

Note: this report is marked as a “Quality Assurance Review” and designated as subject to the protections of 25 U.S.C. 1675. Upon further review, IHS has concluded that designating the report, in its entirety, as a medical quality assurance record is not appropriate. However, the report incorporates or reproduces medical quality assurance records and other confidential information, which have been redacted pursuant to 25 U.S.C. 1675 and 5 U.S.C. 552(b)(3).

IHS Quality Assurance Review of Unity Healing Center

This document is in compliance with contract 285-19-RFQ-0010. This report is designed to provide factual information, analysis of facts, root causes, and recommended remediations. All information is supported by documents reviewed by the contractor (Milam Consulting), interviews (conducted by Milam Consulting) and direct observations made on-site at Unity Healing Center by the contractor (Milam Consulting). Specific allegations of sexual abuse of a Unity (b) (6), (b) (3) (A) by a Unity staff member were reported to multiple Unity staff members in (b) (6) 2016. These allegations were not reported to (b) (6), (b) (3) (A), local tribal law enforcement, The Office of the Inspector General or The Office of General Counsel. There is no evidence the Governing Body was made aware of the specific allegations of sexual abuse. There is evidence the Governing Board and the Nashville Area Office abdicated their oversight of Unity Healing Center and failed to exercise due diligence when they were made aware of a (b) (6) involving a staff member and a Unity (b) (6), (b) (3) (A). In addition to Unity staff, at least 2 Labor Relations Specialists were aware of specific statements of sexual abuse of a Unity (b) (6), (b) (3) (A) by a Unity staff member and the allegations were not reported to authorities by either Labor Relations Specialist.

14



IHS QUALITY ASSURANCE REVIEW

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Executive Summary.....	1
Section I: Persons Interviewed	4
Section II: Documents Reviewed and Observations	6
Section III: Facts Related to Allegations of Sexual Abuse of a Unity (b) (6), (b) (3) (A) by a Unity Staff Member.....	8
Section IV: Summary of Factual Findings	19
Section V: Analysis of Facts	21
Section VI: Summary of Analysis of Facts	56
Section VII: Summary of Interviews	57
Section VIII: Root Causes	93
<small>(Includes tables with the specific root causes and the associated detailed recommended remediation for the identified root cause. This section is intended to provide explanatory narrative that connects the specific root causes summarized in Section IX with the specific recommendations in sections X and XI.)</small>	
Section IX: Summary of Root Causes and Recommended Remediations	142
Section X: Detailed Recommendations	147
Section XI: Recommended policies, policy revisions, policy additions	151
Section XII: Commentary related to analysis of macro systems, personnel behaviors, motivations	156
Section XIII: Summary	158
References	159
Appendix I: Supporting documentation for each fact statement	

IHS Quality Assurance Review of Unity Healing Center

Executive Summary

Synopsis

Multiple staff at Unity failed to comply with mandatory (b) (6), (b) (3) (A) abuse reporting guidelines. The Unity Governing Board and senior leadership at the Nashville Area Office recommended disciplinary action for a staff member secondary to a (b) (6) with a (b) (6), (b) (3) (A) but they failed to exercise due diligence in their inquiry regarding the nature of the (b) (6) Macro systems including the Regional HR office and the Office of General Counsel issued problematic directives and opinions that were adopted without hesitation or meaningful deliberation.

In (b) (6) 2016, a Unity (b) (6), (b) (3) (A) reportedly witnessed a (b) (6) staff member engaged in inappropriate touching of a (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) at Unity. This same (b) (6), (b) (3) (A) reported (b) (6), (b) (3) (A) was also told that the (b) (6) staff member “touched” and was “holding” the alleged victim. The (b) (6), (b) (3) (A) reported both (b) (6), (b) (3) (A) observations and the statements that had been made to (b) (6), (b) (3) (A) to staff members at Unity. Review of documentation revealed that multiple staff at Unity were aware of specific allegations of (b) (6), (b) (3) (A) sexual abuse and failed to comply with mandatory reporting guidelines. Also, in (b) (6) 2016 a Unity staff member and a Nashville Area Office staff member reviewed video footage of the same (b) (6) staff member isolating the alleged victim in (b) (6), (b) (3) (A). Unity leadership dismissed the actions of the (b) (6) staff member as non-sexual and determined that the alleged victim was pursuing the (b) (6) staff member who was ultimately not able to resist the advances of the alleged victim. The alleged victim who was powerless and the most vulnerable was deemed to be the problem.

During the same time in (b) (6) 2016 a staff member at Unity found what they determined to be a romantic letter from the alleged victim to the adult staff member. Unity leadership restricted the staff member from the (b) (6), (b) (3) (A) building. The alleged victim’s subsequent emotional distress surrounding discovery of the letter culminated in a reported (b) (6), (b) (3) (A) Upon receipt of information that a (b) (6), (b) (3) (A) had (b) (6), (b) (3) (A) the Governing Board authorized Unity leadership to conduct a Root Cause Analysis of the reported (b) (6), (b) (3) (A) The Governing Board was advised that one of the root cause analysis findings related to the

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reported (b) (6), (b) (3) (A) was a staff-(b) (6), (b) (3) (A) (b) (6) As a result of this finding, the Governing Board recommended a referral to Employee Relations/Labor Relations (ER/LR) regarding the (b) (6) staff member in question, but they failed to initiate any inquiry or provide sufficient oversight to explore the nature of the (b) (6)

Leadership at Unity compiled the ER/LR file and multiple staff statements were collected that revealed specific allegations of sexual abuse. An ER/LR workload report documented that on 9/28/16 a staff member was restricted from the main building at Unity and an “investigation” of a staff member and inappropriate concerns with a (b) (6), (b) (3) (A) was initiated. This workload report was submitted to the Nashville Area Office and to the Southeast Regional Human Resources office. Unity leadership submitted the completed ER/LR packet to the Southeast Regional Human Resources office on March 2nd, 2017. The ER/LR packet included staff statements describing specific allegations of (b) (6), (b) (3) sexual abuse of a Unity (b) (6), (b) (3) (A) by a Unity staff member. There were numerous emails between Unity leadership and ER/LR specialists acknowledging there were allegations of sexual abuse that, if proven to be true, warranted removal of the staff member.

On May 9th, 2017 the (b) (6) staff member at Unity was presented with a formal letter of (b) (6) from employment. On May 12th, 2017 a report of possible (b) (6), (b) (3) sexual abuse of a Unity (b) (6), (b) (3) (A) by a Unity staff member was received by the Eastern Band of Cherokee Indians (EBCI) Public Health and Human Services, Department of Human Services. EBCI declined to provide information for this review related to their investigation of the allegations. On May 19th, 2017 the accused staff member was placed on administrative leave pending the outcome of the external investigation. In addition to the EBCI investigation, the Office of the Inspector General (OIG) initiated an investigation, and a search warrant was issued for Unity Healing Center in June 2017. To date, OIG has declined to provide information related to their investigation.

In March 2018, approximately 10 months after the external investigation began, Health and Human Services, Office of General Council (OGC) issued (b) (5)

Based on analysis of facts and exploration of root causes, this review has identified specific recommendations to address numerous issues identified at Unity. These recommendations can be summarized in the following seven categories:

1.) Training:

- Dynamics of (b) (6), (b) (3) (A) /reporting and management of abuse concerns
- Documentation-process, structure, timeliness
- Respectfulness of boundaries
- Trauma Informed Care
- Managing staff conflict/Addressing performance issues
- ER/LR referral process
- Proper use of video surveillance system
- Leadership development

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2.) Clinical supervision:

Opportunity for staff members to provide and receive feedback, engage in self-evaluation, and develop critical thinking skills

3.) Creation of flowcharts/templates to guide staff decision making:

Increase access to information

4.) Formalized internal investigative process/administrative inquiry process:

Establish a process to ensure administrative management of all allegations regardless of external investigative activities (This process must be designed to avoid conflict or interference with an external investigation.)

5.) Enhanced/Increased Communication:

Ensure transparent communication within the chain of command and with OGC, OIG, and HHS.

6.) Enhanced ER/LR process:

Creating system redundancy and oversight

7.) Delineation of oversight roles and responsibilities:

Operationalize the role of the Governing Board
Consider assigning oversight of specific areas to each Governing Board Member

Virtually every level of leadership failed to take action despite numerous opportunities to intervene and provide corrective action at Unity. Leadership at Unity, the Unity Governing Board, the Nashville Area Office leadership, Southeast Regional Human Resources, and the Office of General Council all share responsibility for the (b) (6) 2016 situation and subsequent events that unfolded at Unity Healing Center.

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Section I

Persons Interviewed

(b) (6) [Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]

(b) (6), (b) (3) (A) [Redacted]
Allen Bollinger-Facilities engineer
Tiara Ruff-Public Health Analyst-Former Chief Executive Officer at Unity Healing Center

(b) (6) [Redacted]
Dr. Vickie Claymore-Health Systems Supervisor-Director of Field Operations.
Cynthia Slee-Supervisory Social Services Assistant
Tracey Grant-Former Clinical Director

(b) (6) [Redacted]
[Redacted]
[Redacted]
[Redacted]
[Redacted]
Mark Skinner-Nashville Area Office-Assistant Director
Dr. Bruce Finke-Former Chief Medical Officer
Dr. Michael Toedt-Former Chief Medical Officer
Dr. Beverly Cotton-Nashville Area Office Director

Declined or did not respond to request for an interview

(b) (6) [Redacted]
(b) (6) [Redacted]
(b) (6) [Redacted]

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(b) (6)

(b) (6)

(b) (6)

(b) (6)

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Section II

Documents reviewed

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

UHC Governing Board meeting minutes-September 27th, 2016

UHC Governing Board meeting minutes-January 25th, 2017

UHC Governing Board meeting minutes-February 21st, 2019

Unity Healing Center CAPS Review Summary-not dated, but with references to events in November 2018 and January 2019

(b) (6) selected emails

(b) (6), (b) (7)(C) selected emails

Bruce Fink selected emails

Christopher Buchanan selected emails

(b) (6) selected emails

(b) (6) selected emails from February 2017-September 2017

(b) (6) selected emails from October 2017-March 2018

(b) (6) selected emails

(b) (6) selected emails

Tiara Ruff selected emails

Tiara Ruff OIG folder selected emails

(b) (6) selected emails

Tracey Grant selected emails

Vickie Claymore selected emails

(b) (6) file from (b) (6) (b) (6)

(b) (6) file from (b) (6) (b) (6)

EBCI Subpoena

Cease and Desist Order

(b) (5)

(b) (6), (b) (3) (A)

Workload report from (b) (6)

IHS Chapter 20-Abuse Reporting policy

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Unity Healing Center Employee Handbook
IHS-Nashville Area Office Employee Handbook
Unity Admissions Policy
Unity Admission Criteria
Unity Resident Assessment Policy
Unity CTS-20 Abuse Neglect Reporting Policy
Unity CTS-25 Reporting (b) (6), (b) (7) Maltreatment Policy
Unity Pain Management Policy
Unity Telehealth Policy
Unity Video Surveillance Policy
Unity Documentation Policy
Unity Code of Ethical Behavior Policy

Observations

Unity Healing Center facility and grounds including resident rooms, treatment areas, recreation areas, and common areas
Staff entry of progress notes into medical record
Medication Room and Med Cart area
Unity Video Surveillance Camera system and server

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Section III

Facts related to allegations of sexual abuse of a Unity (b) (6), (b) (3) (A) by a Unity staff member.

The facts listed below are supported by written documentation that was created at the time of the events in (b) (6) 2016. Copies of written documentation are attached and labelled with corresponding numbers.

1. (b) (6), (b) (3) (A) [REDACTED].
2. (b) (6), (b) (3) (A) [REDACTED].
3. (b) (6), (b) (3) (A) [REDACTED]
[REDACTED]
[REDACTED]
4. (b) (6), (b) (3) (A) [REDACTED].
5. (b) (6), (b) (3) (A) [REDACTED]
[REDACTED].
6. (b) (6), (b) (3) (A) [REDACTED].
7. (b) (6), (b) (3) (A) [REDACTED].
8. (b) (6), (b) (3) (A) [REDACTED]
[REDACTED]
9. (b) (6), (b) (3) (A) [REDACTED].
10. (b) (6), (b) (3) (A) [REDACTED].
11. (b) (6), (b) (3) (A) [REDACTED].

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12. (b) (6), (b) (3) (A) [REDACTED]
13. (b) (6), (b) (3) (A) [REDACTED]
14. (b) (6)/16-(b) (6) [REDACTED] reportedly advised Cynthia Slee (SSA supervisor) of an incident involving (b) (6) [REDACTED] (b) (6) [REDACTED] and (b) (6), (b) (3) (A) [REDACTED] at Unity. The incident was observed by (b) (6) [REDACTED] physical interactions with (b) (6), (b) (3) (A) [REDACTED] were sufficiently concerning to (b) (6) [REDACTED] that he reported interaction to (b) (6) [REDACTED] reported the incident occurred on (b) (6), (b) (3) (A) [REDACTED]/16. Ms. Slee and her supervisor, Tracey Grant (Unity Clinical Director) reviewed video tape footage of the event and reportedly noted that (b) (6) [REDACTED] entered (b) (6), (b) (3) (A) [REDACTED] with (b) (6), (b) (3) (A) [REDACTED] and stayed in (b) (6), (b) (3) (A) [REDACTED] for what they estimated was approximately 1 minute. (statement signed by Cynthia Slee on 9/27/16)
15. (b) (6), (b) (3) (A) [REDACTED]/16-(b) (6) [REDACTED] (note dated (b) (6), (b) (3) (A) [REDACTED] 16 during which he recalled the incident occurred on (b) (6), (b) (3) (A) [REDACTED] 16) documented a concern by (b) (6), (b) (3) (A) [REDACTED] that (b) (6), (b) (3) (A) [REDACTED] was upset because (b) (6) [REDACTED] was no longer talking to (b) (6), (b) (3) (A) [REDACTED]
16. (b) (6), (b) (3) (A) [REDACTED]
17. (b) (6), (b) (3) (A) [REDACTED]
18. (b) (6), (b) (3) (A) [REDACTED]
19. (b) (6), (b) (3) (A) [REDACTED]
20. (b) (6), (b) (3) (A) [REDACTED]

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(b) (6), (b) (3) (A)

[Redacted]

21. (b) (6), (b) (3) (A)

22. (b) (6), (b) (3) /16-(b) (6) wrote documentation regarding her conversation with (b) (6). Per (b) (6), (b) (6), (b) (3) (A) came to her and reported concerns about (b) (6), (b) (3) (A). (b) (6) documented that she initiated contact with (b) (6) to advise her of the situation. (b) (6) reportedly asked (b) (6) if there was a plan for (b) (6), (b) (3) (A) to (b) (6), (b) (3) (A), (b) (5), (b) (6) reportedly indicated to (b) (6) that was the plan initially, but they were now reconsidering the appropriateness of that plan. This documentation was signed on (b) (6)

23. (b) (6), (b) (3) (A)

[Redacted]

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(b) (6), (b) (3) (A)

24. (b) (6), (b) (3) (A)

25. 9/26/16-Note with date of 9/26/16 in which (b) (6) documented a conversation with (b) (6), (b) (3) (A) that reportedly occurred on 9/25/16. The (b) (6), (b) (3) (A) told (b) (6) that (b) (6) was alone in a bathroom with the door shut with (b) (6) on at least two occasions. (b) (6) noted this information was shared with Tracey Grant. Also, on the same note there was an entry dated 9/27/16 documenting a meeting with (b) (6), (b) (6), (b) (3) (A), and Cynthia Slee. The (b) (6), (b) (3) (A) reported that Ms. Slee and (b) (6) called (b) (6), (b) (3) (A) and advised her of the situation with (b) (6) and that, post phone call with the (b) (6), (b) (3) (A) “everyone” was convinced the relationship was “friendship.” The (b) (6), (b) (3) (A) advised (b) (6) and Ms. Slee that (b) (6) had reportedly described his relationship with (b) (6) as one of the following: (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A) and (b) (6) mostly described it as (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) also reported to (b) (6) and Ms. Slee that she had witnessed (b) (6) “poked” (b) (6) “all the time,” and there were at least two separate episodes of (b) (6) being in the bathroom with (b) (6) for 4-5 minutes after which (b) (6), (b) (3) (A) reportedly said they “held each other.” (b) (6) also noted that (b) (6), (b) (3) (A) told her (b) (6) that (b) (6) checked on (b) (6) while (b) (6) was in Phoenix and sent a text to a male staff member (not identified) asking if (b) (6), (b) (3) (A) had been behaving and to tell (b) (6), (b) (3) (A) (b) (6) would bring (b) (6) belt if (b) (6) wasn’t.

26. 9/27/16-Note with a date of 9/27/16 in which Cynthia Slee documented at least 2 specific allegations of (b) (6), (b) (3) (A) of (b) (6), (b) (3) (A). Specifically, Ms. Slee was told (b) (6) had been touching (b) (6), (b) (3) (A) and that (b) (6), (b) (3) (A) had been talking about being in a bathroom alone with (b) (6) during which time they were touching and holding each other.

27. (b) (6), (b) (3) (A)

28. 9/27/16-Minutes from the Governing Board Meeting indicated the Governing Board was advised of an (b) (6), (b) (3) (A) According to the meeting notes, the Governing Board was advised the (b) (6), (b) (3) (A) and

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there was a plan for the (b) (6), (b) (3) (A). Dr. Toedt recommended a Root Cause Analysis (RCA) be conducted. Tracey Grant and Tiara Ruff were identified as responsible personnel for completion of RCA.

29. 9/27/16-Per request by Dr. Beverly Cotton, a timeline was created by Dr. Vickie Claymore (Director of Field Operations at the Nashville Area Office) indicated (b) (6), (b) (3) (A), (b) (5)
30. RCA was conducted. The RCA appeared to be incomplete. Other than an unspecified “review” that was to occur the week of 10/24/16, there are no dates or timelines noted on the RCA. The RCA identified (b) (6), (b) (3) (A)” and “(b) (6)” but included no Root Cause or Plan of Action. Action Item #5 was (b) (6)” Tiara Ruff and Tracey Grant were identified as the “Position/Title Responsible Party” for this action item, but no “Method: Policy, Education, Audit, Observation & Implementation strategy was identified or documented. Action Item 9 on the RCA described (b) (6), (b) (3) (A)” and listed (b) (6) as one of the “Position/Title Responsible Party” for this Action Item.
31. 9/28/16-Capt. Ruff emailed (b) (6) notifying him he was not allowed in the main building.
32. 9/28/16-Cynthia Slee questioned (b) (6) about whether (b) (6) had been texting staff (b) (6), (b) (3) (A)
33. 9/28/16-January 2017 Workload Report provided to Mark Skinner indicating, “T Ruff placed (b) (6) on (b) (6) and began investigation on (b) (6), (b) (5), (b) (3) (A)
34. 9/28/16-(b) (6) entered a note on an ERLR workflow log indicating issue (b) (6) by (b) (6) supervisor (Tiara Ruff) was recommending (b) (6), (b) (5)
35. 9/29/16-Signed statements from Tiara Ruff that appear to be identical, but the last sentence was not the same. In one statement the last sentence was, (b) (6), (b) (3) (A) On the other statement, the last sentence read, (b) (6), (b) (3) (A) There were other minor differences as well. Both were dated 9/29/16.
36. 9/29/16-Tiara Ruff documented that (b) (6), (b) (3) (A) requested a meeting. During the meeting (b) (6), (b) (3) (A)

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37. 10/11/16-2nd visit to (b) (6), (b) (3) (A) [REDACTED]
[REDACTED]”
38. 10/13/16-(b) (6) [REDACTED] according to the timeline created by Dr. Vickie Claymore (Director of Field Operations-Nashville Area Office). There were no restrictions on (b) (6) [REDACTED].
39. 2/8/17-(b) (6) [REDACTED] noted on January 2017 ERLR Workload Report sent to Mark Skinner that, “Email sent to his supervisor requesting update on this issue.” (b) (6) [REDACTED] The name of the supervisor was not documented in the report.
40. 3/2/17-(b) (6) [REDACTED] sent an email to (b) (6) [REDACTED] (ERLR Specialist) requesting review of the “proposal” documentation for (b) (6) [REDACTED] (b) (6) [REDACTED]. In the email, (b) (6) [REDACTED] indicated the case has been opened since Sept 2016.
41. 3/2/17-Note on ERLR workflow spreadsheet indicating the proposal letter was, “submitted to (b) (6) [REDACTED] for review and next steps of delivery to (b) (6) [REDACTED].”
42. 3/7/17-(b) (6) [REDACTED] sent the following email to Tiara Ruff and (b) (6) [REDACTED], “I have a question. (b) (6), (b) (5), (b) (3) (A) [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED] Was he not interviewed?”
43. 3/12/17-Note on ERLR workflow spreadsheet indicating issue involving (b) (6) [REDACTED] for (b) (6), (b) (5) [REDACTED]
[REDACTED]
44. 3/16/17-(b) (6) [REDACTED] emailed (b) (6) [REDACTED] to advise they would have the “detail and support” to him by Monday (3/20/17).
45. 3/19/17-Letter from (b) (6) [REDACTED] that appears to be (b) (6) [REDACTED] response to allegations that he (b) (6) [REDACTED]. The letter is dated as received by Capt. Ruff on 3/19/17. The letter is signed by (b) (6) [REDACTED]. The date under (b) (6) [REDACTED] signature is 3/19/17

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46. 3/21/17 Tiara received an email from (b) (6) stating (specifically), “I reviewed the documents regarding the latest incident re this employee. I had also looked at the documentation of the (b) (6), (b) (3) (A) and had concerns because it involved a (b) (6), (b) (3) (A) who appears to be (b) (6), (b) (3) (A) who spent several minutes alone in the bathroom with the male employee. (b) (6), (b) (3) (A) stated they were (b) (6), (b) (3) (A) or something to that effect. I don't know how much credence can be given to the (b) (6), (b) (3) (A) that may have (b) (6), (b) (3) (A), but it appears there is something going on and has been observed by (b) (6), (b) (3) (A). (b) (6), (b) (3) (A)
47. 3/28/17-Letter dated 3/28/17 to (b) (6) from Tiara Ruff advising (b) (6) signed the letter on 5/9/17. The letter included (b) (6), (b) (3) (A)
48. 4/9/17-Note on the workflow spreadsheet indicating (b) (6)
49. 4/26/17-Tiara Ruff received an email from (b) (6) referencing an email from (b) (6) about (b) (6), (b) (3) (A) reporting that (b) (6) was in the bathroom alone with (b) (6), (b) (3) (A) for about 5 minutes. Specifically, (b) (6) wrote, “Regarding the (b) (6), (b) (3) (A) : did I see in the documentation that the (b) (6), (b) (3) (A) saw the employee and (b) (6), (b) (3) (A) spend approximately 5 minutes alone in the bathroom? If so, I would include this as (b) (6)
50. 5/9/17-Note on the workflow spreadsheet indicating, “Letter presented on May 09, 2017.”
51. 5/11/17-Note on workflow spreadsheet indicating, “Employee requested supporting documents for appeal. May 12th released documents to employee.”
52. 5/12/17-At 10:10am Allen Bollinger sent an email to (b) (6) at the request of (b) (6) describing an incident involving (b) (6) having been alone with a (b) (6), (b) (3) (A) in a bathroom at Unity Healing Center.
53. 5/12/17-At 12:47pm, the Eastern Band of Cherokee Public Health and Human Services, Department of Human Services, Cherokee, North Carolina received a report alleging (b) (6), (b) (3) (A)

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54. 5/16/17-The clinical supervisor at Unity Healing Center, Tracey Grant, became aware of the (b) (6), (b) (3) (A) [REDACTED] the Center Director, Capt. Ti Ruff of the report. Shortly after staff at Unity were contacted by EBCCI, several individuals at IHS, OGC, and NAO were contacted for guidance and consultation.
55. 5/18/2017-(b) (6) [REDACTED], an attorney from HHS-OGC sent an email to Tracey Grant to (b) (6), (b) (5), (b) (3) (A) [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
56. 5/19/17-Note on workflow spreadsheet that “(b) (6) [REDACTED].”
57. 5/22/17-Email from (b) (6), (b) (7)(C) [REDACTED] Special Agent-OIG) to (b) (6) [REDACTED] (b) (6), (b) (7)(C) [REDACTED] (OIG-OI), (b) (6) [REDACTED] (IHS/HQ, (b) (6) [REDACTED] (IHS/HQ), and (b) (6) [REDACTED] (HHS/OGC/GLD) indicating OIG would not be opening an investigation based on information he received from Tracey Grant and Tiara Ruff.
58. 6/2/17-The Cherokee Court issued a subpoena for numerous records related to events that occurred on (b) (6), (b) (3) (A) [REDACTED] 16 involving (b) (6), (b) (3) (A) [REDACTED].
59. 6/7/17-Email from (b) (6), (b) (7)(C) [REDACTED] to (b) (6) [REDACTED], (b) (6), (b) (7)(C) [REDACTED], (b) (6) [REDACTED], (b) (6) [REDACTED] Tracey Grant, and Tiara Ruff indicating OIG received (b) (3) (A) [REDACTED]. (b) (6), (b) (7)(C) [REDACTED] requested additional information as well as video surveillance footage.
60. 6/8/17-Unity Healing Center received a Cease and Desist Document Removal or Destruction letter from (b) (6) [REDACTED] (b) (6) [REDACTED]
61. 6/13/17-(b) (6), (b) (5) [REDACTED]
[REDACTED]
62. 6/30/17-OIG served warrants at Unity Healing Center and confiscated records and video surveillance data from Unity Healing Center.

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63. 7/7/17-Entry on ERLR workflow spreadsheet, (b) (5)

64. 8/7/17-Entry on ERLR workflow spreadsheet, (b) (5)

65. 8/20/17-Entry on ERLR workflow spreadsheet, (b) (5)

66. 7/6/17-Chris Buchanan (IHS/HQ) requested an update from Martha Ketcher on the OIG investigation at Unity.

67. 7/6/17 Tiara Ruff emailed the following to Martha Ketcher and Vickie Claymore

“Not sure where to start. The OIG came on behalf of the Eastern Band on June 30th, 2017. (b) (6), (b) (7)(C) of the OIG during the inquisition said we still need comply with The Eastern Band’s (subpoenas) request for information. Everything they asked for they OIG took. They are however, able to share the information removed from Unity. We are waiting to hear from Lawyer (b) (6) who is in contact with (b) (6), (b) (7)(C) He is preparing material for the Eastern Band. I am assuming it is the lawyer’s place to do that. (b) (6) Nashville ERLR has a good majority of the information regarding the (b) (6) I will continue to update you as information flows. RADM’s inquiry [on the employee’s detail from Cherokee to Mashpee] occurred back in the latter part of 2016 (b) (6), (b) (3) (A)

The employees proposed actions were complete prior to the OIG involvement (b) (6) We were ready to move on (b) (6) when the anonymous report came on allegations (b) (6), (b) (3) sexual abuse. From here IHS, OGC (b) (5)

There is a record of the employee’s TDY/Travel that (b) (6) could access. That information I do not have.

