Luzerne County Child and Youth Services
Final Report

Troutman Pepper Hamilton Sanders LLP

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I. Introduction

On July 6, 2021, after a lengthy investigation by Pennsylvania's Office of Attorney General ("OAG,") Joanne Van Saun, the former Director of Luzerne County Child and Youth Services ("LCCYS,") was criminally charged with one count of endangering the welfare of a child and two counts of obstruction in violation of 18 Pa.C.S. §§ 4304(a)(1) and 4958(b)(1). According to the complaint, Van Saun directed LCCYS employees to submit false reports to Pennsylvania's Department of Human Services ("DHS"), showing that child welfare referrals "had been investigated and deemed without merit, when that was not true."[1]

As a result of the charges, the County retained Troutman Pepper Hamilton Sanders LLP ("Troutman Pepper") to conduct a review of LCCYS and the allegations in the complaint. The County also removed Van Saun and replaced her with John Alunni as the Acting Director. Alunni is the Deputy Head of the County's Division of Human Services. Immediately following his appointment, Alunni held meetings with LCCYS leaders as well as officials from DHS. After some of these meetings, multiple LCCYS employees advised Alunni of other potential misconduct at the agency, including specific instances where false information was placed in agency files. These LCCYS employees also advised Alunni that they did not feel comfortable raising these issues prior to Van Saun's dismissal because they feared retaliation by Van Saun if they reported the matter to County leadership. The County's removal of Van Saun from her position at LCCYS directly led to a number of agency employees coming forward to County leadership. The County informed Troutman Pepper of these allegations and directed investigators to review these matters as well.

The Troutman Pepper attorneys who conducted the investigation include former federal and state prosecutors Richard Zack and Christen Tuttle, as well as Michael Reed, who is a fellow in Troutman Pepper's Center for Public Service. This is the final report of Troutman Pepper's investigation. At the County's direction, Van Saun was afforded an opportunity to review and respond to this report prior to its publication. She declined.[2]

II. Investigative Process

As part of its investigation, Troutman Pepper conducted regular meetings with County leadership, including Romilda Crocamo, the County Manager, Lynn Hill, the Division Head of Luzerne County Human Services, Alunni, and others, including officials who oversee County employment. County leadership directed Troutman Pepper to conduct a thorough, complete, and independent investigation into the allegations regarding LCCYS. The leadership

[1] The complaint is publicly available at: https://www.attorneygeneral.gov/wp-content/uploads/2021/07/2021-07-06-Joanne-Van-Saun-criminal-complaint.pdf.

[2] Because of the requirements of the Child Protective Services Law, this report does not name specific families and children who have received services from LCCYS or otherwise had contact with the agency. Additionally, this report does not identify the names of individual LCCYS employees other than Van Saun. In order to encourage employees to come forward and to insure that employees continue to provide candid information about problems at the agency, investigators did not name individual employees in this report. However, when investigators uncovered potential misconduct by an agency employee, they provided that information to County leadership. County leadership has taken action where appropriate.

provided Troutman Pepper with access to any LCCYS or County employee with whom the investigators requested to speak, as well as access to all requested records and data. The County directed employees to provide all relevant information and records and to cooperate fully in the investigation. County leadership also directed Troutman Pepper to speak with the Luzerne County District Attorney's Office, OAG and DHS officials regarding the allegations against Van Saun and the investigation's findings.

Troutman Pepper interviewed 19 LCCYS employees in person at the Luzerne County Courthouse over the course of several months. Employees were required to meet with investigators, provide truthful and accurate information, and provide documents as requested.[3] Troutman Pepper also regularly communicated with staff members of the Northeast Regional Office of DHS ("NERO") and provided information about the investigation's findings. Troutman Pepper also spoke with multiple community members who contacted investigators to raise concerns and provide information.

In addition to the above interviews and information-gathering discussions, Troutman Pepper reviewed thousands of documents. This included records in LCCYS agency files, information stored in LCCYS and DHS electronic systems, email communications, and LCCYS organizational and policy documents.[4] Troutman Pepper also oversaw a detailed record review conducted by LCCYS's Quality Assurance Unit regarding specific child welfare referrals identified by NERO, as well as those referenced in the OAG's complaint against Van Saun.

Finally, Troutman Pepper reported its findings to the OAG and Luzerne County District Attorney's Office. Troutman Pepper also delivered two oral interim reports to the Luzerne County Council.

III. **Background**

A. Agency Duties and Responsibilities

LCCYS is tasked with receiving and responding to reports of child abuse and neglect, in addition to providing ongoing support services, overseeing foster care and other placements, conducting permanency planning, and providing other related services to children and families. 23 Pa.C.S. §§ 6362-6375. LCCYS is also responsible for maintaining records of the protective services it provides. 23 Pa.C.S. § 6337(f). LCCYS serves a critical function for the County, and agency leadership was entrusted with some of the more important and difficult work assigned to County employees.

[3] Each interviewee was informed that the investigators are attorneys retained by the County to conduct a review of the agency and concerns that had been raised regarding the agency, and that the investigators represent the County not the individual employee. Where requested by the interviewee, union representatives were present for the interviews.

[4] Troutman Pepper attorneys entered into agreements in which they committed to maintaining the confidentiality of protected records consistent with the Child Protectives Services Law ("CPSL") 23 Pa. C.S. §§ 6301 – 6386.

