ issues and was seeing a ██████████ weekly. ██████████ was also receiving ██████████ and ██████████ through the same ██████████ as the ██████████ and attended a ██████████ after-school program. No other services were in place for the family. The parents were informed of other services that may be helpful to them which included parenting classes, county ██████████ services and ██████████ services. The family followed through with ██████████ services but not with any other service. ██████████ and Jarrod Jr. were not enrolled in school. The ██████████ said they enrolled the children in school but stated that the school district said they couldn't meet the children's needs in the classroom and would be back in touch with the family about other options. Through the investigation, it was also learned that the ██████████ had ██████████ ██████████ in the past due to abuse and neglect issues. The family also was open for services in ██████████ in the past due to concerns of ██████████ and ██████████ and ██████████. The Dauphin CCYA outreached to both Schuylkill County Children and Youth Agency and ██████████ Department of Youth and Family Services to obtain information regarding their past involvement with the family. While some information was received during the assessment period, follow-through with obtaining all documentation from these agencies was not completed. The county completed their assessment of the family on December 20, 2013 and did not find it necessary to continue ongoing services with the family as the children's medical and educational needs were being addressed.

On January 21, 2014, the county received a general protective services report regarding the 10 year sister. The report stated that the 10 year old sister was [REDACTED] at [REDACTED] [REDACTED] for [REDACTED] issues but was noted to be very unkempt with dirty nails that were untrimmed. It was also reported that the family did not visit the child while at the [REDACTED] and that [REDACTED] who had been in the family home in the past refused to work with the family again because they were uncooperative. The [REDACTED] was making a referral to [REDACTED]. The county caseworker made one phone call to [REDACTED] and discussed the child's [REDACTED] home. No additional contacts were made to the family because the case was recently closed out.

Circumstances of Child Fatality and Related Case Activity:

On August 1, 2014, Dauphin County Children and Youth were contacted by the [REDACTED] Police Department regarding a deceased child that was found in a bathroom and had been decomposing for days. The police advised that there were several other children with [REDACTED] in the home. The police stated that the [REDACTED] of the children had called police to inform them of the child's death. [REDACTED] reported to the police that she had smelled an odor and thought it was a dead rat. [REDACTED] eventually told the [REDACTED] that the child had died a few days ago. [REDACTED] said he didn't tell [REDACTED] at the time of the child's death because he was afraid of what may happen.

Dauphin County Children and Youth and the District's Attorney's Office responded to the family home immediately to coordinate with [REDACTED] police. At that time, the [REDACTED] and [REDACTED] had been taken to the police station to give statements. [REDACTED] police reported that the [REDACTED] told them that she hadn't seen the child since July 26, 2014 when the [REDACTED] "brought him down to her". [REDACTED] reported that she had been staying on the second floor, caring for another child, and hadn't left that area. Police stated that [REDACTED] told them that she asked [REDACTED] on August 1, 2014 if the child had died and [REDACTED] stated that he had died on July 30, 2014 and gave no explanation. [REDACTED] told the [REDACTED] that when he found the child, he was "warm to the touch" so he tried to resuscitate him but was unsuccessful. [REDACTED] reported that the child died in the bedroom that he shared with his sibling on the third floor. Once he was deceased, [REDACTED] moved the child to the front room on the third floor where he stayed until [REDACTED] told [REDACTED] told [REDACTED] that he needed to tell someone about the child's death so [REDACTED] called his family-based [REDACTED] who then told [REDACTED] to call the police.

The Dauphin County Children and Youth caseworker toured the house with the police and DA's office. The house had a very strong, distinctive smell. The first floor was well kept with the exception of some flies. On the second floor, the odor was stronger and the deceased child was in the bathroom, wrapped in a white sheet with no clothes on and flies swarming above him. On the third floor, the front room where [REDACTED] said he moved the child to once he was deceased was noted to be feces filled and have a lock on the outside of the door.