I can request those dates from (b) (6)

Thank you,

Ti”

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68. 7/11/17-Vickie Claymore emailed (b) (6), (b) (5)
69. 7/14/(b) (6) emailed Vickie Claymore recommending IHS (b) (5)
70. 9/1/17-Vickie Claymore emailed (b) (6) requesting update (b) (5).
71. 9/1/17-(b) (6) emailed Vickie Claymore advising there was no update (b) (5)
72. 12/11/17-Vickie Claymore emailed (b) (6) advising there was a (b) (5)
73. 12/23/17-Noted on ERLR workflow spreadsheet. (b) (5)
74. 3/5/2018-Vickie Claymore emailed Lisa Gyorda requesting updates and guidance regarding the situation with (b) (6)
75. 3/5/18-(b) (6) emailed Lisa Gyorda with (b) (5)
76. 3/5/18-3/20/18-Several emails were sent between Vickie Claymore, Lisa Gyorda, Bruce Finke, (b) (6) (b) (6) and (b) (6) Dr. Claymore continued to ask for updates and guidance regarding the situation with (b) (6)
77. 3/20/18-Email from Lisa Gyorda to (b) (6) and (b) (6) with an attachment of the (b) (5)
78. 3/28/18-(b) (6) emailed Tiara Ruff indicating the recommendation was to (b) (5)
79. 3/28/18-Letter from Tiara Ruff to (b) (6) informing him that the (b) (6)
80. No date of entry noted-Note on ERLR workflow spreadsheet, "Proposal rescinded 4/5/18."
81. 6/7/19-The Wall Street Journal printed a story outlining allegations of (b) (6), (b) (6) sexual abuse at Unity Healing Center in Cherokee, North Carolina. The report published allegations that staff at Unity Healing Center knew of the abuse, failed to report it to the

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appropriate authorities, and acted to cover up both the abuse and their failure to report the allegations to authorities. (Copy not attached)

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Section IV

Summary of Factual Findings

On 9/27/16, Unity staff were aware of specific allegations of (b) (6), (b) (3) sexual abuse of (b) (6), (b) (3) (A) by (b) (6) (b) (6). These allegations were not reported to any investigative authority. (b) (3) (A), (b) (6)

On 9/27/16, (b) (3) (A), (b) (6), (b) (5)

In March 2017 ERLR specialist (b) (6) questioned why the recommendation (b) (5) (b) (6) was changed to (b) (6) (b) (6). On 5/9/17, (b) (6) was provided with “advance notice” of his (b) (6) (b) (6). On 5/11/17, (b) (6) was provided with the supporting documentation associated with his (b) (6) (b) (6). On 5/12/17, a referral of possible sexual abuse of (b) (6), (b) (3) (A) by (b) (6) was received by EBCI (b) (6), (b) (3) (A).

Between May 2017 and March 2018 various investigative authorities and legal personnel reviewed documentation associated with (b) (6), (b) (3) (A) and (b) (6). The Office of General Counsel recommended (b) (5) (b) (6) (HHS/OGC/GLD) recommended (b) (5) (b) (6) also recommended (b) (5)

To date, no criminal charges related to allegations of (b) (6), (b) (3) sexual abuse of (b) (6), (b) (3) (A) by (b) (6) have been filed. EBCI (b) (6), (b) (3) (b) (6) declined to share information regarding any determination with respect to their investigation of the May 2017 referral of sexual abuse involving (b) (6), (b) (3) (A) and (b) (6)

This report is designed to present information based on thorough review of information that was determined to be factual based on documentation reviewed. Additional facts may be uncovered as analysis of information is conducted. Additionally, documentation not specifically referenced in this report will be provided in subsequent reports. For example, the “Proposing Official’s Douglas Factors” and

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the “Report of Conduct/Performance Incident” statements are not included with this report as there are numerous issues related to those documents that can be more fully addressed in the analysis of information. Detailed and systematic analysis of reviewed information will be presented in a subsequent report.

Finally, summaries of staff interviews will be presented in the analysis of information. Multiple staff provided conflicting information, information not supported by documentation, and information inconsistent with prior statements.

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Section V

Analysis of facts

1. Detailed analysis of the dynamics (micro and macro) within the institutional culture that contributed to positive/negative outcomes.
2. Detailed analysis of the dynamics (micro and macro) within the institutional culture that contributed to positive/negative outcomes.
(For purposes of this review, the terms “micro” and “macro” are defined from a systems perspective in which micro is defined as the environment in the treatment setting at Unity, and macro is understood as the larger system in which Unity resided.)

a. Micro

- Staff conflict.

It is challenging (b) (5). The term “staff conflict” is a broad categorization used to describe the work culture and environment at Unity Healing Center in (b) (6) 2016. Based on interviews with staff, review of records, and the sheer volume of complaints filed by Unity staff, it was clear (b) (5). The conflicted and combative nature of staff interactions appeared (b) (5). The Nashville Area Office appeared (b) (5). These problems left (b) (5). The Governing Board met regularly (b) (5). Capt. Tiara Ruff, Executive Director, was essentially absent from Unity (b) (5). Various staff members filed complaints that alleged a hostile work environment and racial discrimination. Staff members also reported “in-fighting” among staff and preferential treatment of selective staff by Tracey Grant, Clinical Supervisor. Cynthia Slee, Supervisory Social Services Assistant, utilized the video surveillance system as a mechanism to supervise staff and resolve conflicts between staff members or (b) (6), (b) (3) (A). There was a crisis of leadership and management at Unity long before (b) (6), (b) (3) (A) was admitted to the facility. Additional explanation and analysis of these issues will be analyzed and described elsewhere in this report.

- (b) (6), (b) (5).

Staff members believed (b) (5). During her interview for this review, Tracey Grant reported she had reviewed video of (b) (6) as he entered the room of (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) where he stayed for 30 seconds to one minute. Ms. Grant reported that based on this observation she had determined (b) (6) did not have time to do anything sexual to

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(b) (6), (b) (3) (A) This belief appeared, initially, to suggest (b) (5), (b) (6)

Unity had written policy that it was not appropriate for staff to be isolated or alone with (b) (6), (b) (3) (A) in their rooms and that it was the responsibility of staff to monitor verbal and physical interactions with (b) (6), (b) (3) (A) in order to provide (b) (6), (b) (3) (A) with the safest possible space. (b) (5), (b) (6)

(b) (5), (b) (6), (b) (3) (A)

When she was shown written documentation from staff members that included specific (b) (6) of (b) (6), (b) (3) (A) by (b) (6) Capt. Ruff responded that she did not consider the possibility of sexual abuse, because she believed the staff were simply “out to get” (b) (6)

Cynthia Slee, Supervisory SSA, reported she had reviewed video of (b) (6) “poking” at (b) (6), (b) (3) (A) on or near (b) (6), (b) (3) (A) but Ms. Slee found no reason to consider it as possibly abusive. Ms. Slee commented that one had to view the video to understand how difficult (b) (6), (b) (3) (A) made it for (b) (6) to discourage (b) (6), (b) (3) (A) advances. Ms. Slee’s frame of reference or perspective from which she viewed (b) (6) behavior was such that her most easily accessible conclusion was that that (b) (6) acted inappropriately toward (b) (6), (b) (3) (A) but it was somehow (b) (6), (b) (3) (A) behavior that “made” (b) (6) behave in the manner he was behaving. Ms. Slee reported she never considered (b) (6) behavior as concerning for sexual abuse.

- (b) (6), (b) (3) (A)

(b) (6) altered his behavior and normal work patterns to place himself in close proximity to (b) (6), (b) (3) (A) At least two staff members noted that (b) (6) was rarely in the (b) (6), (b) (3) (A) living and community areas prior to (b) (6), (b) (3) (A) arrival. After (b) (6), (b) (3) (A) arrival, (b) (6) routinely came into the (b) (6), (b) (3) (A) living area and common areas to “hang out.” (b) (6), (b) (3) (A), (b) (5)

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(b) (6), (b) (3) (A), (b) (5)

Supervisory staff rationalized that (b) (6) was a victim of insufficient training and somehow ignorant of appropriate personal boundaries. (b) (6), (b) (3) (A), (b) (5)

(b) (6), (b) (3) (A), (b) (5)

During her interview, Ms. Slee described reviewing video footage with Ms. Grant when she noted (b) (6) was touching (b) (6), (b) (3) (A). (b) (6), (b) (3) (A) When asked how she failed to recognize that as concerning for sexual abuse, Ms. Slee responded by explaining that what she had viewed was (b) (6) “just picking at (b) (6), (b) (3) (A) like (b) (6) was picking at him.” Ms. Slee then said (b) (6) wasn’t “really” touching (b) (6), (b) (3) (A) but just touching the areas above and adjacent to (b) (6), (b) (3) (A).

Interviews with Capt. Ruff, Ms. Grant, and Ms. Slee revealed what can best be characterized as a collective belief that (b) (6) was somehow a victim of (b) (6), (b) (3) (A) behavior, and he was powerless to act appropriately when (b) (6), (b) (3) (A) violated his personal space. The possibility that (b) (6) was engaged in classic “grooming” of (b) (6), (b) (3) (A) was, apparently, inconceivable to staff. This is in no way a factual statement about (b) (6) intention or behavior. (b) (5)

(b) (6), (b) (3) (A) (b) (6), (b) (3) (A) reported to (b) (6), Unity Teacher that she had observed (b) (6) touching (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) reported (b) (6), (b) (3) (A) had made statements that (b) (6) was in a bathroom alone with (b) (6), (b) (3) (A) for approximately 5 minutes during which time he “held” (b) (6), (b) (3) (A) and they “touched” each other. This information was reported to Cynthia Slee. Ms. Slee reported this information to Capt. Ruff. No staff made a report to any (b) (6), (b) (3) (A) abuse investigative authority. It is possible Ms. Slee and Capt. Ruff (along with Ms. Grant) actively knew (b) (6), (b) (5), (b) (3) (A). It is possible (b) (5)

. It seems more likely (b) (6), (b) (5), (b) (3) (A)

It is appropriate to consider (b) (6), (b) (5)

. It is also possible Capt. Ruff, Ms.

Grant, and Ms. Slee held (b) (6), (b) (5)

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(b) (6) received a report from (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) of (b) (6) having been in a bathroom alone with (b) (6), (b) (3) (A) on at least 2 occasions for approximately 5 minutes. (b) (6) documented on 9/26/16 (signed on 9/27/16) that she provided written documentation of this incident to Ms. Grant on 9/25/16. (b) (6), (b) (3) (A) and the documentation reportedly submitted to Ms. Grant by (b) (6) was not located during the current review. There was no evidence Ms. Grant acted effectively on this information to address (b) (6) decision to place himself alone with (b) (6), (b) (3) (A)

Several staff described both in documentation from (b) (6) 2016 and in interviews for this review that (b) (6), (b) (3) (A) consistently demonstrated (b) (6) with all staff, and it was only (b) (6) who failed to respond appropriately to (b) (6), (b) (3) (A) behavior. (b) (6), (b) (3) (A)

- (b) (6), (b) (3) (A) .

(b) (6), (b) (3) (A)

[Redacted text block]

(b) (6), (b) (3) (A)

[Redacted text block]

(b) (6), (b) (3) (A), (b) (5)
[Redacted text block]

[Redacted text block]

[Redacted text block]

(b) (6), (b) (3)

(b) (3) (A), (b) (5)
[Redacted text block]

[Redacted text block]

(b) (6), (b) (3) (A), (b) (5)
[Redacted]

(b) (6), (b) (3) (A), (b) (5)
[Redacted]

(b) (6), (b) (3) (A), (b) (5)
[Redacted]

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- Lack of effective communication between the Treatment Team/clinical staff/supervisory staff and SSA staff.

(b) (6), (b) (3) (A)

- Lack of training on reporting concerns of (b) (6), (b) (3) sexual abuse/(b) (6), (b) (3) abuse for SSA staff.

During this review, multiple Social Services Assistants reported that, prior to 2019, they had never received training on reporting of (b) (6), (b) (3) abuse allegations. Current SSA staff reported that they have been trained and understood they were required to report allegations of (b) (6), (b) (3) abuse to the Office of the Investigator General (OIG) and local authorities. SSAs reported that, prior to their recent trainings, they believed they were required to report concerns of (b) (6), (b) (3) abuse to their immediate supervisor only.

Capt. Ruff reported she had participated in recent training on reporting (b) (6), (b) (3) abuse concerns and had prior extensive training in (b) (6) reporting laws in her doctoral program. Despite this, Capt. Ruff stated her current understanding of reporting guidelines required her to report concerns of (b) (6), (b) (3) abuse to her chain of command, a (b) (6), (b) (3) (A) therapist, or to a (b) (6), (b) (3) (A) primary care provider. Capt. Ruff also stated that there was no organized training on reporting allegations of (b) (6), (b) (3) abuse for senior management at Unity or Unity staff prior to recent trainings mandated by the current IHS Director of the Nashville Area Office.

There was no coordinated structure for managers to track training activities. Responsibility for documenting training was left to front line supervisors who were often dependent on employee reports regarding their training activities. There was also no structured annual training designed to deliver basic information to all employees. There was no awareness of any centralized repository for training materials or training offerings. Finally, there was no standardization of training content to ensure that all employees would receive consistent information.

A request was made for a sample of personnel files to examine for this review and analysis. Seven personnel files were reviewed which included (b) (6) (b) (6) (b) (6) (b) (6), Cynthia Slee, Certified Alcohol and Other Drug Counselor, (b) (6) (b) (6) (b) (6) (b) (6) and (b) (6) (b) (6) (b) (6) (b) (6). The review was based on the information found in each of the personnel files that were provided to this reviewer.

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Review of a sample of Unity’s personnel files revealed there was no consistent, systematic approach to the orientation, training, and appraisal of employees. Of the seven personnel files reviewed, only one file (b) (6) had any documentation of orientation to Unity, training received in orientation and acknowledgement that the employee had read Unity’s policies.

The training in the personnel files was documented primarily by certificates of completion. Each employee had certificates of various topics with sporadic dates and no apparent, consistent annual training. Two of the files reviewed (b) (6) and (b) (6) had documentation signed by Ms. Slee (Supervisory SSA) that the SSA had completed some annual training inhouse or online, but there was no documentation or transcripts to verify the training maintained in the personnel files.

Each SSA personnel file contained the document, “Nashville Area IHS Annual Competency Checklist: Clinical Staff 2019,” but the competencies were not completed. (b) (6) file had some competencies documented as valid in 2017, some in 2018 and some were left blank. (b) (6) file had some competencies documented as valid in 2017, some in 2018, some in 2019 and some were left blank. None of the competencies were documented as being done annually. Section G of the checklist entitled “Abuse Recognition and Reporting” which included “1. Domestic violence recognition and reporting 2. (b) (6), (b) (3) abuse recognition and reporting policies 3. (b) (6) prevention protocol 4. Exploitation Recognition” were blank on both (b) (6) and (b) (6) checklist.

The only documented training in the personnel files concerning (b) (6), (b) (3) abuse was located in (b) (6) file under “Core Competencies for Paraprofessional Working with Mentally Ill Adolescents...Technical Skills...Awareness of Abuse/Neglect/Exploitation...” which was dated 7/13/05 and provided by Blue Ridge Health Service. There was no documentation in any of the personnel files for the recognition and reporting requirements for (b) (6), (b) (3) abuse or any information concerning (b) (6), (b) (3) abuse except the one listed above.

The personnel files did contain yearly appraisals documented on the HHS Employee Performance Appraisal Plan, but the appraisals were not consistently documented and maintained in the personnel files. The last complete appraisal plan found in Ms. Slee’s file was for review of the year 1/1/11-12/31/11 and signed on 1/31/12.

The personnel file for (b) (6) contained no documentation of orientation, training or evaluation.

- **Lack of a system for appropriate management of documentation.**

Documentation issues at Unity were extensive. (b) (6), (b) (3) (A)

[REDACTED]

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(b) (6), (b) (3) (A)

As noted earlier, (b) (6) appeared to have been the staff member who initially received a direct report of (b) (6) having been in a bathroom alone with (b) (6), (b) (3) (A) on at least 2 occasions for approximately 5 minutes. (b) (6) documented on 9/26/16 (signed on 9/27/16) that she provided written documentation of this incident to Ms. Grant on 9/25/16. There was no documentation of this information in (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) and the documentation reportedly submitted to Ms. Grant by (b) (6) was not located during the current review. (b) (6) documentation of this information was found in (b) (6) Employee Relations/Labor Relations (ER/LR) file. On this same document signed by (b) (6) on 9/27/16, (b) (6) noted she and Ms. Slee were present on 9/27/16 when (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) reported specific (b) (6) of (b) (6), (b) (3) (A) by (b) (6). No documentation of this report of concerns for (b) (6) was noted in (b) (6), (b) (3) (A) (b) (6), (b) (3) (A). The documentation was found only in (b) (6) ER/LR file.

Documentation related to specific (b) (6) and (b) (6), (b) (3) (A). Neither Ms. Slee nor (b) (6) documented any information surrounding the discovery of the letter found in (b) (6), (b) (3) (A) room, nor did they document the conversations they had with (b) (6), (b) (3) (A). (b) (6), (b) (3) (A)

Also, an SSA progress note documented there was a phone call between Unity staff and (b) (6), (b) (3) (A) (b) (6) but there was no documentation of the phone call by the staff who were reportedly involved in the phone call.

Ms. Slee denied she was ever privy to any statement specific for (b) (6) of (b) (6), (b) (3) (A) by (b) (6). When presented with a statement bearing her signature, Ms. Slee acknowledged it was her signature and that she created the document. Ms. Slee speculated her inability, at the time of her interview for this review, to remember the allegations reported to her and her inability to remember creating the written statement might be a result of “memory problems.” Based on Ms. Slee’s own written statement it is not in dispute that Ms. Slee knew, at a minimum, on 9/27/16 there were concerns of (b) (6) of (b) (6), (b) (3) (A) by (b) (6). Ms. Slee did not document these concerns in (b) (6), (b) (3) (A) (b) (6), (b) (3) (A). The only documentation from Ms. Slee was found in (b) (6) ER/LR file.

(b) (6), (b) (3) (A) was evaluated at Cherokee Indian Hospital on (b) (6) 16. (b) (6), (b) (3) (A)

In her role as the (b) (6), (b) (3) (A)

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(b) (6), (b) (3) (A)

In this current review it was difficult to quantify the degree to which front line staff (SSAs) reported frustration with respect to the reported failures of Ms. Slee, Capt. Ruff, and Ms. Grant to effectively manage concerns or issues reported to them. Multiple SSA staff reported they were not aware of any mechanism to effectively access higher level management without fear of repercussions from Ms. Slee. Despite their fears some front-line staff reported they specifically submitted concerns in writing to Ms. Slee and Capt. Ruff, but at the time of this review no such documentation had been located. There was no identified mechanism for preservation of documentation submitted by front line staff to their immediate supervisor or Capt. Ruff.

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A), the packet (b) (6) for disciplinary action on (b) (6) was also replete with inconsistencies and errors. Capt. Ruff submitted documents that appeared identical but upon closer review were noted to have some sentences deleted, sentences added, or differently worded sentences. Additionally, documents included different signature and dating formats utilized by Capt. Ruff on what appeared to be similar or even identical documents. The ER/LR packet also included documents that were inconsistent. For example, one document titled “Proposing Official’s Douglas Factors” dated 12/2/16 indicated Capt. Ruff was recommending (b) (5) ” The lack of documentation and the haphazard manner in which information was collected, stored, and disseminated reflected (b) (5)

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(b) (5) [REDACTED]. The lack of documentation also hindered efforts to determine the timeline of events surrounding the concerns of (b) (6) [REDACTED] and the process by which decisions related to the concerns were made.

- **Improper use/management/utilization of video surveillance resources.**

Staff members provided a litany of explanations for the purpose of video surveillance at Unity Healing Center. Some staff reported it was for “(b) (6), (b) (3) (A) safety” while others reported it was necessary to monitor staff conduct issues. There was no consistent response to questions about how video was used, archived, accessed, or reproduced. There was no consistent response to questions about policy related to video surveillance. Most respondents reported they simply did not know how video was utilized. What was clear from virtually every respondent was that (b) (6) [REDACTED] had access to the video system and reviewed video on a daily basis. Staff reported (b) (6) [REDACTED] often reviewed video to make sure staff were working and not sleeping or “goofing off.” Staff reported (b) (6) [REDACTED] reviewed video tape when there were reports of (b) (6), (b) (3) (A) conflicts or when something was stolen. Staff reported it was not uncommon for (b) (6) [REDACTED] to spend significant amounts of time in her office looking at video surveillance. Even (b) (6) [REDACTED] reported she frequently “had” to look at video to “deal” with staff and (b) (6), (b) (3) (A) issues.

The inherent value of video surveillance is not in question, but it is appropriate to explore the original purpose of the video cameras, the advantages and disadvantages of the cameras, and the intended and unintended consequences of having video cameras in the facility. It is also necessary and appropriate to develop policy with respect to how the data is accessed, maintained and utilized, and to evaluate who has access to the video system.

(b) (6) [REDACTED] appeared to have assumed a supervisory or management role related to the video surveillance system over time and by default. There was no clear explanation or process by which (b) (6) [REDACTED] assumed this role. Without exception, staff reported (b) (6) [REDACTED] was the primary staff member responsible for the video surveillance system. Several staff assumed the Executive Director also had access, but the current Executive Director (b) (6) [REDACTED] reported she was in the process of determining who to contact and what steps to take in order to gain access to the system. (b) (6) [REDACTED] repeatedly demonstrated a lack of judgement and competence in her approach to how the video surveillance system at Unity was utilized. In March 2017, (b) (6) [REDACTED] viewed video and observed an employee engaged in what she determined was a sexual act on Unity property with an adult non-Unity employee. (b) (6) [REDACTED] shared this information with members of her church. An ER/LR referral was initiated, and (b) (6) [REDACTED] was determined to have acted inappropriately, was disciplined and received a 14-day suspension without pay. Despite this, (b) (6) [REDACTED] returned to work after her suspension and continued in her unofficial role related to the video surveillance system with full access to the system. (b) (5) [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

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Use of video surveillance in any facility also creates the potential for the video footage to become evidence in an investigation. Policies to ensure appropriate access and maintenance of video surveillance must be established for any facility that utilizes a video surveillance system. This will be addressed in more detail in subsequent analysis.

- **Severely flawed investigative effort into the allegation of sexual abuse.**

The management at Unity Healing Center, including Capt. Ruff, Tracey Grant, and Cynthia Slee appeared (b) (6), (b) (5). Review of documentation and staff interviews clearly established that Capt. Ruff and others at Unity knew there was an allegation of sexual abuse of (b) (6), (b) (3) (A) by (b) (6). Documentation and interviews also clearly established that an investigation was conducted by members of the Unity Healing Center staff. Information reviewed suggested Capt. Ruff ultimately determined that no sexual abuse occurred. The investigation conducted by Unity was replete with errors and lacking in every aspect.

The initial moments surrounding the awareness of an allegation or concern of sexual abuse are extremely important. Protecting vulnerable (b) (6), (b) (3) (A) and protecting persons who may be falsely accused are not incompatible goals. Ironically, the path to achieving both goals is identical. Securing the safety of the (b) (6), (b) (3) preservation of documentation, creating space for objective evaluation of information, and deferring to trained professionals are essential tasks. It is understandable that families and persons in the general public are ill-equipped to respond objectively to a concern of sexual abuse. Family members are in an intensely emotionally charged state when they learn their (b) (6), (b) (3) is a possible victim of (b) (6), (b) (3) sexual abuse. Add the reality that the alleged perpetrator is often a family member, and the situation quickly can become unmanageable. Family members and the general public will struggle to respond objectively to a concern of sexual abuse. Professionals in (b) (6), (b) (3) (A) or treatment facilities are held to a different standard. It is quite reasonable to expect these professionals to respond in an objective and professional manner to ensure the safety of (b) (6), (b) (3) (A) as well as the protection of employees who may be incorrectly accused of sexual abuse. Objectivity and professionalism will allow for an effective response in the initial moments post disclosure or discovery of material concerning for sexual abuse.

Ms. Slee came to possess a note/letter (b) (6), (b) (3) (A) wrote which (b) (6) believed was written to (b) (6). A note/letter written by (b) (6), (b) (3) (A) was found in the ER/LR packet, but it was not determined if the note/letter found in the ER/LR packet is the same one found by Ms. Slee. It was also not clear if there were additional written documents. (b) (6), (b) (3) (A)

The circumstances surrounding the note/letter described above is an example of how a situation can quickly deteriorate when addressing a concern of sexual abuse in a non-professional and non-objective manner. Ms. Slee's approach to the note/letter appeared (b) (6), (b) (5)

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(b) (6), (b) (5). Many (b) (6), (b) (5) sexual abuse investigations begin with the discovery of a letter or journal. It is not uncommon for the written material to be written in such a way that it is difficult to assess what has or has not happened. It was clear, (b) (6)

[REDACTED]. It is important to note Ms. Slee was already in possession of knowledge that (b) (6) had been observed acting inappropriately toward (b) (6), (b) (3) (A)

(b) (6), (b) (5), (b) (3) (A)

(b) (6), (b) (3) (A)

This

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(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

At Unity, there was video surveillance that captured numerous interactions between (b) (6) and (b) (6), (b) (3) (A). No video footage was made available for this current review. The Office of the Inspector General (OIG) secured numerous items from Unity. It is unknown if any of the reported video footage was recovered by OIG. Securing the video system and preserving the footage for review by external investigators should have been a priority for Unity staff members. Failing to recognize it was not appropriate for Unity staff members to begin reviewing video to determine if sexual abuse occurred was a serious error. Not only did management fail to secure the video, but multiple staff accessed and viewed the video. Access and review of such video was not only an investigative problem but also a violation of Health Insurance Portability and Accountability Act (HIPAA) guidelines. Allen Bollinger (Facilities Engineer) reported he had made copies of the video that he ultimately released to Capt. Ruff and (b) (6), (b) (3) (A) (Unity (b) (6)). There was no intentionality or logical explanation for Mr. Bollinger's activity. Additionally, Mr. Bollinger reported he acted on his own without direction or instruction from Capt. Ruff or any senior management official. The ability of investigators to accurately assess evidence was dependent on their ability to approach persons of interest with as much information as possible prior to the person of interest becoming aware of the information investigators had in their possession. Again, this would have allowed for maximum opportunity for investigators to effectively question an alleged perpetrator. It would have also allowed for maximum protection of an innocent, alleged perpetrator to provide a valid statement that could have been compared with evidence in the possession of the investigator. If (b) (6) or others viewed the video, it would have negated the opportunity for them to provide an objective statement for investigators to evaluate and compare with evidence in their possession.

In addition to video surveillance footage, there may have been other evidence lost due to the failure to report concerns of (b) (6), (b) (3) abuse. This includes evidence that may have implicated (b) (6) as a perpetrator of sexual abuse or evidence that would have exonerated (b) (6). (b) (6), (b) (3) (A) digital information on (b) (6) phone, review of timesheets, etc. could have yielded valuable

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information that might have corroborated other information provided during interviews of all involved. It was also possible investigators might have been unable to develop any useful information or evidence, but the failure to report to authorities prevented the opportunity for internal or external investigators to conduct a meaningful investigation.

A credible investigation would also have included interviews with residents and staff who might have had important information to provide. It would have been important for these interviews to occur prior to those subject to interview having an opportunity to be influenced by other discussions. “Influenced” is in no way meant to suggest residents or staff would intentionally alter statements, although that is a possibility. Normal memory processes can be highly suggestible. For example, if one person thought they saw (b) (6) go into (b) (6), (b) (3) (A) for a minute or two they might report it that way upon initial interview. If that same person heard others talking about witnessing (b) (6) enter (b) (6), (b) (3) (A) for 10 minutes, they could adopt the same story simply because hearing what someone else said might have caused them to genuinely question their own memory. Records suggested (b) (5), (b) (6)

The initial reaction by Ms. Slee and (b) (6) contributed to the spread of what should have been private and confidential information.