B. Agency Structure and Staffing

LCCYS is led by a Director, formerly Van Saun, who reports to the County's Division Head for Human Services, who then reports to the County Manager. Under the Director, there is a single Deputy Director and five Managers who oversee units of caseworkers. Each unit is assigned to cover different functional areas, including: screening; intake for General Protective Services ("GPS," generally for referrals of neglect); intake for Child Protective Services ("CPS," generally for referrals of physical or sexual abuse); ongoing GPS services; ongoing protective services; the Adolescent Unit; Independent Living; Kinship Care; and the Resource Unit (generally, foster care). Each unit is intended to be staffed by a supervisor, four to six caseworkers, and an aide. However, approximately 46 percent of caseworker positions are currently open.[5]

The agency also has departments for support functions such as Legal, Fiscal, and Clerical. Finally, there is a Quality Assurance Unit ("QA") that is staffed by program specialists who are tasked with conducting file reviews, advising on regulatory requirements, liaising with agency contractors, budgeting, and other duties. In essence, the QA Unit is supposed to serve as an internal auditor tasked with conducting compliance reviews and reviewing and analyzing certain LCCYS operations.

C. Pennsylvania Department of Human Services

Pennsylvania DHS is a state agency composed of seven program offices, one of which is the Office of Child, Youth and Families ("OCYF").[6] OCYF has four regional offices that monitor the delivery of services by county child and youth services agencies. One of these offices, NERO, has responsibility for LCCYS. NERO is LCCYS' primary regulator. As part of its oversight function, NERO conducts annual file audits in which it selects and reviews a sample of agency files. 55 Pa. Code § 3490.42. Deficiencies in files may result in citations issued to the agency. *Id.* If the agency has significant deficiencies, DHS may issue a provisional license that requires a plan of correction. 55 Pa. Code § 20.54. Currently, LCCYS is on a provisional license. Because of NERO's expertise and significant authority over the operations of LCCYS, County leadership relies heavily on NERO's citations, reports, and views regarding the operation of the agency.

D. Child Welfare Referrals

Referrals are made to LCCYS through Pennsylvania's ChildLine system, or directly to the agency through phone, electronic, or in-person reports. Referrals are initially reviewed in LCCYS's screening unit to gather information, conduct an initial assessment, and

[5] As of April 12, 2022, there were 50 open caseworker positions out of a total of 109 positions. In total, the agency currently employs 208 people across all functions. The agency has faced ongoing and significant understaffing issues throughout the time period at issue in this report.

[6] This includes the Office of Child Development and Early Learning, Office of Child, Youth and Families, Office of Developmental Programs, Office of Income Maintenance, Office of Long Term Living, Office of Medical Assistance Programs, and Office of Mental Health and Substance Abuse Services.

determine what if any agency response is appropriate.[7] Then, depending on the nature of the referral, it may be routed to the intake units for CPS or GPS to conduct fact investigation and safety and risk assessments. If a referral relates to a child who is already receiving ongoing services from LCCYS, the referral will be routed to the previously assigned caseworker. Other possible outcomes include routing to the Specialized Adolescent Assessment Unit, referral to law enforcement or another agency when the alleged conduct falls outside of LCCYS's jurisdiction but within the jurisdiction of another entity, or "screening out" when the report does not meet LCCYS's criteria.

Starting in 2015, consistent with the requirements of CPSL, DHS launched the statewide Child Welfare Information System ("CWIS") as a centralized case management system for ChildLine referrals across all counties in Pennsylvania. *See* 23 Pa. C.S. § 6331. County child welfare agencies like LCCYS are required to acknowledge receipt of each referral and then submit the outcome of each referral to CWIS. *See* 23 Pa. C.S. §§ 6367, 6368, 6375. This system allowed DHS to have greater access to LCCYS records and was designed, in part, to modernize recordkeeping at the agency. This system is separate from LCCYS's own record keeping system.

E. Criminal Action against Van Saun

The Pennsylvania OAG conducted an investigation into Van Saun over the course of several years, resulting in the criminal complaint filed in July 2021. In the complaint, OAG stated that a May 4, 2017 newspaper article reported that LCCYS had failed to "timely evaluate 1,388 GPS referrals in 2016." The complaint alleged that, as a result of this publication, Van Saun assembled a team of LCCYS staff directing them that "she wanted the backlog eradicated immediately, and that she did not care how they did it." Clerical employees were then deceived by Van Saun into submitting "screen outs" to CWIS, falsely indicating that "the referral did not allege abuse or neglect," when referrals did in fact allege abuse or neglect. The complaint alleged that "[b]y ordering the summary deletion by screen out of these referrals, Van Saun directly placed the welfare of the subject children in danger."[8] Van Saun concealed the scheme from County leadership and only Van Saun and a few trusted aides knew the scope of Van Saun's scheme and its cover up.

As part of its investigation, the OAG served grand jury subpoenas on the County. The County cooperated with the investigation and provided numerous responsive records to the OAG, including e-mail messages and personnel records. The OAG's investigation was confidential and the County was not informed of the full scope of the investigation until the complaint was filed on July 6, 2021. Recipients of grand jury subpoenas are compelled to provide the records requested and they generally have the force of a court order. Failure to comply can result in significant penalties. Neither the County nor NERO have any similar tools.

[7] Consistent with the Child Protective Services Law, LCCYS receives and responds to referrals 24 hours per day, seven days per week. *See* 23 Pa. C.S. § 6366.

[8] https://www.attorneygeneral.gov/wp-content/uploads/2021/07/2021-07-06-Joanne-Van-Saun-criminal-complaint.pdf

On October 14, 2021, Van Saun pleaded guilty to one count of endangering the welfare of a child and two counts of obstruction. On December 15, 2021, she was sentenced to 34 months of probation.