██████████ later reported to the police that the child died in the front room on the third floor, not in the other room that he shared with his sibling. ██████████ reported that he would keep the child locked in his bedroom to prevent him from falling down the stairs. He also reported that the child died on July 29, 2014. However, once ██████████ was provided with information about the coroner's estimate of the child's time of death being prior to July 29, 2014, ██████████ admitted that he found the child dead on July 29, 2014 but hadn't seen the child since July 27, 2014. ██████████ said he didn't know what to do, so he just left the child in the room until ██████████ started complaining about the odor. ██████████ stated that when he would bring the child out of his room, the child would just throw things, so he would put the child back in the locked room. ██████████ reported that he had been locking the child in the room for the past year. The official date of death as determined by the coroner's office is the date the child was found, which is August 1, 2014.

Current Case Status:

On August 1, 2014, Dauphin CCYA responded to the family home after being contacted by ██████████ Police Department regarding the victim child. Upon arrival at the family home, it was found that there were five other children residing in the home. Based on the initial assessment of the situation, the safety of those five children could not be assured and placement into foster care would be necessary. However, because of the ██████████ of most of the children and the circumstances surrounding the victim child, Dauphin CCYS determined that all of the children needed to be ██████████ first before placement into foster care could occur. On August 2, 2014, after being ██████████ at ██████████, the victim child's five siblings were taken into agency custody. One sibling, the 11 year old sister, remained at ██████████ due to ██████████ problems which resulted in a child protective services report being made on this same date and was certified as a near-fatality case. The other four siblings were placed with foster care families on this date. Once the 11 year old sister was ██████████, she was also placed with a foster family. Three of the siblings are placed together while the other two children are placed with two different foster families. Sibling visits occur once a week plus every third Saturday and sometimes more often.

Each sibling is receiving or has received, various forms of supportive services such as, but not limited to: ██████████ through ██████████ and ██████████ through ██████████, educational evaluations/enrollment through local school districts and ██████████ services, extensive ██████████ and ██████████ services at ██████████ and ██████████ evaluations. ██████████ services are provided by different providers, depending on the location and needs of the identified sibling. The 13 year old sister is ██████████ but is able to ██████████ and can use ██████████ minimally. The 12 year old brother is ██████████. The 11 year old sister continues to struggle ██████████ because of her various ██████████ that include ██████████. She is ██████████, non-verbal and requires ██████████. She has been receiving consistent ██████████ and has been to different ██████████ to receive additional recommendations on how to proceed

with her [REDACTED]. The 6 year old sibling is [REDACTED] with [REDACTED]. The 3 year old sister is [REDACTED] with [REDACTED]. Both the 6 year old and 3 year old are non-verbal and developmentally delayed. Despite the various physical, [REDACTED], emotional and [REDACTED] challenges these children possess, they are all reported to be doing well in their foster homes and have connected with their biological, older half-siblings [REDACTED] through Schuylkill County Children and Youth.

On August 7, 2014, a child protective services report was received regarding the 6 year old sister for [REDACTED] neglect due to lack of [REDACTED]. The child had to have the majority of her [REDACTED] due to lack of [REDACTED]. This case was submitted to ChildLine on September 24, 2014 with an [REDACTED] status with both [REDACTED] listed as the perpetrators.

Additionally on August 7, 2014, the 3 year old sister was [REDACTED] because she would not eat and would barely drink anything. She was [REDACTED] to the [REDACTED] and [REDACTED] on August 11, 2014.

[REDACTED]

The near-fatality [REDACTED] report for the 11 year old sister was submitted to ChildLine on September 24, 2014 with an [REDACTED] status with both [REDACTED] listed as the perpetrators.

The fatality [REDACTED] report for the victim child was submitted to ChildLine on September 24, 2014 with an [REDACTED] status with both [REDACTED] listed as the perpetrators.

On October 6, 2014, a [REDACTED] report was received regarding the 11 year old sister for [REDACTED] neglect. In 2008, [REDACTED] advised the [REDACTED] and [REDACTED] that this child needed [REDACTED] for her [REDACTED] and [REDACTED] for her [REDACTED]. Neither [REDACTED] were ever sought for this child and because of that, the child's [REDACTED] and those [REDACTED] are no longer an option. This case was submitted to ChildLine on November 18, 2014 with an [REDACTED] status with both [REDACTED] listed as the perpetrators.