(b) (6) statement was reportedly received by Capt. Ruff on 3/19/17, approximately 6 months after the allegation of sexual abuse became known to management at Unity. The failure of Unity staff to report the allegations to investigative authorities not only compromised the safety of (b) (6), (b) (3) (A) and other (b) (6), (b) (3) (A) but also (b) (6) opportunity to offer a statement to investigators in a timely manner. It is tempting to dissect (b) (6) statement from a perspective of guilt or innocence, but this review was not intended to assess the veracity of the sexual abuse allegations. It was interesting to note that in his written statement, (b) (6) referred to (b) (6) (b) (6) and wrote he had no (b) (6) toward (b) (6), (b) (3) (A) (b) (6) acknowledged on 3/19/17 that there had been an allegation of sexual abuse made against him. From the time of the incident through the time of this review, Capt. Ruff repeatedly denied there was ever any concern of sexual abuse despite numerous examples in written documentation, along with Capt. Ruff’s own statements during this review that suggested otherwise. Capt. Ruff’s denial of having knowledge of allegations of sexual abuse of (b) (6), (b) (3) (A) by (b) (6) was not valid.

b. Macro:

Macro analysis focused on 5 specific areas:

Director of Field Operations

There was no evidence of any formal process through which the Director of Field Operations (Dr. Vickie Claymore) evaluated or supervised the environment at Unity. During review of Unity records, there was no documentation that Dr. Claymore was consulted or apprised of activities or events (positive or negative) related to Unity including, but not limited to, the events involving (b) (6), (b) (3) (A) in (b) (6) 2016. In her role as the Director of Field Operations, Dr. Claymore appeared to have no practical connection to any responsibility for the supervision of Unity Healing Center. Lack of clarity with respect to the relationship between the Director of Field

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Operations and the Executive Director of Unity Healing Center appeared to be a systemic issue worthy of exploration. Also, there was no evidence Dr. Claymore was aware of the existence of multiple Employment Rights/Labor Rights (ER/LR) referrals and Equal Employment Opportunity (EEO) complaints filed by Unity staff. It is possible Dr. Claymore was aware of the issues and failed to recognize the significance of so many complaints in terms of staff dynamics. Multiple ER/LR referrals or EEO complaints should have signaled that Unity was in distress. Capt. Ruff reported she was frequently overwhelmed by the “manipulative” behavior of staff and (b) (6) but there was no evidence this information was known by Dr. Claymore. Finally, on a Root Cause Analysis document, Capt. Ruff expressed dissatisfaction with the lack of support she received from the Nashville Area Office. There was no evidence Dr. Claymore attempted to address any of these issues with Capt. Ruff. Whether Capt. Ruff’s complaints were valid or not, the fact Capt. Ruff was openly requesting assistance was an indicator of distress that required attention. Competent and timely review and program evaluation would have identified many of the problems at Unity.

Dr. Claymore was identified as Capt. Ruff’s direct supervisor; however, Dr. Claymore was also assigned as the “Deciding Official” for the ER/LR process related to (b) (6). This process systematically placed Dr. Claymore in a compromising position. As the deciding official she was not permitted to know what was in the ER/LR packet until such time the ER/LR staff submitted the packet to her for review. As the direct supervisor of the staff member deemed responsible for creating the packet, it would have been impossible for Dr. Claymore to be available to Capt. Ruff for consultation. If Dr. Claymore provided direct consultation it seemed her role as the Deciding Official would have been prejudicial or, at least, had the appearance of some prejudice. Dr. Claymore was also a member of the Governing Board committee who initiated and developed the Root Cause Analysis that ultimately determined it was appropriate for (b) (6) to be referred to ER/LR for disciplinary action. At a minimum this structure created the appearance of a conflict of interest if not an actual conflict of interest for Dr. Claymore.

Governing Board

The Governing Board was responsible for oversight of Unity Healing Center. The Governing Board failed to exercise due diligence with respect to oversight of Unity Healing Center and failed to protect the residents entrusted to their care. The Governing Board was made aware there was a reported (b) (6), (b) (3) (A) but there was no explicit evidence the Governing Board was aware there were specific allegations of (b) (6), (b) (6) sexual abuse of a Unity resident by a Unity staff member. Governing Board members interviewed during this current review denied knowledge of any specific concerns of sexual abuse at Unity Healing Center. Upon receipt of information there had been a reported (b) (6) in (b) (6) 2016, the Governing Board authorized that a Root Cause Analysis (RCA) be conducted. An RCA is intended to drill down to the root of a problem to identify and unearth the unseen contributing factors. In the case of the reported (b) (6) at Unity Healing Center in (b) (6) 2016, the Governing Board minutes clearly stated the Governing Board directed the Executive Director (Capt. Ruff) and the Clinical Director (Tracey Grant) to conduct the Root Cause Analysis (RCA). (During interviews for this current review, both Capt. Ruff and Tracey Grant denied having a substantial role in the Root Cause Analysis.) The Root Cause Analysis document was reviewed as part of this current review.

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During her interview, Dr. Vickie Claymore reported there was a phone call during which she, Capt. Ruff, Tracey Grant, Dr. Michael Toedt, Dr. Palmeda Taylor and Dr. Bruce Finke (and possibly others) discussed the RCA and determined that it was appropriate to initiate an ER/LR referral for (b) (6) based on concerns of staff boundary issues. In interviews with Dr. Claymore she stated that she could not recall what specific information caused the referral to ER/LR. Dr. Claymore reported neither Capt. Ruff nor Tracey Grant provided any information to suggest there had been an allegation of sexual abuse, but there was information documented in the RCA that caused concern for conduct and performance issues. Per Dr. Claymore, an ER/LR referral was the only mechanism by which a conduct/performance issue could be addressed. The Governing Board, including Dr. Claymore authorized the referral to ER/LR for (b) (6). Dr. Claymore was later named the “Deciding Official” for the ER/LR process involving (b) (6).

In the January 2017 Governing Board meeting minutes, Dr. Toedt was noted to have praised the quality of the RCA conducted on the (b) (6), (b) (3) (A). It was difficult to appreciate which components of the RCA were considered to be high quality. Upon review, multiple errors related to content were noted as well as numerous grammatical and spelling errors. There were no dates or signatures on the RCA to document when the RCA was initiated, when or how meetings were held or who participated in the meetings. The information in the field titled, “Detailed Event Description Including Timeline” was not consistent with documentation from Unity Healing Center. For example, there was a description of (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) to (b) (6). The RCA documentation detailed that (b) (6) “called” (b) (6) (b) (6), (b) (3) (A) to alert her about the situation. In contrast, (b) (6) written statement signed 9/27/16 noted that immediately after (b) (6), (b) (3) (A) reported the (b) (6), (b) (3) (A), she (b) (6) interrupted a conversation (b) (6) was having with (b) (6), (b) (3) (A) in the hallway in order to alert (b) (6) about the situation. (b) (6) (b) (6) there was no “call” to (b) (6) as (b) (6) was close by talking with (b) (6). This may seem like a minor detail, but if minor details are not correct it is more difficult to trust the reliability of more significant details.

Many sections of the RCA were not developed or were only partially developed. The RCA Action Plan was also of particular interest. The Action Items were intended to address the root causes which should have been developed from the Root Cause Analysis Findings, but there were no root causes identified in the RCA. There were no timelines for completion of tasks. The “Method: Policy, Education, Audit, Observation & Implementation” section was essentially empty with the exception of “email” as a method to execute 3 action items. Action Item 6 had no assigned responsible party. The examples below highlight other areas of concern but are not an exhaustive critique of the RCA.

(b) (3) (A), (b) (6)

The Analysis Questions in each section were designed to provide evidence for the Root Cause(s) and opportunities for risk reduction. The Prompts in each section were designed to guide the author(s) to develop the Root Cause Analysis Findings. The author(s) failed to address the questions in many sections or provide information directly relevant to the questions. This failure inhibited the determination of root causes and the development of an appropriate and comprehensive plan of action.

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In Section 3, (b) (6), (b) (3) (A) and (b) (6), (b) (3) (A) were identified as issues related to the (b) (6), (b) (3) (A). Both issues were root causes, but the author(s) did not identify them in the document as such. As a result, there was no other explanation or exploration of how or why these were considered significant. How can (b) (6), (b) (3) (A) and (b) (6), (b) (3) (A) in a facility specifically designed to offer safety and therapeutic intervention be documented as a “Root Cause Analysis Findings” and not be deemed worthy of intense exploration? Even at the time of this current review, many staff were actively in denial that (b) (6), (b) (3) (A) and (b) (6), (b) (3) (A) identified as a concern should have triggered widespread alarms. Safety, trust, effective communication and respect for boundaries are central to a therapeutic environment. It is exceedingly difficult for sexual abuse or exploitation to occur in an environment where there is healthy and effective communication and respect for boundaries. The absence of healthy and effective communication, and disregard for boundaries is a breeding ground for sexual abuse and exploitation. Even more striking is the fact that everyone knew the environment was conflicted, toxic, devoid of effective communication, and teeming with boundary violations, yet upper management (Capt. Ruff and Tracey Grant) claimed they were powerless to intervene. Management at the Nashville Area Office and the Governing Board appeared unaware of the crisis unfolding at Unity. The Governing Board also failed to appreciate the gravity of (b) (6), (b) (3) (A) and “(b) (6), (b) (3) (A)” being included in the RCA. The very nature of the issues at Unity, the Governing Board, and the Nashville Area Office were such that it was almost predictable the root causes would be both in plain view and completely unseen. It appeared the depth and breadth of the impairment in both the micro and macro environments involving Unity, the Governing Board and the Nashville Area Office resulted in deeply rooted denial and inability to recognize the most meaningful issues noted on the Root Cause Analysis. In addition to (b) (6), (b) (3) (A) and “(b) (6), (b) (3) (A)” ineffective leadership, staff conflict, absent leadership, lack of training, lack of vision, lack of clinical supervision, lack of oversight and loss of institutional control appeared to be other root causes that were not identified on the Root Cause Analysis.

(b) (3) (A)

(b) (3) (A), (b) (6), (b) (5)

In Section #8, the author(s) included a list of items that were, at best, difficult to follow. Social outings, bike riding, any outdoor activity or sport, other bathrooms in the community were relevant areas of note. It was, however, difficult to reconcile how issues related to low staffing, outdated policies, and a “frozen” policy review process were pertinent in this section.

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Section #9 presented an opportunity to reflect on whether the staff was qualified and competent for their responsibilities at the time of the event. There was no meaningful comment on staff qualifications. There were two broad statements regarding competency training and credentialing and privileging, but no serious assessment or consideration of whether staff were qualified to be engaging in the activities in which they were engaging. Cynthia Slee was a supervisor for SSA staff, and she was frequently in a position to interpret and/or evaluate clinical data and make decisions related to clinical evaluation. Ms. Slee found the note/letter and then assumed a lead role in approaching (b) (6), (b) (3) (A) about the note/letter. Ms. Slee participated in a decision to plan a meeting for (b) (6), (b) (3) (A) and (b) (6). It appeared no one questioned Ms. Slee's qualifications to make decisions at this level. During interviews for this review, many staff identified Ms. Slee as "basically in charge of Unity." Ms. Slee was involved in planning and decision making for areas of practice for which she had no training or expertise.

Section #10 compared actual staffing levels with ideal staffing level. The author(s) did not provide any data but noted Unity was fully staffed at the time of the incident despite having noted in Section #8 that Unity was historically "under-staffed."

In Section #20 the author(s)' response listed in the Root Cause Analysis Finding did not address the question being asked. Additionally, there was no consideration of other issues that could have been identified in this section, i.e., staff fearfulness to report concerns to supervisory staff or failure of supervisory staff to respond to concerns that were reported, etc.

Sections #23 and #24 specifically directed attention to whether available technology was used as intended and to assess how technology could be used to reduce risk in the future. The author(s) noted "NA" as a response in each section rather than exploring the issues related to the video surveillance system.

It was not clear what training or skill set the author(s) possessed to complete the RCA. The sections reserved for the root cause to be identified were not populated with any root cause. The section for a plan of action to be identified was effectively left blank. No dates or timelines for activities were recorded.

Virtually every Root Cause Analysis training guide or tutorial offers recommendations for RCA committee or team members. Decisions related to committee or team composition are dependent on a variety of factors including the nature of the event being studied. In some cases, it is important to have members who were involved in the event being studied, yet in other cases it is advisable to have members who were not involved (or some combination of the two). It is typically recommended to include staff from all levels of the agency and to keep management level members to a minimum to encourage honest and objective participation by all. There was no evidence any staff member other than management was part of the RCA committee who examined the reported (b) (6), (b) (3) (A) of (b) (6), (b) (3) (A). There was no evidence that the RCA committee members sought input from other staff. Multiple staff reported they were afraid to keep reporting concerns about (b) (6) for fear of retaliation by Ms. Slee. Other staff reported Capt. Ruff was not responsive to staff concerns so there was no need to even consider reporting concerns to her. The same Unity leadership team responsible for the toxic work environment at

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Unity was tasked with responding to questions about the nature of the work environment at Unity. Not surprisingly, there was no mention of possible concerns related to leadership or the culture at Unity.

Action Item 5 on the Root Cause Analysis required an ER/LR referral for “staff boundar [sic] issue.” Although no staff member was identified, interviews with the RCA members confirmed the ER/LR referral was for (b) (6). Despite this, Action Item 9 resulted in (b) (6) being assigned responsibility for reviewing “environmental or physical risks and additional assessment during Mock Survey.” In this particular case, two of the primary environments being assessed were resident rooms and bathrooms. A competent and objective RCA would have identified (b) (6) role in the (b) (6), (b) (3) (A). A competent and objective RCA would have identified that (b) (6) was accused of sexually abusing (b) (6), (b) (3) (A) when he was executing his duty to assess an environmental and physical risk in her bathroom. The absurdity and significance of this detail cannot be overstated, nor can it be overlooked. The RCA was a staggering example of the dysfunction at Unity that was so deeply woven into the fabric of the organization it was, as stated earlier, completely hidden from sight while simultaneously in plain view of the Governing Board.

Of note, Dr. Cotton participated in a Governing Board meeting in January 2019 during which there was discussion of a Corrective Action Plan secondary to a Joint Commission complaint filed by a Unity staff member. Dr. Cotton was an outsider who became immediately alarmed at information she heard regarding the issues at Unity. Dr. Cotton’s initial concern and evaluation of the information represented an appropriate response from a management professional. Dr. Cotton’s evaluation of the information she was presented was filtered through a lens of professionalism, experience, training, leadership, and objectivity. Evaluation of the information filtered through this lens led Dr. Cotton to take immediate action to assess the information and the events that occurred. The reaction by Dr. Cotton was a demonstration of the difference between a professional and objective reaction and approach to the information as compared to the impaired reaction and approach of the prior administration.

NAO Director

It appeared the NAO Director was responsible for activities related to the Governing Board, but there was no documentation of any activity initiated by the NAO Director or any review of RCA findings by the NAO Director. The Nashville Area Office Director was essentially silent or absent and provided no commentary of any substance. The Nashville Area Office Director was ultimately responsible for organization and management of services provided under the umbrella of the Nashville Area Office which included Unity Healing Center. Oversight of Unity Healing Center was achieved through the use of a Governing Board. In September 2016 the Governing Board function was ultimately under the guidance and direction of the Nashville Area Office Director, Martha Ketcher. Ms. Ketcher was a member of the Governing Board and was noted to be present at the meeting on September 27, 2016 when the Governing Board was advised of an (b) (6), (b) (3) (A). During the September 2016 meeting, the Governing Board requested a Root Cause Analysis (RCA) and Capt. Ruff and Tracey Grant were identified as the staff responsible for conducting the RCA. Dr. Toedt also offered his assistance with the RCA. Lack of awareness or any documented interest from the NAO Director with respect to the services and care being provided to Indian Country at Unity was unambiguous and appeared to reflect a gross lack of institutional control at the highest

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level. The Nashville Area Director was included on several emails but there was no documentation available of any action taken by Ms. Ketcher related to the (b) (6) 2016 situation involving (b) (6) and (b) (6), (b) (3) (A). Other than being included in emails related to various situations at Unity, it appeared the NAO Director was either avoiding the production of written documentation or failing to exercise due diligence with respect to the information she was provided.

ER/LR staff and process

At the beginning of this current review, the reviewer was provided with numerous records from Unity. (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A) A reviewer request for personnel files resulted in an additional box of files being identified that included what was described as an ER/LR file held initially by ER/LR specialist (b) (6) (b) (6) reportedly transferred the file to another ER/LR specialist, (b) (6) (b) (6) ultimately sent the file to the Nashville Area Office where ER/LR staff, (b) (6) took receipt of the file and stored the file in her office. This ER/LR file contained invaluable information. While no one has claimed responsibility for creating the file that was ultimately submitted to the ER/LR specialist, there was documentation that Capt. Ruff was responsible for compiling the information in the packet and submitting the packet to (b) (6) in March 2017. In March 2017, Capt. Ruff was involved in several emails with ER/LR staff (b) (6) and (b) (6) that included references to specific allegations of sexual abuse of (b) (6), (b) (3) (A) by (b) (6)

Perhaps one of the more difficult challenges, with respect to collection of records and understanding the system of accountability was related to the ER/LR process. On 1/15/20 Mark Skinner (Nashville Area Office Executive Officer) was interviewed at the Nashville Area Office. Mr. Skinner served in a supervisory role for ER/LR staff during the time the proposal for action on (b) (6) was submitted. Questions related to the ER/LR process and how referrals to ER/LR were documented and managed were the focus of the interview with Mr. Skinner. Mr. Skinner was able to provide valuable information that allowed for identification of “workload reports” submitted by (b) (6) as part of the ER/LR documentation process. Once Mr. Skinner confirmed there was a mechanism by which ER/LR activity was documented, a request was made for copies of the ER/LR workload reports.

On 1/24/20, (b) (6) (ER/LR-NAO) advised she was in receipt of the requested ER/LR documentation and workload reports. Identification and location of the ER/LR file related to the (b) (6) 2016 proposed action on (b) (6) and review of the ER/LR workload report/spreadsheet proved to be perhaps the most informative activities with respect to understanding what occurred at Unity Healing Center in (b) (6) 2016. During initial review of records and interviews with staff, there was no documentation or evidence of any specific allegation of sexual abuse ever being made or ever being reported to Unity staff. Capt. Ruff specifically reported there were no allegations of sexual abuse. Tracey Grant also reported there was no specific allegation of sexual abuse. Capt. Ruff reported she did not conduct any internal investigation into allegations of sexual abuse. Capt. Ruff specifically reported she did not conduct an internal investigation, because there was never an allegation to be investigated. (b) (6), (b) (3) (A)

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(b) (6), (b) (3) (A) . Capt. Ruff initially had no explanation for why an ER/LR referral was initiated on (b) (6) other than to say it was because (b) (6) failed to follow through on training to help him understand appropriate boundaries. In subsequent interviews, Capt. Ruff reported (b) (6) was referred to ER/LR after the RCA determined that was the appropriate course of action. Review of the workload report/spreadsheet revealed that Capt. Ruff initiated the ER/LR referral regarding (b) (6) on 9/28/16. The ER/LR workload report also documented that Capt. Ruff began an investigation on possible inappropriate concerns with a (b) (6), (b) (3) (A). The written documentation on the ER/LR workload report directly contradicted Capt. Ruff's initial statements collected during this review. There was no documentation of the date the packet was ultimately submitted to ER/LR. Whether the packet was submitted in its entirety once collected or submitted in separate pieces over a period of time was also not documented.

On 2/8/2017, (b) (6) entered a note on a workload report indicating she requested an update on the status of the ER/LR referral from (b) (6) supervisor (Capt. Ruff). On 3/2/2017, (b) (6) entered a note that she requested review of the "proposal" by (b) (6) (ER/LR specialist). On 3/7/2017, (b) (6) responded through email that he had reviewed the proposal. (b) (6) email indicated he was concerned about documentation he reviewed in the packet that was concerning for sexual abuse. (b) (6) also questioned whether the allegations of sexual abuse were possibly connected to the (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) (b) (3) (A), (b) (6) noted the (b) (5), (b) (6)

(b) (6) (b) (6) and Capt. Ruff exchanged numerous emails in March and April of 2017 that involved discussion of the allegations of sexual abuse (b) (6) (b) (6), (b) (3) (A). The email conversation ultimately resulted in (b) (6) being "presented" with a letter (b) (6) (b) (6). On 5/9/17, (b) (6) requested supporting documentation and on 5/12/17, the supporting documentation was provided to (b) (6). Also, on 5/12/17, (b) (6), (b) (3) (A)

The ER/LR process appeared to be the mechanism by which information collected during an internal investigation into allegations of sexual abuse of (b) (6), (b) (3) (A) by (b) (6) at Unity Healing Center were documented and evaluated. It was during the Governing Board meeting on 9/27/16 that the Root Cause Analysis process which ultimately recommended referral of (b) (6) to ER/LR was initiated. Capt. Ruff's investigation into the allegations of sexual abuse appeared to occur as a result of the Root Cause Analysis recommendation to initiate an ER/LR referral. At least 6 individuals, Capt. Ruff, Tracey Grant, Dr. Toedt, Dr. Finke, Dr. (b) (6) and Dr. Claymore, participated in a conversation during which a decision was made to (b) (6). Each of those individuals was interviewed for this review. Each of these individuals are highly trained professionals and without exception, each indicated they had no information concerning the underlying reason for recommending the ER/LR referral other than some general (b) (6). Despite multiple interviews, reviews of hundreds of pages of documentation, and extensive analysis of available information, it was arresting, if not at times unbelievable, that the Governing Board was unaware of allegations of sexual abuse (b) (6), (b) (3) (A)

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(b) (6), (b) (3) (A) It was extremely concerning that the Governing Board was not made aware of the results of the investigation conducted by Capt. Ruff. It was even more concerning no person on the Governing Board, no person at the Nashville Area Office, and no person associated with ER/LR recognized the need to intervene, ask obvious questions, or critically evaluate the data that was being collected. As noted in earlier analysis, the very nature of the issues at Unity and the Nashville Area Office were such that it was predictable the Root Cause would be both in plain view and completely unseen. It appeared the depth and breadth of the impairment in both the micro and macro environment at Unity Healing Center and Nashville Area Office, and in the ER/LR process resulted in deeply rooted denial and inability to recognize the most meaningful issues noted on the Root Cause Analysis, (b) (6), (b) (3) (A) and (b) (6), (b) (3) (A). The deeper root causes of ineffective leadership, staff conflict, absent leadership, lack of training, lack of vision, lack of clinical supervision, lack of oversight, loss of institutional control and overwhelming dysfunctional interpersonal and intrapersonal relationships prevented recognition of the most fundamental findings of the RCA.

(b) (6)

(b) (6)

Capt. Ruff failed to offer any substantial reason for her effort to remove (b) (6), and she reported her effort was unsuccessful due to

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guidance/feedback from ER/LR. In contrast, review of ER/LR documentation revealed it was ER/LR staff who advised Capt. Ruff to change the ER/LR proposal from (b) (6)

Although she was part of the process by which the ER/LR referral was initiated, once the ER/LR process began, Dr. Claymore was systematically prevented from accessing or receiving any information collected for the ER/LR process. Information reviewed has suggested Capt. Ruff interpreted the Root Cause Analysis finding to refer (b) (6) to ER/LR as an instruction to conduct an internal investigation into whether (b) (6) sexually abused (b) (6), (b) (3) (A). Given that her recommended action was a 30-day suspension for (b) (6) it appeared Capt. Ruff determined the allegations of sexual abuse were unsubstantiated. However, as required by the Root Cause Analysis findings, Capt. Ruff submitted information from her internal investigation to ER/LR staff who clearly noted specific allegations of sexual abuse and recommended (b) (6) behavior, instead, warranted removal. Capt. Ruff did not act on her mandatory reporting obligation. (b) (6) and (b) (6) did not advise Unity staff of their obligation to report the matter to (b) (6), (b) (3) (A) and/or local law enforcement officials, or the Office of the Inspector General. Based on review of federal law it was unclear if (b) (6) or (b) (6) had a mandatory obligation to report to investigative authorities or if they were obligated to advise Unity staff of their mandatory reporting obligation. Cynthia Slee and (b) (6) also failed to act on their mandatory reporting obligation. (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

IHS/OGC legal staff/OIG/HHS

On 5/16/17 Tracey Grant advised Capt. Ruff that Unity had been contacted by Cherokee Family Safety (Tribal Social Services) regarding a referral alleging sexual abuse of (b) (6), (b) (3) (A) by a (b) (6) at Unity. Once Unity became aware of the sexual abuse referral, IHS/HQ (b) (6) became involved. On 5/18/17, at 4:30 p.m., Ms. Grant sent an email to (b) (6). Ms. Grant indicated to (b) (6) she (Ms. Grant) was available by phone. On 5/18/17 at 5:07 p.m., (b) (6) sent an email to Ms. Grant and copied several individuals (b) (6), (b) (6) and (b) (6). In this email, (b) (6), (b) (5), (b) (3) (A)

(b) (6), (b) (5), (b) (3) (A)

On 5/22/17, (b) (6), (b) (7)(C) Office of the Inspector General (OIG) advised (b) (6) (b) (6) (IHS/HQ) OIG would not open a criminal investigation. On 6/7/17, (b) (6), (b) (7)(C) advised that OIG had received additional information and requested a copy of surveillance video footage as well as other documents and records. On 6/30/17, a search warrant was executed at Unity. On 7/7/17, the OGC recommended (b) (5)

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(b) (5) On 3/5/18, (b) (6) (HHS/OGC/GLD) issued an opinion that recommended (b) (6), (b) (5)

Based on the opinion rendered (b) (6), (b) (5)

(b) (6), (b) (5)

Virtually no information was shared by OIG, and OGC recommended (b) (5)

. OIG essentially indicated they would not be able to formally share any of their information. This cycle of requests for information and responses that no information was available continued for approximately eight months (July 2017-March 2018). (b) (6), (b) (5)

The question of whether the Nashville Area Office is bound by or tethered securely to the legal opinions offered by legal staff within IHS/HHS is a question that will likely require debate and thoughtful consideration. Assuming the Nashville Area Office was obligated to return (b) (6) to duty, it appeared no one considered other duty options for (b) (6). Even if there was no choice but to return him to full time employment, it did not appear there was any mandate for (b) (6) to be employed in a position where there were (b) (6), (b) (3) (A) or vulnerable others. Was there a determination that (b) (6) had a right to the exact job he previously occupied or that he decided he wanted to occupy or was there a decision (b) (6) had a right to full time employment with IHS? The Federal government likely had positions of employment where (b) (6) would be of great value and where his talents could be utilized without placing him or others in jeopardy of failure or harm. The absence of any meaningful debate or resistance regarding (b) (6) being returned to his prior position at Unity reflected a level of internalized and institutional capitulation. This review clearly demonstrated (b) (6) behavior presented a clear and present danger to (b) (6), (b) (3) (A) (and others). That is not to say this review determined (b) (6) to have been guilty of sexual abuse; however, his behavior and the impotence of the system in which he worked created an extremely perilous environment. Sexual abuse will never be 100% preventable, but there are decisions and actions designed to minimize risk and allow for safe environments of care where the vulnerability of (b) (6), (b) (3) (A) can be guarded and not further exploited. This review also clearly demonstrated that management

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at Unity, the Governing Board, and the Nashville Area Office failed, be it all without specific intention or coordination, to act with urgency or competence to the needs of the community they were mandated to serve. Additionally, (b) (6) may have been completely innocent, yet the failures of management also prevented (b) (6) from being reasonably cleared of any wrongdoing.