IV. Findings

A. Executive Summary

In summary, the investigation found that Van Saun established and fostered an environment within LCCYS that instilled fear in its employees, hid problems from people outside the agency such as NERO and County leadership, and encouraged inaccurate and misleading recordkeeping to avoid criticism from the outside. At Van Saun's direction, LCCYS failed to timely submit referral outcomes to DHS's centralized reporting system and then submitted false outcomes in an effort to resolve the substantial backlog after it became public. Additionally, under the culture established by Van Saun, some employees engaged in a practice of altering and fabricating agency records submitted to NERO and others outside the agency to avoid citations or negative feedback. The review further concluded that heavy caseloads, short staffing, and onerous statutorily-imposed recordkeeping requirements also contributed significantly to documentation failures by agency staff.

Van Saun's concealment of her misconduct was extensive and was focused on preventing County leaders and NERO from learning of the scheme. Her concealment and contempt for oversight were clearly illustrated by the fact that agency employees said they felt empowered to report Van Saun's misconduct only after the County removed her and when it became known that County leadership had ordered this investigation. Van Saun's concealment of the scheme prevented NERO from having full access to information and a full view of LCCYS's performance. County leadership reported that it relied heavily on NERO's assessment and was deprived of this valuable feedback.

Troutman Pepper's investigation did not find evidence of serious or systemic child safety concerns as a result of the misconduct, and found that LCCYS employees appropriately demonstrated a recognition of their duty to serve children by conducting in-person visits with children and families to assess their risk and safety. However, while the investigation did not find instances of actual child harm as a result of the recordkeeping misconduct, the investigation concluded that the misconduct created a risk of potential child harm because other LCCYS caseworkers, NERO staff members, County leadership, courts, and other agencies rely on the accuracy of LCCYS records to take appropriate action. If LCCYS records do not timely and accurately reflect a child's or family's condition, then LCCYS or other stakeholders may be misled into taking the wrong course of action that does not adequately protect against the risk of harm.[9]

[9] During the course of the investigation, some interviewees also raised concerns regarding Van Saun's relationships with individuals and entities that contract with LCCYS. These issues are not addressed in this report, but investigators communicated them to County leadership. Investigators understand that the County's Controller has since conducted audits of two contractors, and the County has re-examined the relationships.

To protect the privacy of the LCCYS clients, this report does not detail the individual cases or files where investigators identified false or misleading documents or other problems. Rather, investigators provided this information to the County and to NERO so that they can properly address these matters. This information was also made available to law enforcement.

B. Failures in CWIS Reporting and Submission of False Reports

1. CWIS Backlog

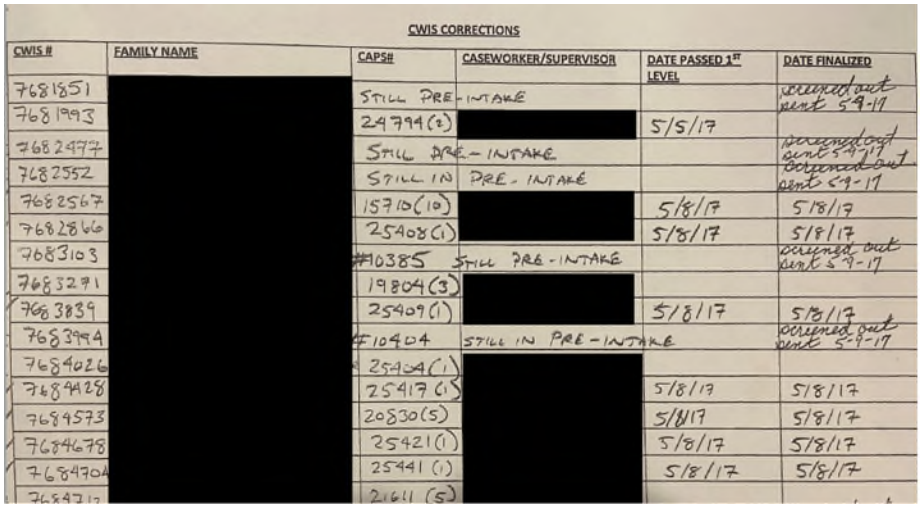
The investigation determined that, at Van Saun's direction, LCCYS staff members failed to submit information to the state's CWIS system regarding the outcome of child welfare referrals as required by statute. Then, after the failure became public, Van Saun directed that the backlog be eliminated immediately, resulting in the submission of false information to CWIS. This conclusion was based on firsthand accounts by interviewees, as well as the review of emails, handwritten charts documenting the process, and system-generated reports of CWIS data. As explained below, the backlog existed, in part, because Van Saun had ignored recordkeeping requirements imposed by state law.

In 2015, Pennsylvania implemented the CWIS system, through which reports of child welfare concerns across the state are centrally tracked. All counties are required to submit the outcomes of child welfare referrals to CWIS. At LCCYS, when CWIS was implemented, Van Saun directed her staff members that they did not need to comply with the regulations and did not need to submit outcomes to the CWIS system. As reported by multiple interviewees, Van Saun told them directly during a supervisor's meeting that "we're not doing this." Van Saun was described by interviewees as treating the new requirement as a "joke" and "B.S." Although many staff members were disturbed by Van Saun's direction regarding CWIS, other staff did not submit information to CWIS and a large backlog of unreported outcomes built up. Investigators found no evidence that Van Saun disclosed to DHS her intention to ignore the requirements of the CWIS system or that she informed County leadership of her direction to staff. Van Saun actively obstructed NERO's ability to properly monitor LCCYS when Van Saun directed employees to violate DHS's mandate to keep records in CWIS. This also prevented County leadership from taking advantage of this critical oversight tool.