[REDACTED]

On August 1, 2014, [REDACTED] was arrested and charged with Endangering the Welfare of Children and Abuse of a Corpse. On September 29, 2014, [REDACTED] was arrested and charged with counts of Criminal Homicide and Endangering the Welfare of Children, and [REDACTED] was also charged with Criminal Homicide on the same date. Both plead not-guilty at their Preliminary Hearing on December 10, 2014. A trial date has not been determined at this time.

County Strengths and Deficiencies and Recommendations for Change as Identified by the County's Child (Near) Fatality Report:

- Strengths: The identified strengths included convening the Act 33 meeting within 30 days, the immediate response by the joint investigative team to the family home and how quickly the immediate needs of the siblings were addressed.
- Deficiencies: The identified concerns/deficiencies were in regard to the agencies previous involvement with the family in 2013. Concerns involved the lack of follow-through by the agency regarding the victim child being enrolled in school and medical documentation for all of the children. There was also concern regarding the lack of communication and follow through by the agency with other service providers.
- Recommendations for Change at the Local Level: There were several recommendations, which include:
 - Establishment of an MDT protocol in regards to the Act 33 time frame.
 - Ensure that all caseworkers and supervisors who had previous involvement with the identified family be present at Act 33 meetings.
 - Establish a protocol to ensure that consultation with medical professionals is provided for cases that involve medical concerns.
 - Provide case background information to the Act 33 team members prior to the Act 33 meeting.
 - Establish a procedure on how to involve the child protection team through [REDACTED].
 - Ensuring that the caseworker who receives the report from ChildLine contacts the referral source immediately to confirm that all information was accurate and provided.
 - Provide supportive services for the siblings, continue the investigation and maintain the children in the custody of the agency.
- Recommendations for Change at the State Level: No recommendations were noted.

Department Review of County Internal Report:

Dauphin CCYA provided a report on the Fatality of the victim child to the Regional Office on October 1, 2014. The report contained all required information and a summary of the findings of the agency Act 33 review team meeting. Written approval of the report was sent to the agency on November 6, 2014.

Department of Human Services Findings:

- **County Strengths:**

- Dauphin CCYAs response to information received was urgent and thorough during the most recent CPS investigations conducted in 2014.
- All recent CPS investigations were completely in a timely manner and included full collaboration with local police and medical professionals.
- The Act 33 meeting was held in an immediate time frame and included professionals that could provide valuable input regarding the children and family.
- Dauphin CCYA attempted to place the children together in one foster home and when that was not possible, they ensured that weekly visitation occurred between the siblings.

- **County Weaknesses:**

Regarding the General Protective Services cases from 2008 and 2010:

- The response time determined when the referrals were initially received were not appropriate considering the referral information and initial level of risk determined by the agency.

Regarding the General Protective Services case from 2013:

- Supervisory oversight of the case could not be determined as there was no documentation of supervisory reviews except for one at the conclusion of the case.
- Based on the agency's knowledge of the family and their history, additional efforts should have been made to obtain child welfare and medical documentation regarding all of the children.
- The agency did not make efforts to confirm information shared by the parents through collateral contacts with community providers.
- The agency did not conduct a thorough assessment of the home by viewing all areas accessible to the children.
- There were apparent discrepancies in the assessment of the case between the assigned workers and supervisory staff which led to the case being closed prematurely.
- Safety Assessments and Risk Assessments differed greatly between the assigned workers within a short timeframe of being completed.
- Supervisory review and approval of Safety Assessment were not completed or were completed outside of regulatory timeframes.

Regarding the 2014 Information Only referral:

- Based on the information contained in this referral and the medical condition of the child, a general protective services assessment should have been completed.

Regarding the four Child Protective Services reports in 2014:

- Supervisory oversight was not consistently completed per regulatory timeframes.
- Safety Assessments were not completed at all required intervals or were completed outside of the required timeframes.