3. Detailed analysis of policy/lack of policy that contributed to positive/negative outcomes

Federal guidelines for reporting (b) (6), (b) (3) abuse: (TITLE 42—THE PUBLIC HEALTH AND WELFARE)

“...SUBCHAPTER IV—REPORTING REQUIREMENTS (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) abuse reporting (a) In general A person who, while engaged in a professional capacity or activity described in subsection (b) of this section on Federal land or in a federally operated (or contracted) facility, learns of facts that give reason to suspect that a (b) (6), (b) (3) has suffered an incident of (b) (6), (b) (3) abuse, shall as soon as possible make a report of the suspected abuse to the agency designated under subsection (d) of this section. (b) Covered professionals: Persons engaged in the following professions and activities are subject to the requirements of subsection (a) of this section: (1) Physicians, dentists, medical residents or interns, hospital personnel and administrators, nurses, health care practitioners, chiropractors, osteopaths, pharmacists, optometrists, podiatrists, emergency medical technicians, ambulance drivers, undertakers, coroners, medical examiners, alcohol or drug treatment personnel, and persons performing a healing role or practicing the healing arts. (2) Psychologists, psychiatrists, and mental health professionals. (3) Social workers licensed or unlicensed marriage, family, and individual counselors. (4) Teachers, teacher’s aides or assistants, school counselors and guidance personnel, school officials, and school administrators. (5) (b) (6), (b) (3) (A) workers and administrators. (6) Law enforcement personnel, probation officers, criminal prosecutors, and juvenile rehabilitation or detention facility employees. (7) Foster parents. (8) Commercial film and photo processors. (c) Definitions: For the purposes of this section (1) the term “(b) (6), (b) (3) abuse” means the physical or mental injury, sexual abuse or exploitation, or negligent treatment of a (b) (6), (b) (3) (2) the term “physical injury” includes but is not limited to lacerations, fractured bones, burns, internal injuries, severe bruising or serious bodily harm; (3) the term “mental injury” means harm to a (b) (6), (b) (3) (A) psychological or intellectual functioning which may be exhibited by severe anxiety, depression, withdrawal or outward aggressive behavior, or a combination of those behaviors, which may be demonstrated by a change in behavior, emotional response or cognition... (4) the term “sexual abuse” includes the employment, use, persuasion, inducement, enticement, or coercion of a (b) (6), (b) (3) to engage in, or assist another person to engage in, sexually explicit conduct or the rape, molestation, prostitution, or other form of sexual exploitation of (b) (6), (b) (3) (A) or incest with (b) (6), (b) (3) (A) (5) the term “sexually explicit conduct” means actual or simulated—(A) sexual intercourse, including sexual contact in the manner of genital-genital, oral-genital, anal-genital, or oral-anal contact, whether between persons of the same or of opposite sex; sexual contact means the intentional touching, either directly or through clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person with an intent to abuse, humiliate, harass, degrade, or arouse or gratify sexual desire of any person; (B) bestiality; (C) masturbation; (D) lascivious exhibition of the genitals or pubic area of a person or animal; or (E) sadistic or masochistic abuse; (6) the term “exploitation” means (b) (6), (b) (3) pornography or (b) (6), (b) (3) prostitution; (7) the term “negligent treatment” means the failure to provide, for reasons other than poverty, adequate food, clothing, shelter, or medical care so as to seriously endanger the physical health of the (b) (6), (b) (3) and (8) the term “(b) (6), (b) (3) abuse” shall not include discipline administered by a (b) (6), (b) (3) (A) to his or her (b) (6), (b) (3) provided it is reasonable in manner and moderate in degree and otherwise does not constitute cruelty. (d) Agency designated to

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receive report and action to be taken for all Federal lands and all federally operated (or contracted) facilities in which (b) (6), (b) (3) (A) are cared for or (b) (6), (b) (3) (A) the Attorney General shall designate an agency to receive and investigate the reports described in subsection (a) of this section. By formal written agreement, the designated agency may be a non-Federal agency. When such reports are received by social services or health care agencies, and involve allegations of sexual abuse, serious physical injury, or life threatening neglect of a (b) (6), (b) (3) there shall be an immediate referral of the report to a law enforcement agency with authority to take emergency action to protect the (b) (6), (b) (3) [This raised questions to be addressed in a subsequent section]. All reports received shall be promptly investigated, and whenever appropriate, investigations shall be conducted jointly by social services and law enforcement personnel, with a view toward avoiding unnecessary multiple interviews with the (b) (6), (b) (3) (e) Reporting form. In every federally operated (or contracted) facility, and on all Federal lands, a standard written reporting form, with instructions, shall be disseminated to all mandated reporter groups. Use of the form shall be encouraged, but its use shall not take the place of the immediate making of oral reports, telephonically or otherwise, when circumstances dictate...”

IHS policy (Abuse/Neglect Reporting CTS-20, created 03/89 and revised 05/07) in September 2016 required the following:

“...Any UHC staff member or volunteer, when made aware of a (b) (6), (b) (3) abuse/neglect incident that may have occurred before, during or after the (b) (6), (b) (3) (A) at UHC, will make a report to the appropriate (b) (6), (b) (3) (A) according to the referring agent's tribal affiliation. If that tribe has no (b) (6), (b) (3) then the report should be made to the appropriate Department of Social Services Personnel and/or Law Enforcement Official for that tribe.”

“If the (b) (6), (b) (3) abuse/neglect incident is believed to have occurred while the (b) (6), (b) (3) (A) it was/is in (b) (6), (b) (3) (A), then the Jackson or Swain County, North Carolina (b) (6), (b) (3) and/or Cherokee Tribal Police should be notified...”

“Any UHC staff member making a report of (b) (6), (b) (3) abuse/neglect in regards to any (b) (6), (b) (3) (A) will immediately complete a UHC (b) (6), (b) (3) (A) Abuse/Neglect Form placing the original in the (b) (6), (b) (3) (A) and submitting a copy to the treatment supervisor and/or the counseling psychologist. This form will be delivered to the Director of this facility and stored there to remain available on a need to know basis...”

IHS policy Section (b) (6), (b) (3) (A) highlighted the (b) (6), (b) (3) (A) right to be protected from mental, physical, sexual and verbal abuse, exploitation and neglect and to report any violations of state and federal statutes that pertain to those issues.

Unity Healing Center policy in 2016 was consistent with Federal law; however, Federal laws, tribal laws, state and county laws related to Indian Country are complicated. It is also important to note that Unity policy and Federal Law referred specifically to a mandatory reporting obligation when, “(b) (6), (b) (3) (A) abuse/neglect incident is believed” to have occurred, there are “abuse/neglect allegations,” or when one has information that “give reason to suspect that a (b) (6), (b) (3) has suffered an incident of (b) (6), (b) (3) abuse...” One could postulate that there is wide variance in these three descriptions. For example, what if one hears an allegation and simply does not believe abuse occurred? Could two individuals

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have the same information which would cause one of the individuals to suspect abuse but also fail to cause suspicion of abuse from the other? Statutory wording and Unity policy guidelines could have been construed for individuals to determine for themselves what constituted a “reasonable” concern or suspicion. This ambiguity, combined with lack of training, may have contributed to failures in the proper management of (b) (6), (b) (3) sexual abuse allegations.

Federal law and Unity policy identified all employees as mandatory reporters of (b) (6), (b) (3) abuse. Based on review of records and staff interviews, it was clear Unity staff members were not familiar with Unity policy with respect to reporting (b) (6), (b) (3) sexual abuse concerns.

Federal law (SUBCHAPTER IV—REPORTING REQUIREMENTS) (b) (6), (b) (3) (A) specifically requires every federal agency to disseminate a standardized reporting form. “...In every federally operated (or contracted) facility, and on all Federal lands, a standard written reporting form, with instructions, shall be disseminated to all mandated reporter groups. Use of the form shall be encouraged, but its use shall not take the place of the immediate making of oral reports, telephonically or otherwise, when circumstances dictate.” While referenced in Unity policy, no such form was identified at Unity Healing Center.

When asked if there was any standard mechanism to document a report of (b) (6), (b) (3) abuse to authorities, no staff member mentioned the UHC (b) (6), (b) (3) Abuse/Neglect Form referenced in Unity policy.

Unity Healing Center policy HRM-08 (Section A. Communications-4) referred to the creation of “Incident Reports” (Webcident) as the mechanism to identify “Patient or staff accidents” and “All unplanned deviations from approved policies and procedures.

Unity policy HRM-08 (Section H. Sentinel Events) outlined several examples of sentinel events that would trigger a Root Cause Analysis (RCA). “Rape” was identified as an example of a sentinel event. Although “rape” was never alleged, sexual assault would seem to classify as a sentinel event as well. This section required completion of the RCA within 30 days from the date of the event. The policy also required the Director to submit the RCA to the PIC (Performance Improvement Committee) and the Area Director of the Nashville Area Office. Finally, the Director and the Area Director, in “conference” with each other, were to make a determination with respect to reporting the sentinel event to JACHO. There was no evidence an RCA was submitted to the PIC or the Area Director.

When (b) (6) and Ms. Slee received the initial report from (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) that she had observed (b) (6) touching (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) and had been alone with (b) (6), (b) (3) (A) in the bathroom where they “held” each other and were “touching” each other, it would have been reasonable to suspect possible sexual abuse. According to IHS policy and Federal law, the incident should have been reported. This information was known to (b) (6) and Ms. Slee on 9/27/16, yet no staff made a report to any (b) (6), (b) (3) abuse investigative authority.

Capt. Ruff became aware of concerns of sexual abuse during collection of information related to the RCA and the ER/LR packet she compiled related to disciplinary action for (b) (6). Capt. Ruff’s failure to report the (b) (6), (b) (3) sexual abuse concerns was not in compliance with Unity policy or Federal statute.

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ER/LR specialist (b) (6) reviewed the ER/LR packet submitted by Capt. Ruff, and on 3/7/17, (b) (6) sent an email to (b) (6) expressing concern that he had reviewed information that included allegations of sexual abuse. (b) (6) noted the information he reviewed, if found to be true, constituted a “criminal offense” in Oklahoma. There was no evidence (b) (6) made a report of possible (b) (6), (b) (6) sexual abuse to any (b) (6), (b) (6) abuse investigative authority.

Unity Healing Center policy (Organizational & Professional ethics, Implementation Date 12/89, Latest Revision: 10/04, 1/05, 2/05, 8/05, 3/06, 7/06, 1/07, 10/09, References: JCAHO R.1.8) provided guidance on interactions with (b) (6), (b) (3) (A). This policy specifically addressed issues related to physical contact and remaining visible to others. This particular policy also advised it was the responsibility of the employee to “always” err on the side of caution with respect to words and behavior. (b) (6) signed a copy of this policy on 3/11/16 indicating he was in receipt of the policy and had reviewed the policy.) Despite this policy (b) (6) altered his behavior and normal work patterns to place himself in close proximity to (b) (6), (b) (3) (A) (b) (6), (b) (3) (A). (b) (6) was unwilling and/or unable to adjust his behavior to (b) (6), (b) (3) (A). At a minimum (b) (6) repeatedly violated Unity policy.

Unity Healing Center policy (Organizational & Professional ethics, Implementation Date 12/89, Latest Revision: 10/04, 1/05, 2/05, 8/05, 3/06, 7/06, 1/07, 10/09, References: JCAHO R.1.8) specifically addressed physical contact with (b) (6), (b) (3) (A) and provided guidance to staff with respect to engaging in physical contact with (b) (6), (b) (3) (A). This same policy also provided instruction for staff to remain visible to others at all times. During her interview for this review, Tracey Grant reported she viewed (b) (6) enter (b) (6), (b) (3) (A) room where he stayed for 30 seconds to one minute; however, Ms. Grant determined (b) (6) did not have time to do anything sexual to (b) (6), (b) (3) (A). Ms. Grant was aware (b) (6) was in violation of agency policy, but there was no documentation Ms. Grant addressed the issue with (b) (6). There was also no evidence Ms. Grant apprised Capt. Ruff of the issue.

Unity Healing Center policy (Documentation, Implementation Date 10/89m Latest Revision: 10/04, 1/05, 5/07, 3/12, References: (b) (6), (b) (3) (A) Records Committee, JCAHO Consolidated Standards Manual 2001-2002) noted progress notes were to be made by staff using the electronic charting system on the particular date the service was provided. Late entries could be made no later than 3 days and should be titled as a late entry. Progress notes were to be dated, timed, and signed by the individual making the entry when the note was completed.

(b) (3) (A), (b) (6)

Even though there was specific policy related to the reporting of (b) (6), (b) (6) abuse concerns and clinical documentation, there was no policy identified with respect to video monitoring or surveillance at the time of the review. Interviews with staff members and review of records revealed at least 2 separate interactions (b) (6) had with (b) (6), (b) (3) (A) that were captured on video surveillance. Tracey Grant and Cynthia

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Slee acknowledged reviewing a video of (b) (6) interacting with (b) (6), (b) (3) (A) after an SSA (b) (6) reported he observed (b) (6) had engaged in inappropriate contact with (b) (6), (b) (3) (A). There was no formal documentation Ms. Grant or Ms. Slee accessed the video footage for purposes of this type of review and no documentation of what they noted as a result of the review. There was no formal documentation or process related to who had the authority to engage in this type of video review, and there was no mechanism to document the manner in which such a review was to occur.

Allen Bollinger (Facilities Engineer) reported he was at Unity in (b) (6) 2016 supervising a work project. A few days after he returned to Nashville, Mr. Bollinger reported he received a phone call from Capt. Ruff who questioned him about (b) (6) behavior on the day he (Mr. Bollinger) was at Unity. Mr. Bollinger reported that after his conversation with Capt. Ruff he took it upon himself to access and review video footage recorded on the day he had been at Unity. Mr. Bollinger reported that Tracey Grant also accompanied him as he reviewed the video. Mr. Bollinger reported that the video showed (b) (6) going into (b) (6), (b) (3) (A) alone with (b) (6), (b) (3) (A) for approximately 5 minutes. Mr. Bollinger reported he made copies of the video and gave a copy to Capt. Ruff and (b) (6). There was no policy that authorized Mr. Bollinger to access and review the video surveillance, make copies of the video footage, or distribute the video footage to others. Mr. Bollinger specifically reported he was acting on his own volition. There was no formal documentation of Mr. Bollinger's actions and no documentation of what he observed on the video.

IHS policy Section (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) Rights & Responsibilities & Grievance Procedures) listed the (b) (6), (b) (3) (A) (b) (6), (b) (3) (A). The video footage was viewed and disseminated by Mr. Bollinger. Mr. Bollinger specifically reported he was acting on his own when he viewed and disseminated the video footage. The absence of policy with regard to access and use of the video system was concerning. Mr. Bollinger failed to document his activities in any manner, he purportedly acted without the knowledge of the Unity CEO or anyone at the Nashville Area Office, and he ultimately disseminated copies of the video footage for which there is now no accounting. (b) (6), (b) (7)(C) reported that any external storage device in her custody was taken by investigative authorities when the OIG search warrant was executed, but the inventory provided by OIG does not list any external storage device from (b) (6), (b) (7)(C). Two USB drives were confiscated from (b) (6) per the OIG inventory document, but no USB was reported to be confiscated from (b) (6), (b) (7)(C). (b) (6) left his position at Unity prior to any inquiry about the thumb drive reportedly given to him by Mr. Bollinger. It is unclear if Mr. Bollinger's actions violated (b) (6), (b) (3) (A) rights given his role and access to the surveillance system but the absence of policy regarding video footage created a high-risk situation for the violation of patient privacy.

4. Detailed analysis of chain of command successes/failures that contributed to positive/negative outcomes

Evidence, noted during this review, highlighted numerous issues and failures in the chain of command. The chain of command appeared severely compromised long before (b) (6), (b) (3) (A) arrived at Unity. As noted elsewhere in the analysis, there were multiple staff conflicts and formal complaints being filed. Staff reported fearfulness with respect to bringing issues to the attention of supervisory staff, and multiple staff members reported that senior supervisory staff were effectively absent from Unity. Despite this chaotic environment, frontline staff made specific reports to supervisory staff that (b) (6) behavior with (b) (6), (b) (3) (A) was concerning. One such report from

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(b) (6), SSA, prompted Ms. Slee and Ms. Grant to review the video surveillance footage of (b) (6) interacting with (b) (6), (b) (3) (A) in a manner that they determined was inappropriate. Ms. Slee and Ms. Grant also reported they witnessed (b) (6) and (b) (6), (b) (3) (A) inside (b) (6), (b) (3) (A) alone together. There was no documentation Ms. Slee or Ms. Grant engaged (b) (6) supervisor (Capt. Ruff) about his behavior. Capt. Ruff has repeatedly stated she was simply in the dark about (b) (6) interactions with (b) (6), (b) (3) (A) until (b) (6), (b) (3) (A). It is possible Capt. Ruff was in the dark; however, if Capt. Ruff was not informed, then neither Ms. Slee nor Ms. Grant understood the “chain of command” need to inform or advise Capt. Ruff of the issue. Capt. Ruff also failed to effectively communicate expectations to staff regarding accountability.

Based on what Mr. Grant reported to senior staff (his chain of command), Ms. Slee and Ms. Grant became concerned enough to retrieve and review video surveillance in order to “see” for themselves what happened. Ms. Slee and Ms. Grant deemed it appropriate to initiate an “investigation” or “review” of (b) (6) behavior, and they viewed (b) (6) engaging in behavior clearly inconsistent with Unity policy. Although they were concerned about (b) (6) behavior, both Ms. Slee and Ms. Grant failed to document and/or report their activities to Capt. Ruff. Review of documentation suggested the culture and climate at Unity was such that this kind of activity was normal. During her interview, Ms. Slee opined that she frequently “had” to review video surveillance due to various allegations of staff misconduct, but there was no apparent involvement of senior management in Ms. Slee’s activity. It is reasonable to conclude at a minimum there was a lack of institutional control and appreciation for any chain of command at Unity.

A lack of communication between Capt. Ruff, Executive Director at Unity, and Dr. Claymore, Nashville Area Office Director of Field Operations, appeared to have also been an issue. There was no documentation of any communication between Capt. Ruff and Dr. Claymore about the situation involving (b) (6) behavior. (b) (6) had been restricted from the (b) (6), (b) (3) (A) building and was temporarily relocated elsewhere, yet there was no documentation Capt. Ruff communicated with Dr. Claymore about any of these issues or decisions. Capt. Ruff determined (b) (6) could not be in the (b) (6), (b) (3) (A) building nor on the property at Unity due to his inappropriate behavior. Capt. Ruff’s decision placed (b) (6) in a facility where other (b) (6), (b) (3) (A) were being served, and her decision created an increased financial burden for the agency related to (b) (6) travel expenses. Capt. Ruff made these decisions without the input nor the knowledge of her direct supervisor, Dr. Claymore. Allen Bollinger (Facilities Engineer) reported he had advised Capt. Ruff that Mashpee Service Unit needed assistance in anticipation of an upcoming survey, and it might be useful to send (b) (6) to Mashpee. Capt. Ruff executed the decision to send (b) (6) to Mashpee under the guise that Mashpee Service Unit needed (b) (6) assistance. Mashpee Service Unit may have benefited from (b) (6) assistance, but Capt. Ruff effectively circumvented the chain of command by failing to inform Dr. Claymore of the actual reason (b) (6) had been deployed to Mashpee.

The role of the Governing Board was somewhat unclear, but it appeared to be the mechanism through which the Nashville Area Office provided oversight of Unity. Not only did Unity staff fail to properly or accurately inform the Governing Board of salient issues, the Governing Board did not adequately follow through on oversight tasks when issues were reported. Of note, the Root Cause Analysis (RCA) activity was central to the “chain of command” question. To date, no staff has been able to describe who was responsible for the RCA, who participated in the RCA, what data was collected for the RCA, or who was responsible for management of the RCA process and

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the implementation of the RCA findings. The RCA document itself yielded few clues to any of these questions. At least 2 staff have reported the RCA was developed during a phone call between several Unity staff and staff from the Nashville Area Office. It was impossible to ignore that the RCA specifically identified issues with staff and (b) (6), (b) (3) (A). All Governing Board members interviewed have said there had been no information presented to the Governing Board that was concerning for sexual abuse. Yet, no person interviewed has been able to provide a description of what caused a “Root Cause Analysis Finding” of (b) (6), (b) (3) (A). No person interviewed has been able to explain what caused an ER/LR referral related to (b) (6) and the identified staff boundary issue. No person has been able to explain how the RCA was accepted as completed without further development of either of these action items. In retrospect, the significance of these action items is abundantly clear, but it was extraordinarily difficult to appreciate how more questions were not asked by the Governing Board at the time of the events in (b) (6) 2016. It was also extraordinarily difficult to appreciate how the Director of Field Operations had been so disconnected that no follow-up questions were asked. Dr. Claymore was a member of the Governing Board, but her role in the chain of command and the role of the Governing Board in the chain of command was vague at best.

Martha Ketcher, Nashville Area Office Director, was the highest link in the chain of command. As Director of the Nashville Area Office and as a member of the Governing Board, Ms. Ketcher had access to the RCA and knew it existed. Although there was no documented evidence, it is possible that Ms. Ketcher reviewed the RCA and failed to exercise any supervision, authority, or judgement to explore the thought processes that prevented her staff from asking additional questions about (b) (6), (b) (3) (A) or making a referral to ER/LR for staff boundary issues. In the absence of documentation, it is impossible to know if Ms. Ketcher simply failed to exercise due diligence to review the RCA, or if she reviewed the RCA and failed to appreciate the significance of what was reported in the RCA.

In spite of their reported fearfulness, Social Services Assistants were clearly reporting concerns within the confines of their chain of command structure. There was no formal documentation of the reports from the SSAs. (b) (6) Cynthia Slee, and Tracey Grant were all aware there was an issue with (b) (6) behavior toward (b) (6), (b) (3) (A). The scarcity of documentation prevented any meaningful analysis of how the “chain of command” managed the concerns reported to them. The lack of documentation provided evidence of a failed chain of command structure. It appeared no supervisor requested or considered it important to document or initiate any structured response to the reported concerns. The most logical conclusion based on reviews of documentation and interviews with staff is that no effective chain of command structure existed at Unity Healing Center. The absence of meaningful oversight from the Governing Board and the Nashville Area Office compounded the problem and created an environment devoid of leadership or guidance at Unity.

A January 2017 workload report from ER/LR specialist (b) (6) to Mark Skinner, Nashville Area Office Executive Officer, documented “...T Ruff placed (b) (6) on restriction from the main Unity facility [sic] and began investigation on possible inappropriate concerns with a (b) (6), (b) (3) (A) and began her investigation.” This is, arguably, language that should have triggered multiple levels of administrative alarms in the chain of command and should have resulted in intervention by the Nashville Area Office to provide guidance, explore the situation, ask questions, and ensure follow-up with respect to all aspects of Capt. Ruff’s “investigation.” This language alone

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should have, at minimum, resulted in consultation with senior management and a report to a (b) (6), (b) (7) (C) abuse investigative authority. Mr. Skinner indicated he had been responsible for supervision of the ER/LR process at the time of the events of (b) (6) 2016. There was no evidence Mr. Skinner reviewed or questioned any of the documentation provided to ER/LR specialists. The ER/LR case was opened in September 2016, but the ER/LR packet was not submitted until March 2017. There was no evidence of any supervisory involvement or scrutiny from Mr. Skinner or the ER/LR management structure with respect to the delay in referral to ER/LR and the submission of the packet to ER/LR for review. There was no evidence Mr. Skinner reviewed or questioned entries on the January workload report from (b) (6) which clearly stated Capt. Ruff initiated an investigation at Unity Healing Center on 9/28/16 into (b) (6), (b) (3) (A) Mr. Skinner's role as an Assistant Director at the Nashville Area Office and his supervisory role for ER/LR placed him in a position of having had access to information that suggested a significant problem at Unity and should have prompted him to act on such information.

Staff members assigned to the ER/LR process were clearly in possession of information they identified in March 2017 as concerning for (b) (6), (b) (3) (A), but there was no documentation that any action was taken. There was no evidence that any chain of command reviewed or questioned any information submitted to (b) (6) or (b) (6)

Finally, there is overwhelming evidence that multiple individuals on the Governing Board and at the Nashville Area Office were in possession of information that Capt. Ruff was investigating a concern of (b) (6) having an "inappropriate" relationship with a (b) (6), (b) (3) Poor documentation prevented determination of an actual date when the Governing Board and Nashville Area Office staff members became aware of the investigation at Unity, but documentation was identified which supported the finding that Governing Board and the Nashville Area Office were in possession of such information no later than January 2017.

An efficient chain of command enforces responsibility and accountability which is crucial to effective management. Although there were attempts to utilize the chain of command by some staff members, the disjointed culture prevalent at Unity Healing Center and the Nashville Area Office disrupted appropriate chain of command functioning and sacrificed the quality of care provided by the facility. The failure of the chain of command likewise placed (b) (6), (b) (3) (A), at risk for potential abuse.

5. Detailed analysis of personnel behavior and motivations related to compliance/lack of compliance with policy initiatives/reporting mandates

The simplest answer to the question of personnel behavior and motivations related to lack of compliance with policy initiative/reporting mandates is that the culture and systems at Unity were severely impaired. The focus of Unity staff was self-preservation both at deeply rooted personal levels and at performance levels. Staff conflict received more attention than the mission of the organization and the needs of the staff outweighed the needs of Unity residents.

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High numbers of complaints from staff, failures in timely documentation, poorly defined roles and boundaries, ineffective communication, lack of direction, lack of vision, and lack of self-monitoring/accountability for the agency and staff all contributed to the chaotic environment at Unity. Capt. Ruff's own statement that she was a victim of manipulation by the (b) (6), (b) (3) (A) and the Unity staff was a sobering indictment of her lack of capacity to have served in the role she occupied at Unity.

Capt. Ruff was by all accounts emotionally disengaged and unavailable. Capt. Ruff's problematic behavior was manifested in withdrawal, silence, inactivity and indifference allowing her disengagement to be easily ignored by the Nashville Area Office. Capt. Ruff appeared to lack the capacity to recognize her own problematic behavior. The geographical separation of Unity from a supervisory system was an ideal situation that allowed her to be completely absent. Unity staff was left with frustration and exasperation as they repeatedly experienced a lack of response, lack of vision, and lack of direction from Capt. Ruff.

Capt. Ruff appeared to lack any awareness of an internal locus of control. She perceived that things were happening to her and appeared to believe she had no power to influence her environment or experiences. Capt. Ruff's failure to assume responsibility for Unity was also a likely explanation for her failure to make a report of possible (b) (6), (b) (3) sexual abuse to the appropriate authorities. In short, Capt. Ruff did not make a report of possible (b) (6), (b) (3) abuse because no one told her to make a report.

Ms. Grant appeared to be a passive and conflict-avoidant leader who avoided holding staff accountable. Ms. Grant's passivity resulted in multiple staff experiencing conflict and ambiguity in their roles. Ms. Grant's failure to hold staff members accountable communicated a clear message that competent performance was neither necessary nor valued. There was an extreme lack of trust in the work environment which resulted in festering conflict and low morale. Ms. Grant often failed to hold employees accountable for conduct problems, poor performance, or failure to adhere to policy mandates. Ms. Grant's failure to make a report of possible (b) (6), (b) (3) sexual abuse likely reflected her inability to engage in any activity that might result in her being required to confront a difficult and uncomfortable situation. It was easier to simply succumb to denial.

Cynthia Slee, Supervisory Social Services Assistant, embodied a role that she had neither been trained for nor qualified to execute. It appeared Ms. Slee attempted to compensate for her lack of training, lack of knowledge, lack of skill, and lack of qualifications by assuming an authoritative role in which she focused on highlighting the errors or deficits of others in an attempt to create a perception of superiority. Ms. Slee appeared to perceive criticism as a personal attack, and she appeared to thrive on chaos and conflict. Ms. Slee's failure to make a report of possible (b) (6), (b) (3) sexual abuse appeared to be a result of her own determination that (b) (6) was an innocent bystander caught in the grasp of a (b) (6), (b) (3) (A). In brief, Ms. Slee viewed (b) (6), (b) (3) (A) as the problem, and she lacked the ability to consider any other perspective. It appeared Ms. Slee never considered a different perspective, e.g., that (b) (6), an adult, was responsible for his behavior and he exploited (b) (6), (b) (3) (A).