On May 3, 2017, a regional media outlet reported that LCCYS had a backlog of more than 1,000 referrals from 2015 and 2016 for which outcomes had not been submitted to CWIS.[10] Immediately after the media report, Van Saun directed a "task force" of LCCYS staff members, led by three now former employees, to eliminate the backlog and submit outcomes to CWIS for all outstanding referrals. In the words of one interviewee, Van Saun "screamed" that "I just want this cleaned up and I don't care how you do it." Van Saun did not inform County leadership of her plan to address the backlog and engaged in extensive efforts to conceal it from the County and NERO.

[10] https://www.citizensvoice.com/news/agency-missing-accurate-reports-on-county-child-welfare-calls-in-2016/article_3fc93392-a34a-5048-a7a6-3aa3a645fa00.html

As part of the illegal "clean[] up" effort, the team reviewed spreadsheets listing the CWIS referrals for which outcomes had not been submitted. At Van Saun's direction, staff members created handwritten charts titled "CWIS Corrections," identifying the child or family involved, the assigned caseworker, and the "CAPS number" (referring to the number within LCCYS's case management system CAPS). In the chart, a subset of the referrals were identified as remaining in the "pre-intake" stage of LCCYS's screening and intake process, and did not have assigned caseworkers or CAPS numbers. A portion of one such chart is below:[11]



CWIS CORRECTIONS

CWIS #	FAMILY NAME	CAPS#	CASEWORKER/SUPERVISOR	DATE PASSED 1ST LEVEL	DATE FINALIZED
7681851	[redacted]	STILL PRE-INTAKE			screened out sent 5-9-17
7681993		24799(2)	[redacted]	5/5/17	
7682477		STILL PRE-INTAKE			screened out sent 5-9-17
7682552		STILL IN PRE-INTAKE			screened out sent 5-9-17
7682567		15710(10)	[redacted]	5/8/17	5/8/17
7682866		25408(1)		5/8/17	5/8/17
7683103		#10385 STILL PRE-INTAKE			screened out sent 5-9-17
7683291		19804(3)	[redacted]		
7683839		25409(1)		5/8/17	5/8/17
7683994		#10404 STILL IN PRE-INTAKE			screened out sent 5-9-17
7684026		25434(1)	[redacted]		
7684428		25417(1)		5/8/17	5/8/17
7684573		20830(5)		5/8/17	5/8/17
7684678		25421(1)		5/8/17	5/8/17
7684704		25441(1)		5/8/17	5/8/17
7684717		21611(5)			

Where the referrals had existing CAPS numbers and assigned caseworkers, they were assigned to unit supervisors to be updated in CWIS. As described by multiple interviewees, the supervisors and/or their caseworkers generally recognized the cases and knew the outcomes because they had worked on them directly. Where needed, they would refer to case files to determine how the referrals were resolved. Based on this process, the investigation did not find any evidence that the information entered into CWIS for these referrals was inaccurate.

However, the referrals that were identified as "pre-intake" were treated differently. Clerical staff were assigned to submit outcomes for these cases, although they did not have knowledge of how the referrals were actually handled by LCCYS. On May 9 and 10, 2017, 118 referral outcomes were submitted by clerical staff.[12] Based on direction they received from the former employees Van Saun put in charge of the "task force," the clerical staff members "screened out" the referrals and selected from a drop down menu the option "Referral did not allege abuse or neglect" as the reason for the screen out.[13] Based on the directions they

[11] For purposes of this report, all personal identifying information of the children, families, and caseworkers have been redacted. *See* 23 Pa. C.S. § 6342.

[12] Investigators reviewed CWIS-generated reports identifying the date and reason for the screenouts, as well as the individual who completed the screenout.

[13] This was the reason selected for 112 of the 118 screen outs. For 6 of the screen outs, other reasons were selected including "Other reason not listed here," "Referral made to community services," and "One face-to-face contact made, no further assessment required."

received, the clerical staff members did not review the case history to determine what had actually occurred when the report was received, nor determine whether the agency actually screened out the report or how the report was otherwise addressed at the time. As described by one clerical staff member, she followed directions and did not understand the import of the information she was entering. The lack of substantive review was also evidenced by the speed with which the screen outs were completed. As shown in the below portion of a time-stamped chart generated from CWIS, screen outs by clerical staff were sent in quick succession.[14]

Referra	Screen Out Reason	Screen Out Sent
7662782	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:14:15 AM
7669723	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:17:40 AM
7670810	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:22:35 AM
7725350	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:24:11 AM
7725464	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:24:53 AM
7728012	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:28:51 AM
7728801	One face-to-face contact made, no further assessm	5/9/2017 11:29:27 AM
7540657	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:30:03 AM
7722299	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:32:46 AM
7723309	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:34:23 AM
7723594	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:35:34 AM
7724579	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:38:41 AM
7536633	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:39:46 AM
7536898	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:42:51 AM
7715882	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:43:17 AM
7715955	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:43:47 AM
7717858	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:44:49 AM
7718822	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:45:21 AM
7681851	Referral did not allege abuse or neglect **Expired*	5/9/2017 11:45:54 AM

Although the clerical staff members did not substantively review the referrals or case histories, in many instances, the referrals did not in fact allege abuse or neglect. Therefore, the information submitted to CWIS for those referrals was accurate, even though the process to do so was clearly flawed. However, other referrals did in fact allege abuse or neglect. Therefore, the investigation concluded that false outcome information was submitted to CWIS for this population of referrals.