- Statutory and Regulatory Areas of Non-Compliance:

- 3130.21(b) - In 1 of the 4 CPS files reviewed, 2 safety assessments completed were not reviewed or signed by a supervisor and one safety assessment was signed by a supervisor beyond 10 days of completion.
- 3130.21(b) - In 1 of the 4 CPS files reviewed, there was no Preliminary Safety Assessment completed.
- 3130.21(b) - In 3 of 4 CPS files, there was no documentation of a Conclusion of Investigation Safety Assessments completed.
- 3130.21(b) - In 1 of 4 CPS files, the Conclusion of Investigation Safety Assessment was completed outside of the required timeframe.
- 3490.235 (e) - In 4 of 4 CPS and one GPS case files reviewed, Supervisory reviews of were not completed every 10 days.
- 3490.232 (g) - In 1 of 3 GPS case files reviewed, while the agency identified two previous child welfare agencies that had previous and extensive history with the family and some information was requested and received from those agencies, there was no documentation in the case file that the agency pursued actions to obtain all records and information regarding the family from the other agencies prior to case closure.
- 3490.232 (g) - In 1 of 3 GPS case files reviewed, based on the extensive medical, cognitive and developmental disorders and disabilities of the children, all medical documentation should have been obtained prior to case closure.
- 3490.232 (g) - In 1 of 3 GPS case files reviewed, the agency did not confirm with the family's school district that the family met with the school district to discuss enrollment of two school-aged children who were not enrolled or attending school.
- 3490.232 (f) - In 1 of 3 GPS case files reviewed, although the agency conducted multiple home visits and assessed the sleeping areas of some of the children, there was no indication within the case file that all areas of the home where the children sleep were assessed.

- 3490.321 (f) - In 1 of 3 GPS case files reviewed, the file did not contain documentation that supported the significant change in the level of risk from the Assessment Conclusion Risk Assessment to the Case Closure Risk Assessment.
- 3490.232 (a) (c) (d) - In 1 of 4 Information Only referral case files, the agency did not assess a new referral regarding the family. The information contained within the new referral was from a credible source and met the criteria for assessment.
- 3490.232 (c) – In 2 of 3 GPS case files reviewed, the initial response time that was determined by the agency was not appropriate based on the referral information.
- 3130.61(a) - The initial Family Service Plan was completed beyond the 60 days after case acceptance.

Department of Human Services Recommendations:

Dauphin CCYA should continue to successfully collaborate with local law enforcement and medical professionals regarding all appropriate cases, complete investigations timely, obtain all relevant collateral information in a timely manner and continue to hold quality Act 33 meetings within the required timeframe. Dauphin CCYA should also continue to make every effort to place siblings in the same foster home, when possible or provide frequent visitation when placement in the same foster home is not possible.

Dauphin CCYA must establish and/or enforce a protocol regarding supervisory oversight and documentation for all cases. This should include review and approval of all Safety Assessment and Risk Assessments within the required timeframes; supervisor and caseworker review of the case at least once every ten days and documented recommendations regarding the case.

Dauphin CCYA must ensure that caseworkers and supervisors are following through with obtaining all necessary documentation regarding a family in order to make an accurate assessment of a family. If the family is not cooperative with providing such documentation or signing consents to obtain such documentation, then appropriate court proceedings should be pursued. This would include records regarding, but limited to medical, dental, mental health, cognitive disabilities, educational and previous child welfare involvement.

Dauphin CCYA must review, amend as appropriate and monitor their policy/protocols regarding their assessment of referrals when they are initially received. Each referral should be reviewed thoroughly and assigned an appropriate case assessment status and response time. If a referral is determined to be an Information Only case, case records must document the specific reasons and rationale for determining that case status. When a referral is determined to need assessed, an appropriate response time must correlate with the level of risk that has been determined and every effort should be made by the agency to see the child or children, and meet with the family within that

response time. Dauphin CCYA should implement or enhance a quality review protocol for all cases. This should include frequent and random reviews of all types of cases and address any concerns immediately.