Senior management and the Governing Board failed to recognize or respond to the disengagement, passivity, chaos, and conflict at Unity. The lack of defined roles (i.e., who was ultimately responsible for review of the RCA and follow-up with respect to the RCA findings)

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within the Governing Board combined with a lack of focused attention on Unity by senior management at the Nashville Area Office left Unity isolated and vulnerable to the repercussions of Unity's impaired management. Failure to inquire about the nature of an ER/LR referral for "investigation on possible inappropriate concerns with a (b) (6), (b) (3) (A) rests with the Nashville Area Office and ER/LR management. Failure to inquire about a Root Cause Analysis Finding of (b) (6), (b) (3) (A) rested with the Governing Board and the Nashville Area Office. It appeared senior management and the Governing Board silently, collectively, and individually operated under the shared delusion that it was not their job to review data presented via the ER/LR process or the RCA authorized by the Governing Board. It appeared senior management at the Nashville Area Office failed to make a report of possible sexual abuse secondary to having abdicated responsibility for Unity Healing Center.

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Section VI

Summary of analysis of facts

This section of the review provided a detailed analysis of the dynamics within the institutional culture, policy/lack of policy, chain of command successes/failures, and personnel behavior and motivations related to compliance/lack of compliance with policy initiatives/reporting mandates that contributed to positive/negative outcomes. Review of facility policy, (b) (6), (b) (3) (A), facility documentation, emails, observations made at Unity Healing Center, and interviews revealed multiple concerns and areas which led to negative outcomes. The concerns listed in this analysis did not constitute an exhaustive list of deficient practices but were included to highlight significant, problematic areas which affected the safety and the care provided to the (b) (6), (b) (3) (A) at Unity Healing Center. The concerns involved staff on every level and were deeply woven into the culture at Unity Healing Center and the Nashville Area Office.

There is substantial evidence that Unity Healing Center was in disarray prior to the events of (b) (6), (b) (3) (A) 2016. It is important to note that there was no evidence of any malicious or intentional conspiracy to hide or conceal what was happening. On the contrary, the staff was documenting and communicating information, but the underlying system in which that occurred was so compromised that the effort was essentially futile. Review of documentation overwhelmingly contradicted speculation that Unity or IHS was engaged in a cover-up. Despite the multiple failures of management (corporate or individual), it would be a grave disservice to view the intervention or response from a punitive perspective. Personnel must be held accountable and considerations regarding appropriateness of employment in certain positions may be necessary, but a solely punitive response would likely jeopardize movement toward a healthy functioning system. Failure to acknowledge and address the underlying systemic issue will result in continued manifestation of the symptoms.

Many changes have taken place at the Nashville Area Office and at Unity Healing Center since September 2016. At present there is new management at the Nashville Area Office and at Unity Healing Center. Dr. Beverly Cotton (Nashville Area Office Director) and Joni Lyon (Executive Director at Unity Healing Center) have dramatically altered the environments at the Nashville Area Office and Unity Healing Center. Dr. Cotton has initiated reviews of processes and systems at the macro level, and Ms. Lyon has instituted new policy and a culture of accountability and vision at Unity.

Staff members employed at Unity in September 2016 who are currently employed at Unity reported dramatic improvements in the work environment that coincided with the arrival of new management at the Nashville Area Office and at Unity Healing Center. Challenges remain, but the commitment to transparency combined with an effort to identify and address underlying, and long-standing problems has been abundantly clear.

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Section VII

Summary of Interviews

(b) (6) (b) (6)

Interview date-12/11/19-Unity

(b) (6) reported he has been employed at Unity for approximately 13 years. (b) (6) stated his responsibilities did not involve direct contact or supervision of (b) (6), (b) (3) (A) (b) (6) described his orientation as “on-the-job training” with little or no formal orientation. (b) (6) reported that in 2009 (approximately) he participated in staff training related to management of aggressive behavior, verbal abuse from (b) (6), (b) (3) (A) and the phases (b) (6), (b) (3) (A) (b) (6) reported he was also provided with a policy manual and was required to provide signature documentation when new policies were reviewed.

(b) (6) reported he had recently participated in training related to reporting of (b) (6), (b) (3) (A) abuse concerns. (b) (6) reported it was his understanding that any concern of (b) (6), (b) (3) (A) abuse was to be reported to one’s immediate supervisor along with written documentation of what was observed to warrant a concern of (b) (6), (b) (3) (A) abuse.

When asked to describe what he recalled about the incident in (b) (6) 2016, (b) (6) reported he “wasn’t in the building.” (b) (6) reported he had observed (b) (6), (b) (3) (A) [REDACTED]

(b) (6) reported he had not been questioned about the situation involving (b) (6) (b) (6) denied having any other knowledge or information related to the incident in (b) (6) 2016.

(On 12/20/19, Allen Bollinger (Facilities Engineer) was interviewed and reported he gave (b) (6) a thumb drive containing video of (b) (6) going into (b) (6), (b) (3) (A) where he stayed with (b) (6), (b) (3) (A) for approximately 5 minutes. An effort to schedule (b) (6) was in process when (b) (6) (b) (6) at Unity (on 12/13/19) and was not available for additional questioning regarding the thumb drive.)

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(b) (6) -Management Assistant

Interview Date-12/11/19-Unity

(b) (6) reported she has been employed at Unity Healing Center for more than 20 years and had reported numerous concerns to local and upper management. (b) (6) explained there had been numerous concerns of staff being sexually involved with (b) (6), (b) (3) (A) and there had been little or no response from the Nashville Area Office. (b) (6) described allegations of sexual abuse of (b) (6) dating back to 1993 or 1994. When asked for specific information, (b) (6) stated, (b) (6) and started messing with one of the staff and now they are married.” (b) (6) identified the staff as (b) (6) (former (b) (6) (b) (6) stated she reported her information to the Director of UHC at the time, (b) (6)

(b) (6) reported another incident in 1996 involving a male (b) (6), (b) (3) (A) who (b) (6) (b) (6) identified the therapist as (b) (6) (b) (6) did not identify the (b) (6), (b) (3) (A) (b) (6) stated she reported her concerns about (b) (6) to (b) (6) who was the Director of UHC at that time.

(b) (6) also reported (b) (6) “had a woman” in the building, and Cynthia Slee took surveillance video of the incident from Unity and shared it with the woman’s father-in-law who then “took it to the church” where (b) (6) and the woman were members. (b) (6) stated this information was shared with the Director, Capt. Ruff, who “tried to take action but Nashville stepped in” to prevent action from being taken.

(b) (6) reported her responsibilities at Unity in 2016 involved management of medical records, business related work and various other administrative activities. (b) (6) reported management of the medical records was her primary function. (b) (6) explained she was responsible for making sure consent forms, assessments, discharge summaries, and treatment notes were properly maintained in the record. (b) (6) reported there were ongoing problems and “lots of missing documentation.” (b) (6) reported she frequently notified upper management of documentation problems. Per (b) (6) Clinical Director, (b) (6), took over management of the documentation issues to prevent (b) (6) from continuing to notify upper management of the problems. (b) (6) further explained that it was not uncommon for (b) (6) to direct her (b) (6) to “hide” charts when “Joint Commission” came to the facility. (b) (6) reported it was common practice for (b) (6) to “choose” charts for Joint Commission to review so she could choose only charts that were in proper order. (b) (6) reported (b) (6) locked problematic charts in a cabinet in her office and routinely directed (b) (6) (b) (6) and (b) (6), to remove the charts from her office so they could be stored in a shed to further conceal her wrongdoing. (b) (6) stated she discovered the charts and reported (b) (6) activities to the Acting Director, (b) (6) and (b) (6) instructed her (b) (6) “to just file them.”

(b) (6) reported Dr. Vickie Claymore was currently responsible for completing treatment summaries and was frequently out of compliance which resulted in Dr. Claymore “always rushing around to get it done for Joint Commission.”

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(b) (6) reported the work environment at Unity was “hostile,” and she (b) (6) was threatened by (b) (6) (b) (6) reported she filed complaints with the Equal Employment Opportunity (EEO) regarding (b) (6) . (b) (6) also reported she (b) (6) “caught” (b) (6) and (b) (6) “in the building after hours having sex.”

(b) (6) reported she did not know about the (b) (6), (b) (3) (A) in (b) (6) 2016 until Capt. Ruff presented the information at a Governing Board meeting. (b) (6) reported her recollection was that Capt. Ruff advised the Governing Board the (b) (6), (b) (3) (A) was “upset” when Capt. Ruff “made” (b) (6) . (b) (6) reported the (b) (6), (b) (3) (A) (b) (6) reported she also recalled that the (b) (6), (b) (3) (A) case manager, (b) (6) “had seen some inappropriate things.” (b) (6) reported she did not know what “inappropriate things” (b) (6) may have seen.

(b) (6) reported she was not questioned by any investigative authority about the incident, but she was aware investigators came to Unity and took (b) (6) phone and computer.

(b) (6) added, “He (b) (6) should never have been allowed around them.” When asked for an explanation, (b) (6) described that (b) (6) was previously employed at a local hospital but was forced to leave his job because of allegations he was sexually harassing women.

When asked about training activities, (b) (6) reported she had received virtually no training. (b) (6) said, “We’re always left out of training because we’re admin [administration].” (b) (6) reported she had participated in recent training because the new Nashville Area Office Director required everyone to “do the training.” Regarding making a report of (b) (6), (b) (3) abuse, (b) (6) said, “Used to we just reported to case managers, but now we are supposed to report to the police. But I would always report to the police. Now we just have written policy to do that.”

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(b) (6) (b) (6)

Interview date-12/11/19-Unity

(b) (6) reported he has been employed at Unity since May 2019. (b) (6) described he had training related to reporting of (b) (6), (b) (3) abuse concerns. (b) (6) reported it was his understanding they were required to report allegations of (b) (6), (b) (3) abuse to the OIG and local authorities. (b) (6) also described he had confidence in the management staff, and there was good communication in the facility. (b) (6) reported that in addition to training related to reporting of (b) (6), (b) (3) abuse concerns, he also had training related to conduct with the (b) (6), (b) (3) (A) and training on how to document in the (b) (6), (b) (3) (A) medical record.

(b) (6) reported he did not have any direct information related to the events of (b) (6) 2016.

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(b) (6) - (b) (6)

Interview date 12/11/19-Unity

(b) (6) has been employed at Unity for approximately 4 years. (b) (6) reported her initial orientation at Unity involved spending 1-2 days with her supervisor (Cynthia Slee) observing the day-to-day activities at Unity. (b) (6) reported she was provided with an employee handbook and a policy manual. (b) (6) reported she also received specific information related to relationships between staff and (b) (6), (b) (3) (A). (b) (6) recalled being told there was a “hands off” approach, and “intimate” contact with (b) (6), (b) (3) (A) was prohibited. (b) (6) described she was provided with specific information about “A-frame” hugs as the most appropriate manner for engaging with (b) (6).

(b) (6) reported when she was initially hired at Unity, the policy with respect to concerns of (b) (6), (b) (3) abuse was to report information to one’s direct supervisor or to the clinical director. (b) (6) reported the current policy at Unity with respect to reporting concerns of (b) (6), (b) (3) abuse was to make a report directly to the police department.

(b) (6), (b) (3) (A)

[REDACTED]

(b) (6) reported she and other staff were afraid to “go over Cynthia’s head” for fear of retaliation. When asked to describe what kind of retaliation she feared, (b) (6) reported she feared she would lose her job, and at the very least she would be denied time off or the schedule would suddenly be changed in a way that negatively affected her. (b) (6) reported the fear of retaliation from Ms. Slee was not limited to her experience but was true for other staff as well. (b) (6) reported she spoke to Ms. Slee about her (b) (6) concerns regarding (b) (6) and Ms. Slee responded by telling (b) (6) she (b) (6) just did not know (b) (6) because if

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(b) (6) knew (b) (6), she (b) (6) would know he would not do anything inappropriate with a (b) (6), (b) (3) (b) (6) advised there were conversations among staff, and most staff expressed they simply did not want to do anything to get on “Cynthia’s shit list.”

(b) (6) stated she reported directly to Ms. Slee, but the Chief Executive Officer, Tiara Ruff, was in charge but “not really.” When asked what she meant, (b) (6) reported the Clinical Director, Tracey Grant, and her supervisor, Cynthia Slee, were the people who “really ran things.”

(b) (6) reported Ms. Slee showed her a letter (b) (6), (b) (3) (A) wrote to (b) (6) (b) (6) recalled that the letter “seemed like a love letter.” (b) (6) reported she and other staff believed there was “more going on” and that the relationship (b) (6) had with (b) (6), (b) (3) (A) was more than just a personal relationship. (b) (6) reported Ms. Grant never spoke to her or questioned her about (b) (6) relationship with (b) (6), (b) (3) (A) (b) (6) reported she had not been contacted or questioned by any investigator regarding the events of (b) (6) 2016.

(b) (6) reported the work environment at Unity had changed dramatically in the last several months. Specifically, communication had improved, and there was confidence current management was committed to creating an environment where (b) (6), (b) (3) (A)

(b) (6) reported the SSAs did not participate in treatment team meetings and that Ms. Slee “goes to meetings and then gets with us at shift change if there is something we need to know.” (b) (6) reported there was also a notebook for shift notes so they could review notes or leave notes for the next shift.

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Joni Lyon-Chief Executive Officer at Unity Healing Center

Interview dates-11/19/19, 12/12/19, 3/10/20-Unity

Ms. Lyon has been employed at the Chief Executive Officer at Unity Healing Center since March 31st, 2019. Ms. Lyon reported she had been working with the Nashville Area Office to revise and update policies related to numerous practice and administrative tasks at Unity. Specifically, Ms. Lyon focused on drafting policies related to expectations with respect to reporting concerns of (b) (6), (b) (3) abuse as well as policies related to management of and access to the video surveillance system in use at Unity. Additionally, Ms. Lyon reported she had invested significant time and energy working with community partners to re-establish trust and effective working relationships. Ms. Lyon reported there were numerous community partners who discontinued referrals to Unity due to a loss of trust and a concern for the safety of residents in the care of Unity Healing Center.

Ms. Lyon reported she did not have any direct knowledge of the events that occurred at Unity in (b) (6) 2016; however, based on information she had received from staff comments and public reporting it was clear there were issues related to how concerns of (b) (6), (b) (3) abuse were to be handled. Additionally, Ms. Lyon reported there were deficits with respect to staff accountability, medical record documentation, and communication between staff members. Ms. Lyon had been working to address these issues as well. Ms. Lyon reported Unity had been severely understaffed due to low census. Unity does not currently have a therapist on staff, nor is there a clinical director on staff. Ms. Lyon has been actively interviewing applicants to create an environment in which therapeutic services could be offered more effectively, and Unity could once again market its services to benefit adolescents in Indian Country.

Ms. Lyon reported the current training for reporting of (b) (6), (b) (3) abuse concerns required staff members to report to the OIG hotline and tribal police.

Ms. Lyon expressed concern and frustration related to accessing the video surveillance system. Currently, Ms. Slee has access to the system. Ms. Lyon reported she has been in contact with the Nashville Area Office and a local vendor. Ms. Lyon was currently in the process of creating policy specific to the surveillance system.

Ms. Lyon reported she has taken action with respect to staff issues at Unity. The former Clinical Director, Tracey Grant, was no longer employed at Unity and numerous other staff members who were present at Unity in (b) (6) 2016 were no longer employed at the agency. Much of Ms. Lyon's time has been spent identifying new staff to replace vacant positions at Unity.

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(b) (6) -Administrative Officer

Interview date-12/11/19-Unity

(b) (6) reported she has been employed at Unity since April 2017. (b) (6) explained her current duties were to manage business related issues, purchasing and budgeting. (b) (6) reported she also made medical appointments for (b) (6), (b) (3) (A) and supervised housekeeping and kitchen staff. (b) (6) reported she provided supervision for (b) (6), (b) (6) and (b) (6) (Management Assistant). (b) (6) reported she was also listed as (b) (6) supervisor when she was initially hired. (b) (6) stressed she was listed as a supervisor for (b) (6), (b) (6) and (b) (6) when she was hired, but the Chief Executive Officer (Capt. Ruff) actually provided supervision of (b) (6), (b) (6) and (b) (6) when she (b) (6) first arrived.

(b) (6) reported her orientation was provided by Cynthia Slee and was “rushed.” (b) (6) received training on the point system utilized for the (b) (6), (b) (3) (A) as well as training on “(b) (6), (b) (3) (A),” first aid, and managing aggression. (b) (6) reported that when Dr. Cotton arrived, they received training on (b) (6), (b) (3) abuse and how to report allegations of (b) (6), (b) (3) abuse. (b) (6) reported that in August 2019 they received new policy on reporting allegations of (b) (6), (b) (3) abuse. Specifically, allegations of (b) (6), (b) (3) abuse were to be reported to the CEO, IHS hotline, and Cherokee Indian Police.

(b) (6) reported (b) (6) was on leave when she was first hired at Unity, but she was aware of some of the issues related to what happened in (b) (6) 2016 although she did not have specific information. (b) (6) reported she did not know who made the decision for (b) (6) to return to Unity, but the transition was “not smooth.” (b) (6) stated she did not know who supervised (b) (6) when he returned. (b) (6) reported things changed dramatically when the Acting CEO (b) (6) arrived at Unity. (b) (6) reported she was assigned to actively supervise (b) (6) when (b) (6) arrived; however, (b) (6) routinely told (b) (6) he reported directly to the CEO, and he simply bypassed (b) (6). (b) (6) reported (b) (6) also “acted like Cynthia was his supervisor.”

(b) (6) reported that within her first year of employment, (b) (6) was put on leave, but she did not know the nature of why he was put on leave. (b) (6) reported (b) (6) was taken off leave in May 2018 and returned to Unity. (b) (6) reported (b) (6) left, and (b) (6) was the Acting CEO when (b) (6) returned to Unity.

(b) (6) reported she actively supervised (b) (6) when he returned in May 2018. In March 2019, (b) (6) completed (b) (6) evaluation (PMAP). (b) (6) was displeased with his PMAP (b) (6) and resigned his position in March 2019.

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(b) (6) - (b) (6)

Interview date-12/12/19-Unity

(b) (6) reported he has been employed at Unity since September 2017. (b) (6) described he was trained by Cynthia Slee. (b) (6) reported he received training on “(b) (6), (b) (3) (A) [redacted],” and he was provided with an orientation manual. (b) (6) reported there had been no training on reporting of (b) (6), (b) (3) abuse concerns when he first arrived, but there had been training in recent months about how to report allegations of (b) (6), (b) (3) abuse. (b) (6) reported it was his understanding (b) (6), (b) (3) abuse concerns were to be reported to his immediate supervisor, the police department, and the OIG.

(b) (6) reported he was shown how to enter notes in the computer, and the expectation was that notes should be entered before the end of a shift. (b) (6) reported he did not participate in the treatment team meetings. Per (b) (6) it was Ms. Slee’s responsibility to communicate treatment team information to the SSAs. Ms. Slee was also responsible for relaying information from the SSAs to the treatment team.

Regarding the video surveillance system, (b) (6) reported it was his understanding that Ms. Slee and Ms. Lyon had access to the surveillance system, and Ms. Slee was responsible for “looking at video if there was a problem.”

(b) (6) reported he was not aware of any issues at Unity until approximately two months after he became employed at Unity when he read a newspaper report about it. (b) (6) reported that after the newspaper report he was told it was not appropriate to be alone with (b) (6), (b) (3) (A). (b) (6) reported he had no information related to the (b) (6) 2016 incident other than what he read in the newspaper.

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(b) (6) (b) (6)

Interview Date-12/12/19-Unity

(b) (6) reported he has been employed at Unity since 2014. When asked to describe his orientation process, (b) (6) reported he was given a tour of the building, a personnel manual and “put to work.” (b) (6) reported he received no training related to reporting of (b) (6), (b) (3) abuse until “earlier this year.” (b) (6) reported the training he received earlier this year instructed staff on how to recognize (b) (6), (b) (3) abuse and to report to HHS, OIG, and to an immediate supervisor. When asked what he would do if a (b) (6), (b) (3) reported an episode concerning for abuse, (b) (6) reported he would ask the (b) (6), (b) (3) to tell him what happened in their own words. He would then ask them if they were hurt, who abused them, when it happened, and how long the abuse had been going on.

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

When asked if he ever witnessed any staff engaged in any inappropriate behavior with (b) (6), (b) (3) (A) (b) (6) said, “(b) (6), (b) (3) (A) (b) (6) said, “(b) (6) (b) (6) reported he had known (b) (6) for a long time, and he was aware (b) (6) had done some things to women at the hospital where he (b) (6) previously worked, but he had never done anything to a (b) (6), (b) (3)

(b) (6), (b) (3) (A)

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(b) (6), (b) (3) (A)

(b) (6) reported he was also told by “IG [OIG]” (b) (6), (b) (3) (A)

(b) (6) expressed other concerns related to his perceptions of fiscal mismanagement at Unity and his concern that (b) (6) was being unfairly targeted by other staff at Unity.

When asked about his participation on the treatment team, (b) (6) reported he shared and received information through Ms. Slee and had no direct involvement in the treatment team.

(b) (6) reported there was no real accountability for staff until Ms. Lyon arrived. (b) (6) reported things had changed dramatically since Ms. Lyon arrived, and there was better communication and staff “listen” to management now.

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Allen Bollinger-Facilities Engineer

Interview date-12/20/19-Nashville Area Office

Mr. Bollinger reported he has been employed by IHS since 2001. Mr. Bollinger reported he was at Unity Healing Center in the fall of 2016 to oversee and evaluate work related to recent resident bathroom renovations as well as work related to a “retro contract/subcontractor.” (Mr. Bollinger indicated he could not remember the date of his trip to Unity in the fall of 2016.) Mr. Bollinger identified several other staff also present at the facility on the day he was there including (b) (6) (b) (6) Tiara Ruff, and Cynthia Slee.

Mr. Bollinger reported he was downstairs when (b) (6) approached him and advised he ((b) (6)) had been informed by a (b) (6), (b) (3) (A) ((b) (6), (b) (3) (A)) that (b) (6) was shocked when (b) (6) touched a light switch in the newly renovated bathroom. Mr. Bollinger described that he and (b) (6) went in the bathroom, and the (b) (6), (b) (3) (A) followed them. Mr. Bollinger assessed the situation and determined there was no hazard related to the switch, and the (b) (6), (b) (3) (A) likely experienced a shock secondary to static electricity. Mr. Bollinger stated he noted something “abnormal” with respect to (b) (6) interaction with the (b) (6), (b) (3) (A). When asked to describe what he thought was “abnormal,” Mr. Bollinger reported that the (b) (6), (b) (3) (A) kept “looping” (b) (6) arm through (b) (6), and (b) (6) and the (b) (6), (b) (3) (A) were “pinching” each other. Mr. Bollinger noted that (b) (6) was not doing anything to discourage or stop the (b) (6), (b) (3) (A) behavior. Mr. Bollinger stated he was concerned enough about the behavior he witnessed that he reported the information to Cynthia Slee and Tiara Ruff. Ms. Slee reportedly advised Mr. Bollinger that (b) (6) had been advised to stop engaging in such behavior with the (b) (6), (b) (3) (A). Mr. Bollinger reported he returned to Nashville with no other thoughts about the situation.

Mr. Bollinger reported it was a few days later, possibly a week (Mr. Bollinger stated he did not know exactly how much later it was) when Capt. Ruff contacted him by phone and advised him the (b) (6), (b) (3) (A) because of something that happened the day Mr. Bollinger had been at Unity. Capt. Ruff reportedly asked Mr. Bollinger what exactly happened that day. Mr. Bollinger indicated he provided Ms. Ruff with the same information noted above.

Mr. Bollinger reported he returned to Unity Healing Center several days later to continue oversight of the contract work being done at Unity. Per Mr. Bollinger, he took it upon himself to review video footage from the day in question when the (b) (6), (b) (3) (A) reported a potential problem with the light switch to (b) (6). Mr. Bollinger reported he retrieved archived video from the surveillance camera system in the server room downstairs. Mr. Bollinger reported he logged into the machine using his name and password. Mr. Bollinger reported that as he was reviewing the video, Tracey Grant walked in and reviewed video surveillance with him. Mr. Bollinger described that he and Ms. Grant observed (b) (6) on the recorded video as he went into the (b) (6), (b) (3) (A). The interior of the (b) (6), (b) (3) (A) were not visible on the video. Mr. Bollinger reported (b) (6) and the (b) (6), (b) (3) (A) for approximately 5 minutes. Mr. Bollinger reported (b) (6) could be seen exiting (b) (6), (b) (3) (A) grabbing his arm and attempting to “drag” him back in (b) (6), (b) (3) (A). (b) (6) eventually exited (b) (6), (b) (3) (A) completely and was observed on video as he walked downstairs to get Mr.

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Bollinger. Mr. Bollinger reported the video also captured him as he and (b) (6) went in (b) (6), (b) (3) (A), and the (b) (6), (b) (3) (A) followed them. Mr. Bollinger reported it was approximately one minute that he, (b) (6) and the (b) (6), (b) (3) (A).

Mr. Bollinger reported he made two copies of the video footage which he stored on 2 USB drives. Mr. Bollinger reported he gave one of the USB drives to Capt. Ruff, and he gave the second USB drive to (b) (6) “for a spare.” According to Mr. Bollinger, the video system automatically stored data for 30 days. Mr. Bollinger reported he was not aware of any mechanism by which the video footage would have been stored permanently on any system. Mr. Bollinger further stated he had since “looked around” at Unity for the USB drives and could not locate either of the drives. Additionally, Mr. Bollinger stated that Capt. Ruff advised him that the USB drive he had given her was confiscated by law enforcement when the search warrant was executed.

Mr. Bollinger expressed concern that staff were not properly trained on how to manage the type of behaviors exhibited by (b) (6), (b) (3) (A). When asked to say more, Mr. Bollinger explained that on one occasion Tracey Grant advised him that the (b) (6), (b) (3) (A) Ms. Grant reportedly advised Mr. Bollinger he needed to be careful because the (b) (6), (b) (3) (A) “knows how to manipulate men.” Mr. Bollinger expressed concern that (b) (6) was in a difficult position given the nature of (b) (6), (b) (3) (A) behavior.

Mr. Bollinger reported he ultimately became aware Capt. Ruff acted to restrict (b) (6) access to the (b) (6), (b) (3) (A) areas at Unity. Mr. Bollinger stated he was aware of a need for assistance at a facility in Mashpee, MA, so he made a recommendation to Capt. Ruff for (b) (6), (b) (3) (A).

Mr. Bollinger reported he received an email from (b) (6) requesting a statement from Mr. Bollinger regarding the events that occurred on the day (b) (6) went in the (b) (6), (b) (3) (A) to check on the light switch. Mr. Bollinger provided (b) (6) with an email describing Mr. Bollinger’s recollection of events.

Mr. Bollinger reported he had no additional information regarding the situation at Unity.

When asked if he had participated in any training with respect to the reporting of (b) (6), (b) (3) (A) abuse concerns, Mr. Bollinger reported he had participated in some “recent training” on (b) (6), (b) (3) (A), and the basic message was that if you “see something say something.” Mr. Bollinger reported it was his understanding he was to “go to the CEO” if he had a suspicion of (b) (6), (b) (3) (A) abuse.

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Tiara Ruff-Public Health Analyst-Former Chief Executive Officer at Unity Healing Center

Interview dates-12/20/19, 1/13/20, 2/7/20-Nashville Area Office

Capt. Ruff reported she has been employed with IHS since 1988 in a variety of roles. Capt. Ruff reported she had participated in numerous training activities within IHS as well as training “on my own.” Capt. Ruff described she received (b) (6), (b) (3) abuse specific training in her role as a Commission Core Officer and in her doctoral program. Additionally, Capt. Ruff had participated in (b) (6), (b) (3) abuse training activities in ongoing training required for maintenance of her nursing license. Capt. Ruff reported her current understanding was that any concern of (b) (6), (b) (3) abuse should be reported to a (b) (6), (b) (3) physician, a direct supervisor, the Nashville Area Office CMO ((b) (6)) or to the “whole team” which Capt. Ruff identified as the Office of Public Health.