The above-described process of providing false information to DHS was hidden from those outside of LCCYS, including County officials and NERO. Van Saun told outsiders that the missing outcomes in CWIS were merely the result of errors that needed to be corrected. She hid the fact that, for many referrals, false information was being submitted to CWIS by clerical staff who did not have knowledge of how the complaints were actually handled.

2. Review of False "Screen Outs"

In order to determine what actually occurred in cases for which inaccurate "screen out" dispositions were submitted to CWIS, Troutman Pepper coordinated with NERO and members of LCCYS's Quality Assurance team to review agency records for these referrals. NERO identified 50 referrals where it believed the "screen out" outcome submitted to CWIS was incorrect. Investigators cross-referenced this list with OAG's complaint against Van Saun and it was found that all 10 referrals cited in the complaint were included on NERO's list.

At the direction of Troutman Pepper and in cooperation with NERO, LCCYS's Quality Assurance team conducted an analysis of the agency's records regarding these 50

[14] This spreadsheet was reviewed by investigators consistent with 23 Pa. C.S. §§ 6335, 6340, and 6342. No personal identifying information is being included in this report. *See* Pa. C.S. § 6342.

referrals.[15] The review included a careful evaluation of what occurred at the time of the initial referral as well as any other contemporaneous or subsequent referrals, contacts or assessments of the children involved. In summary, the review resulted in the following:

Referrals Analyzed	50
Documentation reflects adequate response to referral at time	16 of 50
Insufficient documentation to determine adequacy of response to referral	34 of 50
• **Child was subject of other referrals where the agency responded**	26 of 34
• **New assessments opened in 2021, in coordination with NERO**	9 of 34[16]

For approximately one-third of the referrals (16 of 50), the reviewers found sufficient records to assess how LCCYS actually responded to the referral and to determine that the agency's response was adequate. For the remainder (34 of 50), the existing records were insufficient to make this determination, or to determine how or if the referral was addressed.

Based on investigators' assessment of agency culture, which is discussed in more detail below – that prioritized in-home visits and child safety but routinely disregarded documentation requirements – the investigation did not find that the lack of documentation was evidence that the referral was in fact ignored by agency staff. However, the investigation was also not able to conclude that these referrals were appropriately addressed. Therefore, reviewers went on to evaluate whether there were other contemporaneous or subsequent referrals through which these children were seen and/or the allegations assessed. The review determined that in more than 75 percent of the cases (26 of 34), the children were the subjects of other referrals in which LCCYS, or in some instances another agency, responded. In the remaining referrals, the review was not able to conclude either that (1) the initial referral was handled appropriately at the time, or (2) the child was otherwise assessed.

To rectify the nine unresolved referrals, LCCYS conducted an assessment of each child and family involved to determine what if any intervention was required. Depending on the circumstances of each case, the assessments included records searches, in-person and telephonic interviews, referrals to other jurisdictions, and other steps. During the course of three of the assessments, LCCYS learned that the child had a specific recollection that a caseworker

[15] Troutman Pepper relied on LCCYS's Quality Assurance team because members repeatedly demonstrated the integrity, deep expertise, and institutional knowledge needed to conduct a thorough review. Troutman Pepper also discussed specific findings and analyses with members of the team, and found them to be well-supported. The person who supervised the unit when Van Saun was the director was no longer with the agency at the time of the review.

[16] LCCYS conducted new assessments of eight referrals for which there insufficient documentation to determine if the agency had previously responded, as well as one additional referral at the request of NERO for a total of nine new assessments.

interviewed him or her regarding the allegations at the time they were made in 2016. For the remaining six assessments, LCCYS was not able to confirm what occurred in 2016.

The assessments were completed under the oversight and in cooperation with NERO. None of the assessments resulted in a finding that new services should be provided or a new case opened.

The necessity of this review was the direct result of Van Saun's scheme to improperly close cases. If Van Saun had not concealed her scheme from NERO and County leadership, they would have been able to stop Van Saun from implementing it and taken further action to prevent the risks that Van Saun created.

C. Failure to Keep Accurate Records

The submission of false information to CWIS, described above, did not occur in a vacuum. Overall, the investigation concluded that a number of factors, largely, though not entirely driven by Van Saun, contributed to an environment in which agency records were altered or fabricated by some staff members.

1. Agency Culture

The investigation concluded that Van Saun implemented and fostered a culture of recrimination in the agency. The investigation's findings were consistent with the OAG's description of agency culture under Van Saun. Many employees reported that they feared verbal abuse and discipline by Van Saun for voicing concerns or making mistakes. This fear was consistently described by the majority of interviewees. Employees reported that Van Saun was verbally abusive toward them and others, and was intolerant of what Van Saun viewed as lapses or errors by agency staff. They reported that Van Saun regularly "screamed" and was "demeaning" and "belittling" toward staff, had an "authoritarian" leadership style, and "ruled by fear and threats." If an employee raised a concern to Van Saun, she would "address it in a way that ripped you apart." Investigators found these many accounts to be consistent with one another and credible.

In particular, employees reported that they feared they would face abuse or discipline by Van Saun if they received citations during NERO audits of agency files. As described in more detail below, employees reported that Van Saun was concerned with NERO finding out about issues at the agency and she did not give NERO proper access to agency records and personnel. Additionally, many employees reported that they did not feel they could challenge Van Saun or raise their concerns to County leadership above Van Saun because they feared Van Saun's reaction. Similar to her attitude toward NERO, Van Saun did not want County leadership to learn of problems within the agency and failed to keep County leaders apprised of the status of the agency. Van Saun actively obstructed the efforts of NERO and County leadership to properly oversee the agency by fostering this culture.