With respect to the issues concerning Unity Healing Center, Capt. Ruff reported she could not recall specific dates but that she submitted a “timeline” of events “in a whole package” to the Nashville Area Office in March 2017. Capt. Ruff reported she was on (b) (6) at the time of (b) (6), (b) (3) (A) . Capt. Ruff reported it was her understanding Allen Bollinger was on site at Unity inspecting work completed at the facility, and then Mr. Bollinger determined he (Mr. Bollinger) wanted (b) (6) to be deployed to Mashpee to help with the accreditation survey.

When asked specifically about (b) (6) behavior with (b) (6), (b) (3) (A) Capt. Ruff reported she observed that (b) (6), (b) (3) (A) was “hanging all over him,” and (b) (6) was “insistent” that (b) (6) was (b) (6), (b) (3) (A) best friend and “needed” to see him daily. Capt. Ruff reported (b) (6) was “calling” and “helping work with kids overseeing tribal community center where they would go shoot archery.” Capt. Ruff reported, “(b) (6) was always grabbing his arm and others observed it as well.” Capt. Ruff reported the Unity Clinical Supervisor, Tracey Grant was “trying to help him learn appropriate boundaries” referring to (b) (6) .

Capt. Ruff reported she eventually told (b) (6) he could not be in the building because it was “interfering” with (b) (6), (b) (3) (A) . Capt. Ruff reported, “(b) (6), (b) (3) (A) ” Capt. Ruff reported that even after she told (b) (6) he could not be in the building, there was an incident when (b) (6) was outside putting on solar panels, and (b) (6), (b) (3) (A) was “in a window trying to get his attention.” Capt. Ruff reported, “I sent him to Mashpee for a month. There was a video of (b) (6), (b) (3) (A) grabbing his arm and hanging on to him. They were not in (b) (6), (b) (3) (A) long enough.” Capt. Ruff reported she never viewed the video but was told by Ms. Grant there was not enough time for anything to have happened.

Capt. Ruff then reported there was an incident when a supervisor was reviewing video footage of an unrelated event and observed (b) (6) engaged in some inappropriate behavior with a non-Unity employee. The supervisor, Cynthia Slee, reportedly told Capt. Ruff she (Ms. Slee) was addressing the issue with her church. Capt., Ruff reported she told Ms. Slee that she (Capt. Ruff) trusted Ms. Slee’s judgment

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regarding how she handled the situation. Capt. Ruff reported she later learned Ms. Slee had shared images from the Unity video system with members of her church at which time she told Ms. Slee she (Capt. Ruff) would have to report the incident.

Capt. Ruff reported she had all the “processes and paperwork” in place and “submitted” in May 2017, but then the OIG “raided” the building in July or August.

When asked if Unity had any policy with respect to physical contact between staff and (b) (6), (b) (3) (A) Capt. Ruff responded, “There was [sic] no guidelines. There are now, I don’t know but I don’t think there were guidelines in place at the time of the incident.”

Capt. Ruff commented that when (b) (6), (b) (3) (A) questioned (b) (6), (b) (3) (A) (b) (6) said nothing happened and that (b) (6) was just (b) (6), best friend. Capt. Ruff reported she and Tracey Grant questioned (b) (6), and he “denied” and stated he would never do anything like that, but he could not help if people just liked him. When asked what was meant, by “never do anything like that,” Capt. Ruff responded, “You don’t understand. It wasn’t sexual, that’s all. He was just trying to be nice to (b) (6), (b) (3) (A).” When asked why (b) (6) would deny doing anything sexual if there was no concern of (b) (6) suspected or verbalized by staff, Capt. Ruff continued to repeat that it was difficult to understand.

When asked if she received any documentation from staff members about (b) (6) behavior, Capt. Ruff responded, “SSA staff were complaining to their supervisors and counselors that it was inappropriate, and he was not stopping it. He brought them beads. There would have been more complaints if there had been more to the story.” When asked what she meant, Capt. Ruff said, “I just think someone would have said something if more had been going on.” Capt. Ruff then referred to the teacher (b) (6) being “in the room.” When asked what she was referring to, Capt. Ruff said, “She (b) (6) was in the camera room. They were looking. Cynthia brought it to my attention doing an investigation of him and a woman. She went to the clinical supervisor and then to me.” When asked again what exactly she referred to, Capt. Ruff said, “(b) (6) and the woman.” When asked to recall when the incident she was referencing occurred, Capt. Ruff said, “In (b) (6) 2016, but I can’t remember for sure. Maybe later. Maybe (b) (6), or later part of that year.” Capt. Ruff was never able to provide any specific information about what incident she was describing. Capt. Ruff eventually said, “You can look it up. I had paper notes. OIG took them. They were trying to find me in a lie.” Capt. Ruff said, “There were incident reports. I had everything in March 2017, and nobody did anything.” Capt. Ruff reported she sent information electronically to ER/LR (b) (6). When asked what she sent ER/LR, Capt. Ruff said, “Him and (b) (6), (b) (3) (A). Him and the woman. ER/LR told us what to do.”

When asked about the video system and whether Mr. Bollinger provided her with a thumb drive, Capt. Ruff reported she, (b) (6), Tracey Grant, and Cynthia Slee had access to the video system using one master password. Capt. Ruff reported she did not recall whether there was any video, but if there was, OIG “took it.”

Capt. Ruff reported she never saw any of the written material reportedly found in (b) (6), (b) (3) (A) until OIG presented it to her.

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Regarding documentation, Capt. Ruff explained providers and nurses were expected to document within 24 hours, and SSAs were expected to document within 48 hours. Capt. Ruff reported that Tracey Grant was responsible for documentation issues.

When asked about the RCA, Capt. Ruff reported she recalled Tracey Grant, Cynthia Slee, and (b) (6) collected information at the request of Tracey Grant. Capt. Ruff reported she did not know who wrote the RCA document. Capt. Ruff reported she had never received any training on how to conduct the RCA, and the Governing Board told them to “just follow the instructions.” Capt. Ruff reported Tracey Grant was primarily responsible for the RCA and that she (Capt. Ruff) may have participated in a phone call related to the RCA. Capt. Ruff reported the Governing Board never specified exactly what they wanted.

Capt. Ruff advised that (b) (6) from ER/LR collected several statements from staff, and she (Capt. Ruff) was not privy to the information (b) (6) collected. Capt. Ruff also advised that the Office of the Inspector General (OIG) provided information to ER/LR as well, and she was also not privy to that information.

During her final interview on 2/7/20, Capt. Ruff was presented with specific written material including a copy of the ER/LR workload report, the RCA, and staff statements written by (b) (6) and Cynthia Slee. During this interview, Capt. Ruff reported there was an “investigation” into the allegations, and the investigation was conducted by Tracey Grant and (b) (6). Specifically, Capt. Ruff said, “You have to understand they were all out to get him. Not that I was trying to protect him, but we had to be sure if we were going to report something like that. Cynthia Slee and Dr. Claymore teamed up to get me. The staff and (b) (6), (b) (3) (A) manipulated me to get me to do what they wanted.” When asked how she supervised the investigative process conducted by Ms. Grant and (b) (6) Capt. Ruff indicated she simply allowed Ms. Grant to conduct the investigation.

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Dr. Beverly Cotton-Nashville Area Office Director

Interview Date-12/31/19-Nashville Area Office

Dr. Cotton reported she has been in her current position since January 2019. Dr. Cotton reported she first learned about the situation at Unity Healing Center shortly after she arrived as the Director. Dr. Cotton reported there was a Governing Board Meeting in January 2019 during which the Board reviewed a Corrective Action Plan required for Joint Commission. Per Dr. Cotton, Joint Commission made no finding related to the specific incident involving (b) (6), but there were other specific findings related to documentation issues. Dr. Cotton indicated she was obviously concerned about the documentation issues, but she was particularly concerned about the issues related to (b) (6). Dr. Cotton reported she called an Executive Team meeting to allow for a briefing on the situation and to create an action plan moving forward.

Dr. Cotton explained that as she began to ask questions and collect information, she was advised there was an issue with a (b) (6), (b) (3) (A) but there were never any specific allegations of (b) (6), (b) (3) sexual abuse. Dr. Cotton reported she was advised there was a (b) (6), (b) (3) (A) who had (b) (6). Dr. Cotton reported she began to ask questions about how the (b) (6), (b) (3) (A) was counselled, how issues with (b) (6) were addressed, and what specific policies were in place with respect to staff and (b) (6), (b) (3) (A) interactions. Dr. Cotton reported she became increasingly concerned based on some of the information she was provided. When asked to describe her concerns, Dr. Cotton reported she was advised there nothing concerning for sexual abuse, but that (b) (6) had placed himself in situations that were not appropriate. (b) (6) was reportedly alone in a bathroom with the (b) (6), (b) (3) (A) and was engaged in some type of physical contact with the (b) (6), (b) (3) (A) that was determined to be inappropriate but not sexual or concerning for sexual abuse. Dr. Cotton indicated she understood she was being advised there was nothing “sexual” about the relationship and she was aware IHS was in receipt of a (b) (6), (b) (5) (b) (6), (b) (3) (A), but her concern for sexual abuse was obviously triggered given (b) (6) behavior toward the (b) (6), (b) (3) (A) and his lack of adherence to agency policy.

Dr. Cotton reported she directed Dr. Vickie Claymore to create a timeline of events related to the situation involving (b) (6). Dr. Cotton reported she also contacted OIG and was advised there was no specific information that could be shared on whether OIG would take criminal action, but there was nothing related to the OIG investigation that prevented her from taking whatever action she deemed appropriate. Dr. Cotton reported (b) (6) resigned his position before the Nashville Area Office initiated any action.

Dr. Cotton discussed the complexities related to the prior internal and external investigation of (b) (6) conduct and the nature of taking additional action considering the (b) (5). Dr. Cotton indicated she was extremely concerned that (b) (6) was aware of Unity Healing Center and IHS policy with respect to being in a bathroom alone with a (b) (6), (b) (3) (A) yet he chose to put himself in that position. Dr. Cotton also expressed concern about the perception of Unity staff that the (b) (6), (b) (3) (A) was the problem. Dr. Cotton reported she was also concerned about the lack of investigation by management in place at Unity at the time of the incident in (b) (6). Dr. Cotton

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speculated it seem prudent that more questions should have been asked at every level including the Governing Board and the Nashville Area Office.

Dr. Cotton indicated she was concerned about the effect on the (b) (6), (b) (3) (A) as well as other (b) (6), (b) (3) (A). Dr. Cotton expressed concern that the tribes served by Unity Healing Center had lost confidence and trust in Unity due to a lack of transparency about the incident. Dr. Cotton indicated she requested review and analysis by an outside contractor to not only understand what happened at Unity, but to create policy guidelines to prevent a similar situation from occurring in the future. Dr. Cotton stated her primary concern was to create an environment where (b) (6), (b) (3) (A) could seek help, hope and healing. Dr. Cotton also indicated she was committed to creating an environment where staff members at every level could perform at a high level with integrity, transparency, and accountability.

Dr. Cotton reported the Nashville Area Office and the current Executive Director at Unity have created training and policy specific to reporting of (b) (6), (b) (3) (A) abuse allegations. Implementation of policy and training initiatives were ongoing. Dr. Cotton reported numerous staff changes had been effected at Unity with some staff being reassigned and some staff leaving government service.

When asked about personnel files, Dr. Cotton indicated she had been made aware that (b) (6) (ER/LR) was in possession of files related to Unity staff members. Dr. Cotton directed (b) (6) to make the ER/LR files available for this review.

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(b) (6) -Clinical Psychologist, Behavioral Health Consultant

Interview date-12/20/19-Nashville Area Office

(b) (6) reported she had limited memory and limited information regarding the situation that occurred at Unity Healing Center in (b) (6) 2016. (b) (6) had limited memory that she was asked to participate in a Root Cause Analysis related to a (b) (6), (b) (3) (A) by a (b) (6), (b) (3) (A) at Unity. (b) (6) recalled she was included on a phone call during which the Executive Director (Capt. Ruff) and the Clinical Director (Tracey Grant) were identified as the staff responsible for collecting the data necessary for the Root Cause Analysis.

(b) (6) reviewed her records and provided a copy of emails involving (b) (6), Dr. Claymore, Dr. Toedt, and Capt. Ruff. The emails reflected an effort to schedule a meeting to discuss an “RCA,” “security mitigation,” and “credential files.” (b) (6) advised she had no other information or reports related to events at Unity in (b) (6) 2016.

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Dr. Vickie Claymore-Health Systems Supervisor-Director of Field Operations.

Interview dates 12/31/19, 2/7/20-Nashville Area Office

Dr. Claymore reported she has been employed at the Nashville Area Office since 2015. Dr. Claymore indicated she was responsible for numerous programs including Micmac, Mashpee, Catawaba, Shinnacock, Lockport, Manlius, Richmond, and Unity. In addition, Dr. Claymore reported she was responsible for the Nashville Area Office Purchase and Referred Care and the Business Office.

Dr. Claymore was extremely knowledgeable with (b)(6), (b)(7)(C) abuse reporting mandates and the complex nature of determining jurisdiction for investigative authorities involving Indian Country, the Federal Government, local and state authorities. Dr. Claymore described current IHS policy that concerns of (b)(6), (b)(7)(C) abuse should be reported to the local (b)(6), (b)(3)(A) unit, tribal police, and the OIG hotline.

Dr. Claymore advised that she was a member of the Governing Board at Unity and was aware of an (b)(6), (b)(3)(A) at Unity in (b)(6) 2016. Dr. Claymore indicated that Capt. Ruff and the Clinical Director, Tracey Grant, were responsible for the RCA document authorized by the Governing Board. Dr. Claymore reported she participated in a phone call related to the RCA during which there was a (b)(6), (b)(3)(A)

When asked what kind of boundary issue was identified with (b)(6), Dr. Claymore indicated she did not know exactly, but was aware there was a (b)(6), (b)(3)(A) at Unity who was having (b)(6). Dr. Claymore had no memory of any formal presentation of the RCA findings. Dr. Claymore reported she did not engage Capt. Ruff in any formal discussion related to the RCA. Dr. Claymore reported she had no knowledge with respect to whether Capt. Ruff had any training on how to conduct and RCA.

When asked about formal supervision of Capt. Ruff, Dr. Claymore explained supervision and oversight of Unity was achieved through the Governing Board.

Dr. Claymore reported she created a timeline of events at the direction of Dr. Beverly Cotton, the current Nashville Area Office Director. Dr. Claymore indicated she used emails and other documents to create the timeline. Dr. Claymore indicated she would make the emails and other documentation available to the reviewer.

Dr. Claymore reported she was also assigned as the Deciding Official for the ER/LR referral on (b)(6). Dr. Claymore reported that prior to the ER/LR decision, IHS received (b)(6), (b)(5)

A second interview with Dr. Claymore focused on information related to the RCA document and the ER/LR referral. Dr. Claymore reported she could not describe the thought process related to the decision of the Governing Board (or as Capt. Ruff's direct supervisor)

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not to explore the issues related to staff boundary issues or trust issues identified on the RCA. Dr. Claymore explained the focus of the (b) (3) (A), (b) (6)

Dr. Claymore also had no explanation regarding what information was presented during the RCA phone call meeting that prompted the RCA committee to recommend a referral to ER/LR for (b) (6). Dr. Claymore repeated several times that the ER/LR referral was for “boundary issues.” Dr. Claymore could not describe what (b) (6) did or what behavior of (b) (6) caused the ER/LR referral. Dr. Claymore insisted there was no indication from Unity staff members that (b) (6) had engaged in behaviors concerning for sexual abuse.

Dr. Claymore reported it was not until much later that she became aware of the specific allegations of sexual abuse of (b) (6), (b) (3) (A) by (b) (6). Dr. Claymore reported she could not recall the exact date she reviewed information from the ER/LR file, but by the time she began to be aware of the specific nature of the issue, there (b) (5)

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Cynthia Slee-Supervisory Social Services Assistant

Interview date-1/6/20-Unity

Ms. Slee reported there have been numerous changes at Unity since Dr. Cotton was installed as the Nashville Area Director and since Joni Lyon was installed as the Executive Director at Unity Healing Center. Ms. Slee stated that in 2016 she was not familiar with any specific policy with respect to reporting allegations of (b) (6), (b) (3) (A) abuse, but the “practice” was for any staff who was concerned about possible (b) (6), (b) (3) (A) abuse should report that information to “a supervisor or therapist.” Ms. Slee stated there was no written policy to support the “practice” of reporting to a supervisor or therapist, but the direction was “verbal from Tracey Grant.” Ms. Slee reported the current policy was that all staff were “mandated reporters,” and the policy was to report to “local authorities” and to “OIG.”

Ms. Slee reported at least 3 other incidents of possible sexual misconduct involving staff at Unity. Ms. Slee identified (b) (6) as a staff member who had a sexual relationship with a (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) in early 1992. (b) (6) reportedly picked (b) (6) up after (b) (6) discharge and married (b) (6) approximately one month later. Ms. Slee also identified (b) (6) being “caught” in his office “masturbating” while viewing “(b) (6), (b) (3) (A) pornography.” Ms. Slee reported a 1991 incident involving Unity staff member (b) (6) who reportedly sexually abused a (b) (6), (b) (3) (A) identified as (b) (6) (unsure of spelling of last name).

Regarding the incident involving (b) (6), (b) (3) (A) in (b) (6) 2016, Ms. Slee reported there was a treatment team meeting in (b) (6) 2016 when (b) (6) reported information from an SSA (b) (6) about (b) (6) failing to redirect the advances of (b) (6), (b) (3) (A). Specifically, (b) (6), (b) (3) (A) was reported to be overly “touchy/feely” with male staff. Apart from (b) (6) male staff acted appropriately with respect to addressing (b) (6), (b) (3) (A) behavior. Mr. Grant reportedly described a specific incident involving (b) (6) returning from Arizona and began showing (b) (6), (b) (3) (A) pictures on his phone from his trip. (b) (6), (b) (3) (A) reportedly “grabbed” (b) (6) phone. (b) (6) did not immediately retrieve the phone. (b) (6) entered (b) (6), (b) (3) (A), and (b) (6), (b) (3) (A) followed him. (b) (6) stayed in the room with (b) (6), (b) (3) (A) for approximately 1 minute or less. Ms. Slee reported the Clinical Director instructed her to review video tape of the incident. Ms. Slee and Ms. Grant reviewed the tape together according to Ms. Slee and determined there was not sufficient time for (b) (6) to have done anything inappropriate to (b) (6), (b) (3) (A). Ms. Slee reported she and Ms. Grant noted (b) (6) was “poking” (b) (6), (b) (3) (A) near (b) (6), (b) (3) (A) (b) (6) but it was not contact that appeared sexual in nature. Ms. Slee reported the CEO (Capt. Ruff) was not on site, so Ms. Grant talked to (b) (6), (b) (3) (A) who reportedly denied that (b) (6) had done anything sexual or inappropriate.

Ms. Slee reported (b) (6), (b) (3) (A) had expressed concerns because (b) (6), (b) (3) (A) had made statements that (b) (6) and (b) (6) had a “secret language” using numbers to communicate that they were boyfriend and girlfriend. Ms. Slee stated she recalled seeing (b) (6), (b) (3) (A) communicate with (b) (6) using one, two, or three fingers, and three fingers meant they were boyfriend and girlfriend. Per Ms. Slee, she was advised by Ms. Grant to “get with (b) (6), (b) (3) (A) (b) (6) and “have a sit down” with (b) (6), (b) (3) (A). Ms. Slee reported that (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) “confirmed” that (b) (6) communicated with (b) (6), (b) (3) (A) via hand signals using numbers and that (b) (6), (b) (3) (A) had

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talked about “kissing” and “hugging.” Ms. Slee reported this information was “written up” and provided to Ms. Grant, and Ms. Grant determined, based on her review of the video with Ms. Slee, that there was insufficient time for (b) (6) to have done anything to

(b) (6), (b) (3) (A)

Ms. Slee reported the following day she was in (b) (6), (b) (3) (A) when (b) (6), (b) (3) (A) spilled a glass of water. Ms. Slee reacted by grabbing some papers in an attempt to keep them from getting wet. When (b) (6), (b) (3) (A) saw Ms. Slee holding the papers, (b) (6), (b) (3) (A) reacted with concern. Ms. Slee reported she looked down at the papers and noted the writing involved (b) (6), (b) (3) (A) making a reference to being in love. Ms. Slee reported she asked (b) (6), (b) (3) (A) if the letter was written to (b) (6), and (b) (6), (b) (3) (A) said it was written to her boyfriend. Ms. Slee reported she gave the letter to Ms. Grant. Ms. Slee stated Ms. Grant instructed her and (b) (6) to talk to (b) (6), (b) (3) (A). (b) (6), (b) (3) (A) reportedly denied that (b) (6) had done anything sexual or inappropriate. Ms. Slee reported she believed Ms. Weerts documented their conversation with (b) (6), (b) (3) (A)

Ms. Slee reported she then learned that (b) (6), (b) (3) (A) told (b) (6), (b) (3) (A) was upset about being “accused” of “such a thing” with (b) (6) and, as a result, (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) was taken to the (b) (6), (b) (3) (A) where (b) (6), (b) (3) (A)

Ms. Slee reported that Tracey Grant determined someone needed to “work” with (b) (6) to assist him with developing skills to more effectively address the interactions with (b) (6), (b) (3) (A). Ms. Grant reportedly identified (b) (6) as the most appropriate person to intervene with (b) (6). Ms. Slee added that (b) (6) had been put in a difficult situation because he had been engaged to “monitor” the (b) (6), (b) (3) (A) when he did not have the necessary training for that specific task. Per Ms. Slee, after (b) (6), (b) (3) (A) it was determined it was “not a good plan,” and a decision was made to “tell” (b) (6) to “stay away from the building.”

Ms. Slee reported (b) (6), (b) (3) (A), so Allen Bollinger “talked to Ti” (Capt. Ruff), and they arranged for (b) (6), (b) (3) (A)

Ms. Slee reported she was questioned by OIG sometime in 2017. Ms. Slee reported she had not been questioned by any other person, and there had been no request for her to document any of the events associated with the 2016 incident. Ms. Slee stated she had never been invited to participate in a Root Cause Analysis related to the (b) (6), (b) (3) (A).

(b) (6), (b) (3) (A)

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When asked again if she had ever created any documentation related to the events of (b) (6) 2016, Ms. Slee stated she had not created any documentation. When asked again if she had participated in a Root Cause Analysis related to the events of (b) (6) 2016, Ms. Slee stated she had not been invited to participate in a Root Cause Analysis in (b) (6) 2016. When presented with documentation signed by her, Ms. Slee verified it was her signature and stated she had no memory of creating either document.

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Tracey Grant-Former Clinical Director

Interview date-1/6/20 (phone interview per Ms. Grant's request)

Ms. Grant reported her first awareness of "(b) (6)" between "(b) (6)" and "(b) (6), (b) (3) (A)" was in "(b) (6)" 2016 after she returned from an "Archaeological Symposium" and was advised by "(b) (6)" of an incident between "(b) (6)" and "(b) (6), (b) (3) (A)". Ms. Grant reported she and Cynthia Slee reviewed video of the incident ("(b) (6)" showing "(b) (6), (b) (3) (A)" pictures on his phone) "several times," and both agreed there were "(b) (6)" with "(b) (6)". Ms. Grant characterized the content she viewed on the video as "just carrying on like kids." Ms. Grant stated, "I saw behavior that needed to be corrected through supervision." Ms. Grant reported that Tiara Ruff was out of the office, but upon her return she (Ms. Grant) notified Capt. Ruff. Ms. Grant reported she provided Capt. Ruff with a "time stamp" of the video along with her (Ms. Grant) recommendation for "(b) (6)" to work with "(b) (6)", because Ms. Grant believed "(b) (6)" was "good at teaching boundaries." Ms. Grant stated when she spoke to "(b) (6)" "a few days later," he and "(b) (6)" scheduled an appointment to meet the following Monday.

Ms. Grant stated "(b) (6), (b) (5), (b) (3) (A)". "(b) (6)" was "very friendly" and, due to "staffing issues," she (Ms. Grant) asked "(b) (6)" to be involved in working with the "(b) (6), (b) (3) (A)" on archery, because he was skilled in archery. Ms. Grant reported there were also times when "(b) (6)" was enlisted to be "on the floor" with "(b) (6), (b) (3) (A)".

Ms. Grant reported that on Friday "(b) (6)/16" she was called away for a "(b) (6)" emergency. Ms. Grant recalled that she was in transit the following day when she received a call from Unity staff. She was advised that "(b) (6)" and Ms. Slee, "(b) (6), (b) (3) (A)"

When asked about her participation in the Root Cause Analysis, Ms. Grant stated there was a Governing Board Meeting a few days after the "(b) (6), (b) (3) (A)" and Dr. Toedt suggested a Root Cause Analysis might be helpful. Ms. Grant reported there was "brief" conversation at the Governing Board Meeting regarding "(b) (6)" because the primary focus was on the "(b) (6), (b) (3) (A)". Ms. Grant reported she, Tiara Ruff, Dr. Claymore, Cynthia Slee, and Dr. Toedt were assigned to work on the Root Cause Analysis. Ms. Grant reported the focus of the Root Cause Analysis was the "(b) (6), (b) (3) (A)" because there was no concern or allegation of sexual abuse. Ms. Grant could not recall specific information related to how information for the RCA was collected, or how the RCA document was ultimately created. Ms. Grant indicated she did not recall creating the document.

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When asked if there had been any prior concerns of inappropriate sexual behavior by Unity staff, Ms. Grant reported there was an incident in 2008 or 2009 involving a (b) (3) (A) staff member and a (b) (6), (b) (3) (A) Ms. Grant stated, “But I was not admin [administration] during that time.” Ms. Grant reported there was also in incident involving 2 staff members who were viewing pornography on facility computers, but it was not (b) (6), (b) (3) pornography, and the staff were ultimately terminated for use of computers that was not consistent with guidelines.

When asked specifically if she had ever directed staff to create documentation related to any of the events in (b) (6) 2016 related to (b) (6), (b) (3) (A) Ms. Grant specifically stated she did not instruct staff to create any documentation. When advised such documentation existed, Ms. Grant stated, “I don’t recall asking for staff to create those memos.”

When asked if she had been made aware of any other video, Ms. Grant stated the video observed when (b) (6) returned from Phoenix was the only video she reviewed. When asked if she had received any verbal or written account of (b) (6) touching (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) hugging (b) (6), (b) (3) (A) kissing (b) (6), (b) (3) (A) or of (b) (6) being in a bathroom alone with (b) (6), (b) (3) (A) Ms. Grant specifically denied she had ever been informed verbally or in writing of (b) (6) touching (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) hugging (b) (6), (b) (3) (A) kissing (b) (6), (b) (3) (A) or of (b) (6) being in a bathroom alone with (b) (6), (b) (3) (A) Ms. Grant stated specifically that my (reviewer) report to her of specific allegations of sexual abuse of (b) (6), (b) (3) (A) by (b) (6) was her first knowledge of any specific allegation. Ms. Grant further stated she had not been previously made aware of any video footage where (b) (6) was observed to be in a room with (b) (6), (b) (3) (A)

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(b) (6) (b) (6)

Interview date-1/7/20-at Unity

(b) (6) reported he was recently hired at Unity. Prior to employment at Unity, (b) (6) was employed at Job Corp. (b) (6) reported he has participated in orientation since being hired at Unity. (b) (6) struggled to recall specific information provided during his orientation. Ms. Baldwin stated he believed, that in the event of a concern of (b) (6), (b) (3) sexual abuse of a (b) (6), (b) (3) (A) the policy at Unity Healing Center required him to complete a form, collect statements from the alleged victim, interview potential witnesses, separate the alleged perpetrator from the (b) (6), (b) (3) (A) and then notify his supervisor of the situation. (b) (6) spontaneously stated he previously worked at Job Corp and was aware of numerous situations of inappropriate sexual behavior involving staff and clients at Job Corp. (b) (6) stated, "I was investigated 3 times myself." (b) (6) was not asked to explain the circumstances of the investigations he referenced. (The decision to defer questioning of (b) (6) regarding any prior investigation was made secondary to concerns regarding the scope of the administrative inquiry being conducted and the need to assess whether there was an existing process by which this information could be obtained. The current administrative inquiry was designed to examine systemic processes including whether there was a mechanism or structure whereby individuals could move between governmental agencies without effective scrutiny.)

(b) (6) reported he did not have any information related to the events of (b) (6), (b) (3) (A) 2016. (b) (6) reported he knew there was a newspaper article about something happening, but he had not really read the article.

(b) (6) reported he did not participate in treatment team meetings. (b) (6) reported he was not yet fully aware of how communication occurred with respect to the treatment team, but it was his understanding Ms. Slee would "let us know if there is anything we need to know."

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(b) (6) - (b) (6)

Interview date-1/7/20-Unity

(b) (6) has been employed at Unity since 2012. (b) (6) recalled that his orientation at Unity involved spending 3-4 days in the Butler building reading material and listening to information provided by various staff. (b) (6) described that he had also had numerous “mandatory trainings” over the years at Unity. Per (b) (6) there had been a recent focus on the process for reporting concerns of (b) (6), (b) (6) abuse.

With respect to the current work environment, (b) (6) expressed confidence that things “seem to be rolling in the right direction now,” and Unity was “getting more qualified staff in here.”

Regarding the events of (b) (6), (b) (3) (A) 2016, (b) (6) reported he was obviously aware of what happened, but the majority of his information came from what was reported in the newspaper. (b) (6) stated he did not have any first-hand knowledge of what happened or how the matter was handled internally. (b) (6) explained he worked the night shift, and he had avoided the “gossip and talking” that went on between staff. (b) (6) recalled he did remember arriving at work one day when federal agents were in the building. (b) (6) reported the agents were professional and pleasant in his interactions with them. (b) (6) reported he was not questioned by the agents, nor had he ever been questioned by anyone regarding the events that took place in (b) (6), (b) (3) (A) 2016.

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(b) (6) (b) (6)

Interview date-1/7/20-Unity

(b) (6) reported she has been employed at Unity since April 2019. (b) (6) reported she participated in an employee orientation program at the Nashville Area Office in November 2019. (b) (6) described the orientation as informative and very helpful. (b) (6) reported the orientation included information with respect to the process for making a report of (b) (6), (b) (3) abuse, as well as “tribe information” or “TFP.” (b) (6) reported she had also since received training on issues related to media communication and medical record documentation.

(b) (6) explained she had noticed a significant change with respect to the working environment over the last few months. (b) (6) stated the environment was “stressful,” and there seemed to be “lots of drama” when she was first hired. (b) (6) reported that since her orientation there had been a dramatic improvement in the work environment. (b) (6) explained there had been several staffing changes which resulted in a decrease in “drama” and an increase in confidence in upper management. (b) (6) also explained there was a “sense” or “belief” the agency was headed in a “positive” direction, and there was excitement and energy among the staff that Unity could once again become a place where (b) (6) in Indian Country could find healing.

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(b) (6) (b) (6)

Interview date-1/7/20-Unity

(b) (6) has been employed at Unity since July 2019. (b) (6) reported she served as an SSA but was also responsible for “medication,” “nursing education,” and “infection control.” (b) (6) reported her orientation and training included online training with respect to reporting of (b) (6), (b) (6) abuse concerns. (b) (6) had “on-the-job training” with respect to processes related to documentation in the medical record and her role within the treatment team.

(b) (6) described the work-place environment as “good and improving.” (b) (6) expressed confidence in current management staff, and she indicated she was excited to participate in a program that offered hope to (b) (6) and families.

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(b) (6) (b) (6)

Interview date-1/08/20-at Unity

(b) (6) has been employed at Unity since December 2019. (b) (6) reported she was currently in the process of employee training and orientation. (b) (6) described she had received training on appropriate relationships and interactions with (b) (6), (b) (3) (A) including interactions involving physical contact with (b) (6), (b) (3) (A). (b) (6) reported she had also received training on issues related to reporting concerns of (b) (6), (b) (3) (A) abuse/neglect.

(b) (6) reported she did not have any information related to the events in question that occurred at Unity Healing Center in (b) (6), (b) (3) (A) 2016.

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(b) (6) ER/LR Specialist

Interview Date-1/13/20-Nashville Area Office

(b) (6) reported she has been employed at the Nashville Area Office since April 2017. (b) (6) reported she had no first-hand knowledge of the events that unfolded at Unity in (b) (6), (b) (3) (A) 2016, but she did receive numerous phone calls and records related to Unity Healing Center. (b) (6) reported she requested outstanding ER/LR files from ER/LR specialist (b) (6) on or around 2/22/19. In April 2019, (b) (6) received a box of files from ER/LR specialist (b) (6). (b) (6) absorbed the ER/LR caseload from (b) (6) when (b) (6) left her position. (b) (6) reported she stored the files in her office secondary to anticipating a need for the files, given the nature of the situation at Unity Healing Center. (b) (6) indicated she did not review the files. Per (b) (6), she received a request for (b) (6) file from Dr. Claymore on or around 5/20/19. No other personnel had requested or reviewed the files until the request for the files related to this current review.

(b) (6) explained that since she has been at the Nashville Area Office, she had received more EEO (Equal Employment Opportunity) complaints from Unity Healing Center than from any other facility. (b) (6) reported she was in receipt of complaints related to (b) (6)

(b) (6) reported she experienced frequent phone calls from Tracey Grant at Unity. Ms. Grant reportedly advised (b) (6) that employees at Unity were not in compliance, and she had lots of problems with her employees. (b) (6) reported she provided specific counsel to Ms. Grant, but Ms. Grant failed to implement the recommendations made to her. (b) (6) reported she travelled to Unity in December 2018, and virtually every employee at Unity wanted to meet with her to discuss concerns related to the (b) (6). (b) (6) explained the ER/LR role was designed to provide guidance and advice to supervisory staff only. Supervisory staff was then responsible for implementing recommendations.

(b) (6) reported that once a disciplinary action was taken with respect to an employee, there would be documentation of the action in the EOPF (Employee Office Personnel File). The documentation of disciplinary action remained in the EOPF file for two years. If there were no other actions taken the documentation would be removed from the file and no longer available for use in employment related decisions. (b) (6) indicated there were exceptions, but generally the system was designed to prevent adverse actions from following an employee from one position to another position. The rule was not designed to hide employees with problematic behaviors or prevent accountability but was designed to ensure fair treatment for employees.

(b) (6) explained that local supervisors were responsible for the creation and maintenance of information in personnel files related to training and minor disciplinary actions. HHS (Health and Human Services) maintained a learning portal (LMS) where employees could

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access training materials. Employees were responsible for completing training, printing a completion of training certificate, and then providing the certificate to their immediate supervisor to demonstrate the training was completed.

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Mark Skinner-Nashville Area Office Executive Officer

Interview Date-1/15/20-At Nashville Area Office

Mr. Skinner reported he was the acting supervisor for ER/LR staff in September 2016. Mr. Skinner explained ER/LR complaints and activities were recorded on “ER/LR logs” and “workload reports.” The logs and reports were housed on an HR (Human Resources) shared drive where they could be accessed only by HR staff. Mr. Skinner indicated he had no recollection of the information documented on the ER/LR logs or workload reports related to the disciplinary action involving (b) (6)

For purposes of the current review, Mr. Skinner indicated he would submit the necessary information to the appropriate individuals to retrieve and release copies of the September 2016 and subsequent ER/LR logs and workload reports.

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Dr. Finke-Senior Advisor for Improvement and Innovation, IHS Office of Quality Senior Advisor, CMS Innovation Center Learning and Diffusion Group-Former Acting Director Nashville Area Office

Interview Date-1/15/20-by phone

Dr. Finke indicated he was the Acting Director for the Nashville Area Office in 2018 when the decision was made for (b) (6) to return to work. Dr. Finke reported he was also active on the Governing Board in September 2016 when the Unity Executive Director, Capt. Ruff, advised (b) (6), (b) (3) (A). Dr. Finke reported he could not recall many details given how much time has elapsed since September 2016. Dr. Finke reported the Governing Board was never advised of any specific concerns or allegations of sexual abuse of a Unity (b) (6), (b) (3) (A) by (b) (6).

Dr. Finke indicated he could not recall the specific details related to the Root Cause Analysis conducted in (b) (6), (b) (3) (A) 2016. Dr. Finke reported that the Nashville Area Office was obviously concerned when a referral of sexual abuse was made and that all actions were put on hold once there was a criminal investigation. Dr. Finke reported IHS was advised by their legal counsel (b) (6), (b) (5)

Dr. Finke reported he was never aware of any documents that described specific allegations of sexual abuse nor was he aware of any investigation conducted by Capt. Ruff.

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Dr. Toedt-Assistant Surgeon General, USPHS Chief Medical Officer Indian Health Service-Former Chief Medical Officer, Nashville Area Office

Interview Date-1/21/20-by phone

Dr. Toedt reported he was the Chief Medical Officer for the Nashville Area Office of IHS in September 2016. Dr. Toedt reported the Governing Board was made aware of the (b) (6), (b) (3) (A) in (b) (6) 2016, but the Board was never advised of any specific allegations of sexual abuse of the (b) (6), (b) (3) (A) by (b) (6). Dr. Toedt indicated there was no question the Board would have taken measures to intervene immediately had there been specific information presented that was concerning for sexual abuse.

Dr. Toedt reported the RCA evaluated issues specific to the reported (b) (6), (b) (3) (A). Dr. Toedt reported he could not recall information related to what information was collected for the RCA or how the information was collected. Dr. Toedt reported he believed Capt. Ruff was responsible for writing up the RCA findings, but he could not recall specifically who was responsible for creating the RCA document. Dr. Toedt reported he recalled some language related to (b) (6), but nothing that was deemed concerning for sexual abuse. Dr. Toedt reported he was unaware there was any documentation that specifically described allegations of sexual contact of the (b) (6), (b) (3) (A) by (b) (6).

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SECTION VIII

Root Causes

The following discussion examines the micro dynamics within the institutional culture to identify essential root causes and recommended remediation to address the root causes.

Root Cause Analysis Finding	Root Causes	Recommended Remediation
Boundary violation by staff member	Inability/refusal to alter behavior	<ol style="list-style-type: none">1. Initial training on the importance of boundaries with (b) (6), (b) (3) (A).2. Trauma informed care training.3. Zero tolerance for lack of respect for boundaries.

1. Boundary violation by staff member

Root Causes

(b) (6) either had no control over his behavior, or he was unwilling to alter his behavior. Per his own statement, (b) (6) suggested he had no control over his behavior. This is the most dangerous condition. An employee who cannot control their reaction to a (b) (6), (b) (3) (A) behavior or verbal statement cannot be employed in a setting where services are being provided to (b) (6), (b) (3) (A) especially to (b) (6), (b) (3) (A) who may have emotional, cognitive, mental health, and/or development impairments. All staff must have confidence that colleagues are in control of their behavior. The foundation of a decision to place a (b) (6), (b) (3) (A) in the care and control of another rests on the premise that one has the ability to control their own behavior. If that premise is false or known to be in question, then there is no option for that individual to be employed with vulnerable populations who are, by status or condition, without control or power. If a staff member verbalizes or demonstrates an inability or refusal to control basic physical actions (involving any kind of touch or physical isolation of another, verbal or written behavior), then there is simply no option for that individual to be employed in an environment where vulnerable populations are being served. There is no legitimate argument to the contrary, and this should be non-negotiable.

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Recommended Remediation

1. **Training on the importance of respectfulness of boundaries. (Covered below in “Failure to recognize the high-risk interaction of (b) (6), (b) (3) (A))**
2. **Training on Trauma Informed Care. (Covered below in “Failure to create a (b) (6), (b) (3) (A) consistent with (b) (6), (b) (3) (A) to meet (b) (6), (b) (3) (A)**
3. **Zero tolerance for lack of respect for boundaries.**

Many problematic behaviors can be addressed with corrective action plans. Even violation of policies with respect to boundaries and respectfulness of (b) (6), (b) (3) (A) physical and emotional space require training and guidance. It is quite plausible that an employee could innocently violate a physical or emotional boundary. The problem and the place where zero tolerance must be employed is the moment when that employee is advised they have engaged in an action/behavior which is inappropriate and must be altered. If said employee is unwilling or unable to alter their behavior, then that employee simply cannot be employed with a vulnerable population. If an employee cannot give that type of basic counsel and instruction serious and immediate attention in the form of awareness and responsiveness, then it is a clear signal of danger. If employees cannot or will not exemplify trustworthiness with a small and simple responsibility, then they cannot be trusted with important and sacred responsibilities. It really is that simple.

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
Failure to report (b) (6), (b) (3) (A) [Redacted] [Redacted]	See below.	See below.

(b) (6), (b) (3) (A) [Redacted]

[Redacted]

[Redacted]

[Redacted]

(b) (6), (b) (3) (A), (b)

[Redacted text block]

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
Staff Conflict	Ineffective and/or absent leadership, lack of vision, and lack of oversight/loss of institutional control.	<ol style="list-style-type: none"> 1. Ongoing, meaningful evaluation of CEO to assess competence and performance. 2. Identify quality indicators to measure specific outputs and outcomes and create dashboard so data can be accessed by supervisory staff and Governing Board. 3. Training for supervisory staff focused on identifying and managing staff conflict. 4. Training for supervisory staff on assessing the least drastic alternatives when considering staff intervention/discipline. 5. Training for supervisory staff to inform the process on how to initiate and complete an ER/LR referral. 6. Establish a mission statement to focus on the primary purpose and goal for the facility.

3. Staff Conflict.

Root Causes

The staff at Unity were hindered in their ability to provide a safe environment and appropriate care by the conflict prevalent among the staff at the facility. The individuals in supervisory roles (Capt. Ruff, Ms. Grant, and Ms. Slee) provided inadequate leadership to resolve staff issues which led to the escalation of a chaotic environment. Capt. Ruff believed the staff and residents were manipulating her. Ms. Slee filed a response to an ER/LR referral in relation to a separate matter alleging Ms. Grant was out to get (b) (6). Other staff believed (b) (6) was receiving favorable treatment. Still other staff reported (b) (6) and (b) (6) were involved in a sexual relationship. These are only a few of the underlying staff interactions and conflicts that were the focus of the staff. (b) (6), (b) (3) (A) were simply not the primary focus of care or energy for the Unity supervisory staff. Staff conflict was the primary lens through which (b) (6), (b) (3) (A) experiences, (b) (6), (b) (3) (A) needs, (b) (6), (b) (3) (A) successes, and (b) (6), (b) (3) (A) struggles were processed. Supervisory staff did not objectively evaluate staff behavior or performance. Reports of staff behavior (positive or negative) were often viewed from a perspective of whether the report was made under false pretense secondary to some personal motivation. The relationships between Capt. Ruff, Ms. Grant, and Ms. Slee were enmeshed and lacked trust and professionalism on the most basic level.

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There appeared to be no guiding principal or vision for the supervisory role of the leadership or daily work of the staff at Unity. The result was a loss of focus on important tasks, meaningful and intentional resident interactions, and treatment objectives and outcomes. Substance abuse and suicide are realities that disproportionately affect Native American (b) (6), (b) (3) (A) in the United States (Swaim & Stanley, 2018, Subica & Wu, 2018, Emerson, Moore, & Caetano, 2017). Ironically, the supervisory staff at Unity and at the Nashville Area Office exuded the powerlessness and hopelessness that so often fuel substance abuse and suicide. The system designed to address issues related to powerlessness and hopelessness had taken on those same dynamics. Help, hope, and healing are powerful messages, and Unity Healing Center must be a place where those messages are championed, embraced, internalized and communicated to the larger Native American Community. The ability to keep focus on the vision of help, hope, and healing will define effective leaders. Effective leaders will communicate this vision in every action. Effective leaders believe every person has value and is worthy of help, hope, and healing.

The Nashville Area Office and Governing Board appeared detached from the leaders, staff, and dysfunctional system at Unity. The Nashville Area Office and Governing Board abdicated their oversight and guidance (lack of oversight) of Unity contributing to and compounding the challenging dynamics which permeated the culture at Unity (lack of institutional control). The challenges of providing long-distance oversight of a facility are not insurmountable. Much like the supervisory staff at Unity, it appeared the Nashville Area Office had also fallen prey to the weight of challenging tasks. Identifying leadership who can produce effective strategies to measure success, create accountability, and empower staff to strive for excellence will generate an environment where success will become the norm.

Recommended Remediation

1. Ongoing, meaningful evaluation of CEO to assess competence and performance.

The Director of Field Operations should provide an ongoing, meaningful evaluation of the Chief Executive Officer (CEO) to assess competence and performance. The evaluation should be performed regularly (quarterly, annually etc.) and include formal and informal components. The formal component could be based on a pre-existing system of evaluation or developed to address the unique role of the CEO at Unity. The formal component should provide a benchmark for the Director of Field Operations to provide guidance and supervision to the CEO. The informal component would include regular telephone calls, teleconferencing, visits to the facility, etc. The informal component should help to provide an open system of communication and feedback as well as help to develop a stronger and healthier relationship between the Director of Field Operations and the CEO.

2. Identify quality indicators to measure specific outputs and outcomes and create a dashboard so data can be accessed by supervisory staff and Governing Board.

The facility should identify certain quality indicators (referrals for admission, census, training activities, documentation compliance, complaints by residents, complaints by staff, etc.) to measure specific outputs and outcomes. The facility should develop a dashboard to capture the data which could be accessed by supervisory staff and the Governing Board. Goals for each quality standard should be established, and the results of the data should be monitored regularly (monthly, quarterly, etc.). Quality indicators may be added as new

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concerns arise (transient indicators). An action plan or interventions should be developed for those indicators which fail to meet the goal. The quality indicators should continue to be monitored for established indicators and for a specific period of time with transient indicators even after the goal has been met to ensure the effectiveness of the plan or intervention.

3. Training for supervisory staff focused on identifying and managing staff conflict.

Supervisory staff should receive regular training on identifying and managing staff conflict. Any staff new to the role of supervisor (through hire or promotion) should receive this training prior to assuming their position. The training should provide specific strategies and resources supervisors can utilize to foster critical thinking skills, accountability, and self-evaluation among staff.

4. Training for supervisory staff on assessing the least drastic alternatives when considering staff intervention/discipline.

Supervisory staff should receive regular training on staff development to include assessing the least drastic alternatives to address performance or behavioral concerns. The training should provide supervisors with a decision tree to determine what levels of intervention are available, and how to assess the appropriate level of intervention to be deployed. The training should help supervisors to address staff concerns consistently and promote trust and confidence among staff that they will be treated fairly.

5. Training for supervisory staff to inform the process on how to initiate and complete an ER/LR referral.

Supervisory staff should receive regular training on the process of how to initiate and complete an ER/LR referral. The training should provide guidance on how to ensure the ER/LR referral is initiated, appropriate, and accurately completed in a timely manner. The training should help provide consistency in addressing significant disciplinary concerns as well as minimize the possibility of legal repercussions from mishandled disciplinary actions.

6. Establish a mission statement to focus on the primary purpose and goal for the facility.

The facility should establish a mission statement to focus on the primary purpose and goal of Unity Healing Center. If a mission statement exists, then the facility should retrain staff on the mission statement and how the provision of care, treatment of the residents, and the treatment of all staff underscores and reinforces the vision of the mission statement. The Chief Executive Officer will set the vision for the agency and provide supervisors and staff members with clear tasks designed to create movement toward the desired goals and outcomes for the residents. Supervisors will focus their efforts to engage staff members to access their best selves to work toward the desired goals and outcomes for the residents. High level and mid-level managers who are successful will seek to identify the strengths of staff members and inspire staff members to excel. High level and mid-level managers will also seek to create an environment where accountability results in encouragement to improve poor performance and recognition of exceptional performance. All staff will work with residents and other staff members to provide the highest quality of care in a safe and therapeutic environment.

Root Cause Analysis Finding	Root Causes	Recommended Remediation
Unwillingness of staff to acknowledge sexual abuse could occur in the facility	Lack of training and lack of clinical supervision	<ol style="list-style-type: none"> 1. Training for all staff on the dynamics of (b) (6), (b) (3) sexual abuse. 2. Ongoing clinical supervision for clinical staff to provide opportunity for clinical staff to explore interpersonal and intrapersonal experiences as they relate to provision of clinical services. 3. Ongoing group meetings with peers (peer review) for Social Services Assistants (SSAs) designed to allow for processing of experiences and observations.

4. Unwillingness of staff to acknowledge sexual abuse could occur in the facility.

Root Causes

The collective unwillingness of the staff to consider the possibility that (b) (6) was sexually abusing (b) (6), (b) (3) (A) was directly related to a lack of understanding of the dynamics of sexual abuse and the nature and behaviors of sex offenders as well as an inability to critically and objectively evaluate information and observations. Unity staff appeared to succumb to bias secondary to their relationship with (b) (6) and their belief that sexual abuse simply could not happen on their watch. A review of the personnel files and interviews with former and current staff revealed there had been historically a lack of training provided for staff concerning the dynamics of sexual abuse. The lack of training led to uninformed and inconsistent responses by staff to the possibility that sexual abuse could occur in the facility.

Clinical staff received inadequate clinical supervision which could have challenged misconceptions regarding sexual abuse and personal biases. Clinical supervision would have provided guidance to process clinical data and observations therapeutically and objectively. Social Services Assistants (SSAs) would not have participated in formal clinical supervision, nor did they have a functioning mechanism to reflect on and analyze their experiences with resident and staff interactions.

Recommended Remediation

1. Training for all staff on the dynamics of (b) (6), (b) (3) sexual abuse.

All staff should receive regular training on the dynamics of sexual abuse. The training should include at a minimum the components of prevention, identification, protection of the residents, investigation, and reporting of sexual abuse. Training on the dynamics of sexual abuse will provide an opportunity for staff to explore their own biases related to what sexual abuse “looks like” and how it can happen in a

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facility. Training on “investigation” of (b) (6), (b) (3) abuse will provide the staff with a frame of reference to understand the purpose and importance of external investigations. Training on investigations is not intended or designed to encourage or support investigative activity by Unity staff. Current sexual abuse training models focus heavily on the role of adult caretakers as the guardians of (b) (6), (b) (3) safety. The goal of trainings such as Darkness to Light (as well as others) now offered by most (b) (6), (b) (3) Advocacy Centers is to empower adults to embrace their role as protector and to learn skills that will allow adult caretakers to effectively recognize and respond when adults or older (b) (6), (b) (3) (A) are creating high risk situations for (b) (6), (b) (3) (A).

2. Ongoing clinical supervision for clinical staff to provide opportunity for clinical staff to explore interpersonal and intrapersonal experiences as they relate to provision of clinical services.

Clinical supervision will provide clinical providers with information on how to think critically and explore situations from multiple perspectives so that clinical decisions are made after careful thought and consideration of multiple options. Therapists and front-line providers are engaged in emotionally intense interactions with clients and remaining grounded is imperative. The emotionally charged nature of addressing psychological, behavioral, and emotional struggles can be overwhelming. Clinical supervision and peer review (addressed below) provide opportunity for providers to give and receive meaningful feedback. Dealing with the high intensity emotions of adolescents can become even more overwhelming when there is conflict in the work setting. Staff members at Unity were likely distracted by the ongoing peer to peer conflicts, and no one was aware of the dynamic of transference and countertransference that was taking place between staff or (b) (6), (b) (3) (A). Clinical supervision should be provided by a licensed professional and should occur on a regular schedule. Ongoing clinical supervision will provide clinical providers an opportunity to explore and challenge bias and lack of objectivity and will allow staff an opportunity to evaluate their own actions and behaviors through a lens of objective and compassionate scrutiny. Clinical supervision serves as an opportunity for providers to discuss therapeutic interventions, ethical issues, transference and countertransference, training, and other areas of practice.

3. Ongoing group meetings with peers (peer review) for Social Services Assistants (SSAs) designed to allow for processing of experiences and observations.

While peer review does not fit the professional definition of formal clinical supervision, it is a structure that will allow SSAs an opportunity to have meaningful participation in a process designed to increase their critical thinking skills. Regular peer review for Social Services Assistants is an ambitious recommendation; however, SSAs typically spend more time with residents than any other staff at the facility. SSAs cannot be considered babysitters for residents. SSAs observe and document resident behaviors, needs, moods, struggles, strengths, etc. Peer review would provide SSAs an opportunity to share experiences and give and receive feedback related to resident observations, interactions, and behaviors. Peer review could be utilized to provide SSAs with regular information on interventions with residents and how SSAs could actively participate in therapeutic interventions to achieve resident goals. Peer review would also allow an opportunity for SSAs to express concerns related to training needs, management techniques, performance evaluation measures, or other concerns.

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
Failure to recognize the (b) (6), (b) (3) (A) (b) (6) toward (b) (6), (b) (3) (A)	Ineffective/absent leadership, lack of training, and (b) (6), (b) (3) (b) (6) boundary violation	1. Guidance and training for supervisory staff to address concerns when staff behavior is inconsistent with policy and conduct expectations. 2. Training for all staff on issues related to physical contact with (b) (6), (b) (3) (A)

5. Failure to recognize the (b) (6), (b) (3) (A) of (b) (6) toward (b) (6), (b) (3) (A), (b) (3) (B), (b) (3) (C)

Root Causes

The ineffectiveness or absence of leadership at Unity helped to create an environment in which (b) (6) could act with impunity. (b) (6) (b) (6) took advantage of the void in leadership, either consciously or subconsciously, to violate (b) (6), (b) (3) (A) (b) (6), (b) (3) (A). The leadership at Unity assumed a position of powerlessness and failed to prevent the high-risk behaviors of (b) (6) or to protect (b) (6), (b) (3) (A) from exploitation.