Investigators found convincing evidence that Van Saun's actions caused at least some employees not to report issues because, once Van Saun was gone, several employees immediately voiced concerns to Acting Director Alunni. Alunni then immediately provided the information to County leadership who directed Troutman Pepper to investigate. This would not

have occurred under Van Saun's leadership. Indeed, as we discuss below, only the OAG, with powerful law enforcement tools at its disposal, was able to uncover both Van Saun's underlying misconduct and her efforts to conceal and obstruct.

Van Saun's actions were not consistent with her duties as Director, as laid out in Luzerne County's job description for the role. Per the job description, Van Saun had responsibility to "[d]evelop, direct and monitor Agency programs to ensure they are consistent with ethical professional practice standards" and to "[p]erform functions in a professional and ethical manner." Van Saun failed to meet these obligations. We also note that Van Saun's efforts to frustrate NERO and the County's oversight responsibility were especially harmful. Van Saun's efforts were antithetical to good agency management.

2. Lack of Transparency and Concealment of Problems in the Agency

The investigation also found that, under Van Saun, LCCYS did not properly cooperate with its oversight agency NERO or County leadership. Because of the importance of the agency's mission, employees should be empowered to provide information regarding waste, fraud, and abuse to NERO, County leadership or other regulators. Such a function is critical to identify problems in the agency that are inconsistent with the agency's mission. Former agency leaders actively frustrated this function.

To function properly, agencies like LCCYS must have a robust system that encourages employees to report problems, including waste, fraud or abuse in the agency. Employees should be empowered to report this misconduct even if it involves agency leaders. There did not appear to be an effective system in place for employees to report such misconduct. This failure prevented both NERO and County leadership from learning of the agency's problems, including the misconduct of leadership.

The lack of transparency was largely driven by Van Saun's desire to ensure that LCCYS and, by extension, Van Saun did not receive citations, critical feedback, or negative publicity. In the words of one interviewee, Van Saun fostered a culture to "cover things up and make things look good even when they're not." As consistently reported by interviewees, Van Saun established an antagonistic relationship with NERO and treated NERO as "the enemy." With respect to County leadership, she fostered an atmosphere of obstruction and concealment, portraying County leaders as an obstacle rather than a partner. Agency staff were not permitted to talk to NERO staff or seek guidance and support from NERO, even where they had done so freely before Van Saun's tenure. Historically, there had been frequent information-sharing with NERO, especially because many NERO staff had previously worked at LCCYS. Interviewees said that they would call NERO and ask questions about specific regulations or seek guidance on how to handle a challenging issue. However, these interviewees advised investigators that Van Saun did not permit employees to talk to NERO directly so they stopped speaking to NERO staff. Van Saun changed the relationship with NERO from one of cooperation to one of hostility. She changed the relationship with County leadership in a similar way.

Van Saun's lack of cooperation with NERO was particularly apparent during annual audits of agency files. As described in more detail below, employees were directed to "fix" any errors or deficiencies in their files before they were provided to NERO. Van Saun

directed that, before each NERO audit, Quality Assurance specialists must review every file that was subject to the audit and fill out checklists identifying all deficiencies. There was then a "flurry" of activity in which records were altered and/or added to the files. One interviewee recounted an experience in which she heard Van Saun screaming at another employee because Van Saun believed a file was going to be provided to NERO before it was "ready." This resulted in NERO receiving inaccurate and misleading records, which thwarted NERO's ability to effectively provide monitoring and oversight over LCCYS. It also thwarted the County's ability to have accurate information regarding the functioning of LCCYS and to track problems in the agency.

3. Caseload and Job Requirements

In addition to the environment that Van Saun created and fostered, the realities of the job also put significant pressure on caseworkers. First, workers have extremely heavy caseloads. There is a significant number of vacant positions at LCCYS (currently approximately 46% of caseworker positions are unfilled) that puts strain on caseworkers, increases caseloads, and leads to even more turnover. Additionally, LCCYS caseworkers receive a starting salary of $32,418.66 (for caseworker I positions) or $38,956.25 (for caseworker II positions), which is not commensurate with the extremely important, challenging and often dangerous work that they do and leads to challenges in attracting and retaining qualified staff. Additionally, as described by multiple interviewees, larger societal factors such as the opioid epidemic contribute to an increase in child welfare referrals and concerns that must be met by the agency.

Finally, caseworkers have significant statutorily-imposed recordkeeping requirements with tight timing deadlines. Many interviewees expressed a view that there simply are not enough hours in the day to visit the families and maintain the paperwork. Investigators heard a view from many staff members that paperwork was less important than ensuring child safety through in-person home visits and assessments. The result is that documentation was not completed timely.[17]

Rather than address these concerns constructively, Van Saun encouraged employees to cut corners and evade recordkeeping requirements. She did not communicate how the above factors were impacting the agency and the ability of the caseworkers to meet the demands of the job. Instead, she actively covered up the problems and misrepresented the agency to NERO and County leadership.

4. Fabrication and Alteration of Agency Records

Because of all of the above-described factors, many agency staff were faced with record deficiencies in their case files and were highly motivated to do whatever was necessary to avoid citations during NERO's audits of LCCYS files. Van Saun used LCCYS's Quality Assurance unit to review all files before they were provided to NERO, so that any deficiencies could be identified. Agency staff members were then directed to "correct" the deficiencies,

[17] The issues described in this section are consistent with those found by the Pennsylvania Auditor General in a 2017 report "State of the Child." Available at: https://www.paauditor.gov/Media/Default/Reports/RPT_CYS_091417_FINAL.pdf.

including by fabricating or altering records. Agency staff reported that they feared retaliation and verbal abuse by Van Saun should they fail to do so. This resulted in an abuse of the QA function and a routine practice in which staff members altered and/or created records in advance of NERO's audits.

Investigators observed multiple examples of altered or fabricated records, based on firsthand accounts by interviewees as well as a review of the records themselves. For example, in some instances, Word versions of forms were used, rather than electronically-generated forms, so that they could be manually backdated and not subject to an electronic time stamp. In other instances, family service plans and safety and risk assessment forms were filled out weeks, months and sometimes years late.[18] In another instance, child development worksheets ("Ages & Stages" forms that are intended to document a child's physical development at a certain age) were created years after the fact. In another instance, letters that were never actually sent to parents were added to files. And, in another instance, a staff member pulled a photograph of a child from Facebook and placed it in the agency's file but then labeled and dated the photograph as if it was taken by a caseworker on a home visit.

Generally, these records were backdated and presented in a manner to make it appear they were created timely, although they were actually created or revised only in advance of outside review. For example, one interviewee admitted to cutting off the date stamp showing when medical records were faxed to the agency, so that NERO would not be able to tell that the records were not obtained timely but were only obtained just before the audit. The purpose was to mislead NERO, or others that may be reviewing agency files, into believing that the records had been created in accordance with regulatory requirements when they had not been.

This practice was routine for some staff, but it was not universal. Many agency staff indicated that they were very troubled by the practice, which they understood to be dishonest and to have the potential to put children at risk. Many interviewees also complained that such practices created hostility between the agency and NERO, which led to a lack of cooperation and a view that employees would suffer if they cooperated with NERO.

5. Role of Agency Leadership

The investigation concluded that the practice was done with the actual knowledge and facilitation of prior agency leadership. This conclusion is based, in part, on the fact that the practice was widely known throughout the agency but it went unchecked. Additionally, multiple interviewees advised that they understood that Van Saun and other former leaders expected them to "correct" problems with files, which included altering or fabricating records. One interviewee described a particular instance in which she observed Van Saun direct an administrative staff member to forge a parent's signature on a document because the parent had signed the document in the wrong place. Per the interviewee, the administrative staff member did as instructed.

Van Saun also gave directions and instituted processes that encouraged the practice. For example, multiple interviewees reported that Van Saun encouraged the use of handwritten paper records rather than electronic records, so that they could avoid timestamps.

[18] As one interviewee bluntly put it, "we'll do a risk or safety [assessment form] if it's missing."

Employees recalled that Van Saun said that handwritten records avoided timestamps. Additionally, Van Saun misused the Quality Assurance unit and distorted its intended function. Quality Assurance is intended to help ensure that the agency is operating compliantly and serve as a control function, similar to internal audit. Program specialists, who were known to have particular regulatory knowledge and expertise, were recruited from within the agency to work in Quality Assurance. As described in the County's job description for the role, they should "[c]onduct regular case and quality services reviews of agency active cases" and "[e]nsure all files are in compliance. If a file is non-compliant, make recommendations to staff. Follow-up to ensure compliance." As described by the members of Quality Assurance, these file reviews are intended to identify trends, train and educate staff, and (where appropriate) fix errors.[19] However, Van Saun instead used the reviews to identify deficiencies so that documents could be fabricated or altered to mislead NERO into believing that regulatory requirements had been met when they had not. As described by one interviewee, "QA was used to protect the agency from NERO."

Investigators interviewed the members of the Quality Assurance unit, and found that all of the current members demonstrated an understanding of their intended function and were disturbed at the way in which their work had been coopted under Van Saun. They told investigators that they had attempted to raise concerns and, in some instances did raise concerns with former agency leaders, but they were ignored. Investigators found them to be credible, and their accounts to be consistent with other interviewees.[20]

Interviewees advised that they did not feel comfortable raising concerns until after Van Saun was dismissed and the County appointed a new Acting Director. Indeed, complaints from agency employees were delivered to acting director Alunni immediately after he was in place and Van Saun had been removed. Only after Van Saun's dismissal did the agency adopt a cooperative approach with NERO, in which information is shared freely and accurately and the agency is more transparent. The new agency leadership instituted a policy that files are now provided to NERO immediately upon request without interference. If NERO has follow up questions, they are now given direct access to the supervisor or caseworker assigned to the case so that an open discussion can take place without filtering through leadership. NERO has noted the significant change in approach and acknowledged that it is now getting a free flow of information, which it did not get under Van Saun's leadership. Similarly, County leadership have advised that, unlike before, it is now getting accurate information and engaging in open dialogue with the Acting Director and other current agency leaders, so that they can provide more effective oversight. Likewise, a clear message to agency staff that the alteration and

[19] Interviewees indicated that, for example, it would be appropriate to add a document that had been previously saved on the caseworker's computer but where a physical copy had not been placed in the file. Additionally, where a caseworker had conducted a home visit but had not documented the visit, it would be appropriate to draft a contact sheet to ensure the file was complete and accurate. However, the late-drafted document should make clear when the document was created, rather than backdated to be misleading.

[20] In contrast, investigators found that some interviewees, who are now former members of leadership, were not open and transparent during the process. They attempted to obstruct rather than assist investigators in their review of the agency.

falsification of records is not acceptable was only communicated under the new agency leadership.

The current agency leadership has also changed the function of the Quality Assurance unit, so that it is functioning as intended to improve compliance rather than acting as a shield to protect the agency. Quality Assurance no longer reviews files and completes checklists identifying deficiencies prior to NERO audits. Instead, the new leadership has adopted a "Continuous Quality Improvement" methodology in which Quality Assurance collects data on a daily basis to identify trends so that the agency can improve certain pre-determined metrics such reducing the number of children in congregate care and reducing the number of children in placement for lengthy periods without a permanency plan. The current leadership is also using the Quality Assurance function to review metrics so that bottlenecks can be cleared to allow cases to move to resolution more quickly and reduce caseload. As described by the Acting Director, the intention is to use the Quality Assurance function to be "more predictive and less reactive." While County leadership will have a difficult challenge to manage these new functions after Van Saun's improper treatment of the Quality Assurance unit, the program specialists in Quality Assurance have welcomed the changes.

The new agency leaders have also taken steps to improve the culture. For example, they retained an experienced social services consultant to assess the agency and advise on improvements to culture and communication, including improving recruitment and retention. They are also taking steps to minimize paper records, such as through the use of a transcription service, to both eliminate extra steps for caseworkers and ensure an audit trail. More information regarding remediation efforts and recommendations is discussed in Section III below.

D. Child Safety

The investigation did not find evidence of actual child harm as a result of the recordkeeping failures, nor evidence of systemic child safety concerns. Throughout the investigative process, LCCYS employees repeatedly and credibly expressed their concern for serving children and their commitment to ensuring that "the child was seen." This refrain was consistent, whether the interviewee attempted to excuse the above-described recordkeeping failures or was deeply disturbed by them. No interviewee indicated that they believed there was a pattern of caseworkers not seeing children. Additionally, investigators noted that the OAG investigation of Van Saun was wide-ranging and conducted over several years, but the OAG did not allege any instances of actual child harm as a result of the false reporting. Finally, investigators received outreach from many community members who raised concerns. None of the individuals reported child safety concerns that had not been addressed previously by LCCYS through existing controls.

Despite the commitment to child welfare that was credibly expressed by interviewees, investigators found that the failure to maintain accurate records can nonetheless create the risk of potential child safety concerns. For example, if false information is submitted to CWIS incorrectly claiming that a referral did not allege abuse when it in fact did, another county may rely on that finding and misjudge the risk of a new allegation. Additionally, the state courts rely on information and evidence supplied by LCCYS in making decisions in family court matters such as proceedings which could lead to the termination of parental rights, and

must be provided accurate information upon which to base those decisions. Similarly, NERO relies on the agency's records to monitor the quality of service that LCCYS is providing to children and families. If the records are false, this frustrates the ability of NERO to accurately monitor and assess the services provided by the agency. Finally, if County leadership does not get accurate information, the County cannot act appropriately to ensure the safety of children.[21] The investigation concluded that the practice of altering and fabricating agency records creates the risk of potential harm and should not be tolerated.

III. Recommendations

During the course of the investigation, Troutman Pepper met regularly with current agency and County leadership and discussed detailed recommendations for remediation. Therefore, many of the below steps have already been taken or are in process.

1. This report should be made available to the public. Consideration should be given to the need to maintain the confidentiality of certain underlying information or records consistent with the provisions of the CPSL, regulations governing personnel matters, or other legal requirements. Consideration should also be given to the need to protect the privacy of individuals who cooperated with investigators so that LCCYS employees are not discouraged from reporting concerns in the future.

2. Personnel actions should be taken to discipline individuals who directed or participated in the falsification of agency records, including separation from the agency as appropriate.

3. Agency culture should be improved so that LCCYS staff are treated with professionalism and respect by agency leadership.

4. LCCYS staff should be encouraged to raise issues and should not fear retaliation for the good faith reporting of concerns. An agency whistleblower policy and system should be developed and communicated to staff.[22] County officials should provide greater oversight of the agency by, among other things, meeting regularly with staff so that staff have an avenue to raise concerns with County leaders. Frustration of the County's oversight was one of Van Saun's principal aims and the County should work to undo the damage Van Saun caused.

5. The agency should improve its relationship with NERO through regular and transparent communication. NERO should be permitted to review agency records without interference.

6. The Quality Assurance process should be used as intended to train staff, audit compliance, and identify trends and areas of improvement. To ensure independence, the

[21] In addition to child safety concerns, the failure also limits the ability of the County, NERO and others to understand the challenges caseworkers are facing. The significant caseworker vacancies, crushing caseloads, and low pay make it nearly impossible for workers to fully meet the requirements of the job. This reality is not accurately depicted when case files selected for review are cleaned up in advance of audits.

[22] Investigators understand that the County already has a whistleblower policy in place.

Quality Assurance unit should have a dotted reporting line into the County Division of Human Services in addition to its reporting line within LCCYS.

7. The agency should develop a clear policy on what is and is not permitted to remedy documentation errors or failures. The policy should include: (1) records should always accurately reflect work actually performed, (2) electronic, time-stamped records should be used wherever feasible, and (3) records should never be backdated or otherwise drafted in a misleading manner.

8. Agency staff should be trained on the importance of accuracy in recordkeeping.

9. The County should assess and increase LCCYS's staff salary levels.

10. The County should proactively recruit caseworkers to fill open positions. The County should proactively recruit a permanent Director.