Review of the personnel files, review of (b) (6), (b) (3) (A) and interviews with staff employed in September 2016, revealed there was little consistency in the training program and no documented training on maintaining appropriate (b) (6), (b) (3) (A) boundaries. Several staff witnessed (b) (6) violating (b) (6), (b) (3) (A) and witnessed his failure to redirect (b) (6), (b) (3) (A) (b) (6) but they failed to comprehend the seriousness of the (b) (6), (b) (3) (A) (b) (6) violated Unity policy about being alone with a (b) (6), (b) (3) (A) which was reportedly captured on video, but Tracey Grant, Cynthia Slee, and Allen Bollinger, who reviewed the video footage, failed to grasp the potential gravity of (b) (6) actions. Staff consistently demonstrated a lack of understanding and appreciation for the high-risk interaction of (b) (6) toward (b) (6), (b) (3) (A)

The issue of boundaries, physical space, and physical contact with (b) (6) is not limited to a simple matter of whether physical contact occurs. Respect for boundaries includes awareness of physical space and interactions but also an awareness of the responsibility of an (b) (6), (b) (3) (A) to alter their behavior to meet the needs of a (b) (6), (b) (3) (A). The question is not limited to whether an (b) (6), (b) (3) (A) “physically” touched a (b) (6), (b) (3) (A) on the arm or leg or any body part for that matter. It is more important to consider why the contact is taking place. What is the context and what has been the pattern of behavior? Is the contact initiated to meet the needs of the (b) (6), (b) (3) (A) or the needs of the (b) (6), (b) (3) (A) (b) (6) refused to alter

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his behavior to meet (b) (6), (b) (3) (A) needs. Whether his behavior was sexually motivated or not will likely remain a mystery. What was clear from the review was that (b) (6) acted to fulfill his needs rather than the needs of (b) (6), (b) (3) (A). Therein lies the root of the boundary problem. When this fact is understood, all other questions and answers become much clearer. There is no such thing as “non-sexual” physical contact for a sex offender. Touching of the hands, arms, shoulders, etc. are all designed to reduce resistance and desensitize the (b) (6), (b) (3) to touch. This behavior also desensitizes those who may observe the interaction. Once the (b) (6), (b) (3) and those observing are desensitized to this type of touching, a sex offender can move to more invasive touching (i.e. touching around or near the areas close to a (b) (6), (b) (3) (A) genital area or breasts and ultimately touching of genitalia, buttocks, or breasts). Ms. Slee literally described her observation as (b) (6) “(b) (6), (b) (3) (A) (b) (6), (b) (3) (A) When asked how that was not considered sexual in nature, Ms. Slee adamantly claimed he was just touching near (b) (6), (b) (3) (A) he was just “picking” at (b) (6), (b) (3) (A) and it was not sexual. Behavior that is simply an error or a lapse in judgement can be quickly corrected. Behaviors that are need driven from a personal perspective present a very different problem and will not be easily or quickly altered. Numerous staff reported that they specifically re-directed (b) (6) advised him to behave differently, and most importantly, modeled appropriate responses to (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) Despite all this, (b) (6) continued to violate (b) (6), (b) (3) (A) (b) (6) was noted by several staff as encouraging the behavior from (b) (6), (b) (3) (A) In his own written statement, (b) (6) defended himself by claiming he had no control over his behavior. (b) (6) wrote that he “did try” but just could not “make” (b) (6), (b) (3) (A) stop. (b) (6) believed that he had no control of his behavior and that a (b) (6), (b) (3) (A) was somehow making him behave in a certain way. It is this personality trait that cannot be tolerated in an environment where services are being provided to vulnerable (b) (6), (b) (3) (A) (b) (6) behavior was very clearly need driven from his own personal need which explains his failure to make the adjustment he was counseled to make. (b) (6) refused to alter his behavior, and supervisory staff failed to consider (b) (6) behavior from an informed perspective. Ultimately, supervisory staff and area office leadership at IHS failed to act on (b) (6), (b) (3) (A) behalf. Oversight of Unity appeared to be little more than pretense.

Recommended Remediation

1. Guidance and training for supervisory staff to address concerns when staff behavior is inconsistent with policy and conduct expectations.

Senior leadership on the Governing Board, the Nashville Area Office, and supervisory staff should receive regular training to include specific strategies for approaching employees, identifying specific expectations for conduct and behavior, and implementation of remedial actions to encourage compliance with policy and expectations. Employees who exhibit complete disregard for policies or direction from supervisory staff require immediate action and intervention. Training should include the creation of Corrective Action Plans as well as tools/templates to allow for documentation of issues and problematic behaviors. Training should also include the structured involvement of the chain of command, measurable tasks, and a timeline for completion of those tasks related to employee conduct and behavior.

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2. Training for all staff on issues related to physical contact with (b) (6), (b) (3) (A)

All staff should receive regular training on the importance of boundary recognition and intentionality with respect to boundaries. Training must include material on how sex offenders utilize seemingly innocent physical contact and boundary violations to groom victims. Training should include the awareness of one's own boundaries and recognizing violations of resident-resident and staff-resident boundaries. Training on boundary issues will also include a perspective that respect for boundaries involves more than just physical space. Understanding issues related to power and vulnerability and acknowledgement of the dignity of others are central concepts of boundary training. At a minimum, boundary training should include the following:

-Conduct/demeanor

Training should address the concepts and significance of appearance, body language, speech, and overall presentation of self. All client interactions are an opportunity to model appropriate behavior for a client.

-Favorable treatment or gift giving/receiving

It is appropriate to provide explanation that favorable treatment or gift giving/receiving are not appropriate in the treatment setting

-Physical contact

The most basic question is whether touch or physical contact meets the needs of the client or the caregiver. Physical contact in a therapeutic environment should have purpose and be intentional. Caregivers must understand that physical touch is experienced differently by different people. Open, transparent, and healthy conversations about physical contact are encouraged. Touch can be a powerful therapeutic tool. Touch can also be harmful. The concepts of thoughtfulness, intent, and self-control are central to conversations involving physical contact.

-Awareness/use of self/affective experience

Professionals employed in roles where they are caretakers must be aware of their own emotional responses to certain situations. Awareness of self will allow caregivers (regardless of role-therapist, administrative, environmental, facility, medical, etc.) to respond rather than react in highly charged emotional environments. Response is thoughtful and intentional whereas reaction is simply an emotional reflex that is often unhelpful and potentially abusive. This also includes sharing of personal information. Clients are not "friends" or bystanders with whom we interact. Caretakers must always be aware of the power differential in the relationship.

-Sexual/romantic relationships with clients

Sexual or romantic relationships with a client are simply never appropriate. As noted earlier, there is an inherent power differential in the relationship. It is not an equal playing field. Our clients must always be treated with dignity and respect. Sexual/romantic relationships in the context of an unequal power structure can never be truly consensual.

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
Lack of clinical supervision	The lack of clinical supervision is addressed as a root cause in the above finding of unwillingness of staff to acknowledge sexual abuse could occur in the facility.	Recommended remediations are also detailed in the same finding above.

6. Lack of Clinical Supervision.

Addressed above.

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Root Cause Analysis Findings	Root Causes	Recommended Remediation
(b) (6), (b) (3) (A) [Redacted]	(b) (6), (b) (3) (A) [Redacted]	1. Streamlining of pre-admission evaluation and treatment planning. 2. Develop or implement more effective evaluation tools. 3. Training on trauma informed care.

(b) (6), (b) (3) (A) [Redacted]

Root Causes

(b) (6), (b) (3) (A) [Redacted]
 [Redacted]
 [Redacted]
 [Redacted]
 [Redacted]
 [Redacted]
 [Redacted]
 [Redacted]
 [Redacted]
 [Redacted] (b) (6)
 [Redacted]
 [Redacted]
 [Redacted]
 [Redacted]

As noted above, there appeared to be very little attention to training efforts or opportunities. Trauma informed care has become the expected standard of care for (b) (6), (b) (3) (A) and (b) (6), (b) (3) (A). Although there is no current standardized definition of trauma informed care, it can be generally defined as an awareness of the effects of trauma and appropriate responses to individuals who are identified as having experienced trauma. (b) (6), (b) (3) (A) who are noted to be defiant may require a response that involves de-escalation rather than the threat of disciplinary action. (b) (6), (b) (3) (A) [Redacted]

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(b) (6), (b) (3) (A) Trauma informed responses require intentional thought and action. Every encounter with residents at Unity is a therapeutic encounter and opportunity. There is no “down time.” Review of Governing Board meeting notes revealed that Capt. Ruff mentioned a need for training on trauma informed care, but there was no evidence the staff was actively utilizing any of the core components of trauma informed care. It will be necessary for the Governing Board and senior staff at the Nashville Area Office to commit to the provision of trauma informed care. It will not be possible for Unity to move toward true trauma informed care without the support of the Governing Board and the Nashville Area Office.

Recommended Remediation

1. Streamlining of pre-admission evaluation and treatment planning.

(b) (6), (b) (3) (A)

[Redacted text block]

2. Develop or implement more effective evaluation tools.

(b) (6), (b) (3) (A)

[Redacted text block]

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3. Training on trauma informed care.

Given the prevalence of complex trauma and substance abuse in the Native American community, it is reasonable to consider a dual approach that includes treating not just the symptom (substance abuse) but the underlying issue of substance abuse which is often unresolved or unidentified trauma. Trauma survivors may resort to substances to cope with emotional distress. Training on and delivery of trauma informed care that informs all aspects of organizational functioning and service delivery will allow Unity to become a center of excellence in the treatment of substance abuse. Training should include trauma training for all staff, including administrative and support personnel. Training should allow providers to recognize the numerous, complex interactions between substance use and abuse and trauma. Review of policies and procedures to ensure that they reflect thoughtful understanding of trauma and the needs of trauma survivors is also recommended.

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
Lack of effective communication between the Treatment Team/clinical staff/supervisory staff and SSA staff	Lack of communication	1. Participation of SSAs in treatment team meetings.

8. Lack of effective communication between the Treatment Team/clinical staff, supervisory staff, and SSA staff.

Root Causes

Review of documentation and interviews with staff revealed SSAs did not participate in treatment team meetings, and there appeared to be a lack of communication between the SSAs and the treatment team. As mentioned above, the SSAs typically spend more time with residents than any other staff. SSAs can provide invaluable information and insights about a resident's emotional state, behaviors and daily interactions with other residents and staff. The treatment team can provide SSAs with guidance and information relevant to resident treatment goals as well as feedback from observations and interactions with the residents.

Recommended Remediation

1. Participation of SSAs in treatment team meetings.

SSAs should participate in treatment team meetings to foster communication between staff and provide continuity of care for the residents. The treatment team should provide meaningful sharing of assessment information and intervention goals with SSAs to inform their activities and interactions with residents. SSAs can provide information and insights to the treatment team concerning observations and interactions which would assist the treatment team with their assessment of how residents are progressing toward established goals and to identify any necessary revision of the treatment plan.

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
Lack of training on reporting concerns of (b) (6), (b) (3) sexual abuse/(b) (6), (b) (3) abuse for staff	Lack of training	<ol style="list-style-type: none"> 1. Training for all staff should include basic reporting information for (b) (6), (b) (3) abuse/neglect (b) (6), (b) (3) (A) sexual abuse. Development of a structured training curriculum for all relevant aspects of (b) (6), (b) (3) abuse. 2. Training for all staff on management of (b) (6), (b) (3) abuse allegations. 3. Development of specific informational sheets designed as a “quick reference” on a variety of topics including the process for reporting (b) (6), (b) (3) abuse concerns which would be easily accessible to all staff. 4. Advanced training for clinical staff to include the different types of sexual abuse and the complexities of addressing (b) (6), (b) (3) sexual abuse in Indian Country.

9. Lack of training on reporting concerns of (b) (6), (b) (3) sexual abuse (b) (6), (b) (3) (A) abuse for staff

Root Causes

The lack of organized training activities for Unity staff was particularly concerning. Unity policy regarding reporting of (b) (6), (b) (3) abuse concerns was consistent with Federal policy, but training/review related to the policy was almost non-existent. Review of the personnel files and interviews with staff revealed there had been no consistent educational program for staff members. There was no evidence of training for any aspect of sexual abuse for Unity staff. Senior management failed to outline expectations with respect to a training curriculum to meet even minimum standards of learning. In 2016 and 2017, the Nashville Area Office demonstrated little initiative to compel Unity staff to stay abreast of current standards of practice much less achieve excellence in service delivery.

Recommended Remediation

1. Training for all staff should include basic reporting information for (b) (6), (b) (3) abuse/neglect/(b) (6), (b) (3) sexual abuse. Development of a structured training curriculum for all relevant aspects of (b) (6), (b) (3) abuse.

New management at Unity and the Nashville Area Office has mandated recent training, but it is unlikely that a single training will be sufficient for staff to achieve subject matter competence. The facility should develop a structured training curriculum to include all relevant aspects of (b) (6), (b) (3) sexual abuse appropriate to the level of staff. At a minimum, trainings should be mandated for staff upon hire and regularly

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(e.g., annually) and include pre and post testing to assess learning and retention of information. Documentation of all training by staff should be maintained by Unity to ensure all staff receives mandatory training. Unity is responsible for maintaining documentation that all staff has received appropriate training and is informed about the appropriate response to allegations of (b) (6), (b) (7)(C) abuse.

All staff should receive regular training to include basic reporting information for (b) (6), (b) (7)(C) abuse/neglect/(b) (6), (b) (7)(C) sexual abuse. Staff should receive the training upon hire (before providing care for residents) and regularly (it is recommended the training be required for all staff annually and as needed). The training should inform staff on Unity's policy as well as legal requirements for reporting (b) (6), (b) (7)(C) sexual abuse. Regardless of the policy enacted by IHS there is still the potential for a report to be made anonymously. Many states have reporting laws that allow for an anonymous report to be made. (Department of Health and Human Services (HHS)/IHS will likely require legal review of any policy related to reporting of (b) (6), (b) (7)(C) abuse that includes the potential of an anonymous report.) A staff member may well utilize this option and bypass formal reporting policy and procedure. Training should include information on how to maintain documentation if a report is filed anonymously to demonstrate they have fulfilled the reporting requirements (i.e., retaining documentation submitted for the allegation which is dated and maintaining any information from the reporting system such as the number assigned, etc.).

2. Training for all staff on management of abuse allegations.

Allegations of abuse can involve a number of scenarios. Alleged perpetrators could be family members, peers, other residents, staff, family friends, etc. All staff should receive training on the management of abuse allegations regardless of the relationship of the alleged perpetrator. Staff should know how to respond appropriately and professionally to an allegation of abuse. Staff should first know how to protect the resident (alleged victim) as well as other residents from further potential abuse. Staff should know who they should notify and how to document their activities. The training should enable staff to respond appropriately to any allegation of (b) (6), (b) (7)(C) abuse, provide protection for the resident, and provide a clear and consistent response from all staff who are involved in the care of the resident. Training must also include basic information on management of allegations that involve a staff member or other situations that present a potentially immediate danger. Most allegations of abuse will not involve activities related to HHS or IHS programming. HHS/IHS staff will most often manage allegations reported to them that involve past abuse that occurred in a private setting. Training must also address management of these allegations and the subsequent mental health interventions and considerations needed secondary to these allegations.

3. Development of specific informational sheets designed as a “quick reference” on a variety of topics including the process for reporting (b) (6), (b) (7)(C) abuse concerns which would be easily accessible to all staff.

Information sheets which can be used as a quick reference guide by any staff can provide staff with a valuable tool to assist them during a time of crisis. These sheets can provide essential information quickly to staff and help them manage a difficult situation more competently. The sheets should be easily accessible, and staff should know how and where to access them.

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4. Advanced training for clinical staff to include the different types of sexual abuse and the complexities of addressing (b) (6), (b) (7) sexual abuse in Indian Country.

Clinical staff should receive advanced training in (b) (6), (b) (7) sexual abuse to include the different types of sexual abuse as well as the complexities of addressing (b) (6), (b) (7) sexual abuse in Indian Country. Sexual assault disproportionately affects Native Americans and requires special attention in the clinical setting. Clinicians must understand sexual assault in Indian Country as complex trauma that exists in a larger system of injustice and inequality. The complex nature of addressing sexual abuse in Indian Country is further complicated by the jurisdictional issues that begin immediately upon report of a suspected crime to an investigative agency. The goal of advanced training for clinicians and supervisors is not to achieve expertise knowledge, but to develop a broad understanding of the complex nature of sexual assault in Indian Country so that allegations can be managed effectively and properly.

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
Lack of a system for appropriate management of documentation	Ineffective/absent leadership, lack of training, ineffective documentation system, and lack of oversight/loss of institutional control	<ol style="list-style-type: none"> 1. Create and/or revise process for monitoring documentation for supervisory staff. 2. Provide regular training to all staff involved in the documentation process. 3. Evaluate current system of documentation or explore options for EMR to assess for opportunities for streamlining/improvement of process. 4. Adherence to documentation compliance should be identified as a quality indicator which is monitored regularly by supervisory staff and Governing Board.

10. Lack of a system for appropriate management of documentation

Root Causes

It appeared from review that Unity has already responded to a Corrective Action Plan related to a Joint Commission investigation to address documentation issues. No current resident records were evaluated during this review. The records reviewed from (b) (6), (b) (3) (A) 2016 reflected overwhelming deficits with respect to documentation. Multiple providers were entering documentation days, week, and months post resident encounter. Some documentation was either incomplete or missing. Senior management was aware of documentation issues and failed to initiate effective action to address the issue.

Staff reported they received some initial training, but documentation suggested staff failed to understand the expected structure for entry of progress notes, and there appeared to be no structure for entry of therapy notes. Documentation by staff was inconsistent and failed to capture information which would reflect the challenges and successes of (b) (6), (b) (3) (A). The documentation available for this review painted an incomplete and disjointed picture, and pertinent information surrounding the events from (b) (6) 2016, apparently was not documented. For example, there was no documentation found from Ms. Slee describing the events surrounding her discovery of the (b) (6), (b) (3) (A). There was no documentation found from Ms. Slee or (b) (6) related to the questioning of (b) (6), (b) (3) (A) by Ms. Slee and (b) (6). These details, as well as other vital information, are now lost or relegated to the mutable memories of the staff who were employed during these events.

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A significant number of the progress notes were signed days, weeks, or months after they were created. There appeared to be no functioning system of accountability for adherence to Unity policy regarding documentation requirements. Several of the documents reviewed concerning the events of (b) (6), (b) (3) (A) 2016, were typed on standard copy paper with no date or indication when the documentation was written. Multiple copies of the same (or similar) documentation were found with multiple dates. There was no way to verify when these documents were created, edited, or amended. Review of the Root Cause Analysis (RCA) (b) (6), (b) (3) (A)

There was no documented evidence of who was responsible for conducting the RCA, collecting the information, identifying the root causes, developing the action plan, or implementing the action plan. The documentation for (b) (6), (b) (3) (A) was inconsistent. The documentation related to the events of (b) (6), (b) (3) (A) 2016, was exceedingly disorganized, fragmented, and/or simply nonexistent.

The Governing Board is ultimately responsible for supervision/oversight of Unity Healing Center and for all activities that occur at the facility which includes documentation. The Governing Board should be aware of any concerns with the documentation process as well as interventions developed and implemented to address those concerns. The Governing Board should be aware of the challenges present at Unity and how the facility is progressing to meet those challenges. The Governing Board may rely on designated individuals to develop, implement, and monitor interventions, but the Governing Board should expect regular feedback from those individuals during their regular meetings.

Recommended Remediation

1. Create and/or revise process for monitoring documentation for supervisory staff.

Review of facility documentation and interviews revealed that Unity did have some monitoring system in place during September 2016; however, supervisory staff failed to utilize the system effectively to ensure accurate and complete documentation. Unity should either create a new system or revise the current system to ensure the accountability of staff documentation and supervisory staff monitoring. Supervisory staff should monitor documentation regularly and consistently and be held accountable for this process. For example, any staff who has delinquent documentation should be notified immediately and held responsible to the submission of a plan for compliance. Lack of compliance more than 3 times in a quarter would result in an automatic supervisory session to assess needs and barriers to timely completion of documentation. Supervisor and employee would then create a written plan for improvement signed by the employee and supervisory staff. The facility may analyze ways to utilize the current system or explore a new system which would assist with the monitoring process. Many EMR systems have monitoring systems built-in to flag for incomplete or missing documentation. It is important to stress, however, that no system relinquishes the responsibility of oversight for the supervisory staff. Specific individuals should be identified who are responsible for this task, and specific individuals should be designated to oversee the monitoring process to ensure compliance.

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2. Provide regular training to all staff involved in the documentation process.

All staff should receive regular training on the documentation process. Staff should be able to state Unity's policy on documentation and what is expected of them. Staff should know what, where, and how to document daily interactions with residents as well as unusual incidents. Supervisory staff should receive additional regular training on the monitoring process and what is expected of them to ensure compliance of documentation. All staff should be aware of the need for transparency in regard to the documentation process within the facility but also understand the role of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in regard to resident information.

3. Evaluate current system of documentation or explore options for EMR to assess for opportunities for streamlining/improvement of process.

As mentioned above, the documentation in (b) (6), (b) (3) (A) and facility documents examined for this review were often convoluted and difficult to follow. The facility should evaluate the current system of documentation to assess for opportunities for streamlining/improvement of process. Documentation should always be complete and comprehensive as possible, but the system of documentation should provide staff a tool to utilize in the assessment of residents, development of the treatment plan, and revision of the treatment plan as the resident progresses. Completion of forms that have no therapeutic value and provide no assistance to the staff in the provision of care can waste time and resources. The facility may explore options for EMR to adopt new strategies or mechanisms to promote efficiency in the documentation process.

4. Adherence to documentation compliance should be identified as a quality indicator which is monitored regularly by supervisory staff and Governing Board.

The facility should include adherence to documentation as a quality indicator to be monitored regularly by supervisory staff and the Governing Board. Although the Governing Board would not be directly involved in the monitoring process, they should be aware of how the facility is progressing toward (or digressing from) the goal of documentation compliance. The data from this quality indicator should be presented to the Governing Board in their meetings to keep them abreast of the information. The Governing Board should be aware of this quality indicator and expect to receive this information (from a designated individual) during their regular meetings. The Governing Board should inquire about information concerning quality indicators not presented to them during their meetings or about any information not consistent with progress toward establish goals. The Governing Board should also be informed about the process implemented to improve compliance and any new interventions developed for a failure to achieve the established goal.

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
Improper use/management/utilization of video surveillance resources	Ineffective/absent leadership, lack of training, lack of oversight/loss of institutional control	<ol style="list-style-type: none"> 1. Create policy/procedure for the video surveillance system. 2. Training for all staff on the purpose, responsibilities of the video system and who has access to the system. 3. Develop a mandatory log (preferably electronic log generated by the system login process) to track access of video surveillance (who, why, when, and what was reviewed). 4. Establish a backup system for stored/archived video. 5. Develop a system/process to track requests for and release of video to internal and external sources. 6. A concerted effort to locate two USB drives for which there is no current accounting.

11. Improper use/management/utilization of video surveillance resources.

Root Causes

Interviews with current and prior staff revealed there was a great deal of confusion concerning the facility’s video system. Staff members were unsure who had access to video surveillance, how to maintain or archive video footage, or the purpose of video surveillance. Staff often stated the primary purpose of video surveillance in September 2016, was for Cynthia Slee to monitor staff behavior and was used as a disciplinary tool by her. There were multiple reports of Ms. Slee and others using the video surveillance in ways that may have contradicted resident rights (i.e., HIPAA, confidentiality) as well as employee rights (e.g., sharing personal information of an employee with outside sources, privacy in the workplace, freedom from harassment). Senior leadership at Unity failed to maintain a process for the video system to utilize video footage appropriately and to protect the rights of the residents and employees.

There was no evidence Unity staff received education or training on the purpose and process of the video system. Staff members were often left to their own thoughts and experiences about the purpose of the video system. This led to the abuse of the system by Ms. Slee in an apparent attempt to manipulate staff and also may have been a violation of resident and employee rights by her and other staff. The lack

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of training created a void which was taken advantage of in ways that may have violated Unity policy, created distrust among staff, and sacrificed the safety and welfare of the residents.

Senior leadership at Unity appeared to have little understanding of how the video surveillance was being used and seemed to have little concern that Ms. Slee was using the system as a disciplinary tool. In addition, interviews with staff revealed that a staff member from the Nashville Area Office, Allen Bollinger, made and distributed two copies of video footage involving (b) (6) and (b) (6), (b) (3) (A) without any documented authorization or awareness from senior leadership. There appeared to be no involvement by senior management staff concerning the video footage and no policy to guide access to the video system. Although Capt. Ruff reported the Universal Serial Bus (USB) Mr. Bollinger gave her was confiscated from her office, no such USB was noted on the evidence receipt from the Office of Inspector General (OIG). Additionally, no USB was noted to have been confiscated from (b) (6). It appeared these two USB copies were not secured or properly stored and maintained. Review of the RCA revealed there were no concerns documented about how staff handled the video footage. The analysis question in Section #23 was “Was available technology used as intended?” and in Section #24 was “How might technology be introduced or redesigned to reduce risk in the future?” The response to both of these questions was “NA [not applicable].” There was apparently no awareness by Unity leadership, the Governing Board, or the Nashville Area Office that the lack of a consistent method or procedure related to the video system was problematic.

Recommended Remediation

1. Create policy/procedure for the video surveillance system.

The facility should develop a policy/procedure for the video surveillance system. The policy/procedure should articulate the primary purpose of video surveillance at Unity. It should designate the individuals who can have access to the video system as well as how the system can be accessed. It is recommended that access be limited to one or two primary staff members and senior management staff. The policy/procedure should delineate the purposes of video monitoring and the importance of maintaining resident and employee rights within the context of video surveillance. The policy/procedure should detail how access to the system is tracked (e.g., mandatory log) and how requests for and release of video footage is tracked (e.g., paper or electronic documented requests) for internal and external sources. The policy/procedure should provide clear guidelines on how and when video footage is stored/archived as well as who should have access to the video. Any stored video should be encrypted and stored in a secure location to prevent access from unauthorized sources. The policy should address the consent of legal guardians with respect to video surveillance. Are legal guardians and/or residents informed upon admission that the facility utilizes video surveillance, and the resident may be videotaped? Is the legal guardian informed of the facility’s cameras and the purpose of the video surveillance? Does the legal guardian give written consent for the resident to be videotaped?

2. Training for all staff on the purpose of the video system and who has access to the system.

Staff should receive regular training on the purpose of the video system and who has been designated to access the system. Staff should receive training on resident rights and employee rights in relation to video footage. Only designated and/or authorized staff members should be able to view video footage of residents. It is a violation of HIPAA and a resident’s right to confidentiality for any staff who is not

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directly involved in a situation and duly authorized to view video footage of an incident concerning a resident. Unity leadership must determine on a case by case basis whether it is necessary for the benefit of the resident for a staff member to see any video footage of that resident. Designated individuals responsible for viewing video footage should receive additional regular training on the purpose and process of video review and when and how to archive video footage.

3. Develop a mandatory log (preferably an electronic log generated by the system login process) to track access of video surveillance (who, why, when, and what was reviewed).

The facility should develop a mandatory log (i.e., electronic log generated by the system login process) to track who, why, and when the system was accessed as well as what was reviewed. If the system can be accessed at multiple locations (computers), the log should also document which computer was used to access the system. The log should be available for access by senior leadership to help ensure the system is being accessed for appropriate reasons and to maintain accountability for access to the video system.

4. Establish a backup system for stored/archived video.

The facility should establish a backup system for stored/archived video. Video footage may be stored in the system itself or on a designated external storage device. The storage of any video footage on a device must be encrypted, and the device must be stored in a secure location to prevent access of the video footage from unauthorized sources. The facility should establish clear guidelines when video footage is stored/archived and who should have access to the video footage.

5. Develop a system/process to track requests for and release of video to internal and external sources.

The facility should develop a system/process to track requests for and release of video to internal and external sources. Any request for video footage should be made in writing, signed and dated by the person(s) who are making the request. The request should either be electronic (with e-signature) or on paper (hard copy). Requests for the release of any video footage should be determined by the CEO on a case by case basis. The CEO may consult legal staff to determine the appropriateness of the release of video footage. No other staff member should be authorized to release video footage to an internal or external source.

6. A concerted effort to locate two USB drives for which there is no current accounting.

During this review, Allen Bollinger (Facilities Engineer) reported he made two copies of video surveillance footage of (b) (6) entering (b) (6), (b) (3) (A) Mr. Bollinger reported he gave one copy to Capt. Ruff and the second copy to (b) (6), (b) (7)(C). (b) (6), (b) (7)(C) advised that any USB device in her possession was confiscated by law enforcement (OIG). The only USB drives referenced on the "Receipt for Property Seized" by the OIG were (b) (6), (b) (7)(C) USB external image" and two items both labelled (b) (6), (b) (7)(C) USB." The Receipt referenced a box of miscellaneous documents from (b) (6), (b) (7)(C) office, but there was no documentation of a USB drive being confiscated (b) (6), (b) (7)(C). Also, there was no indication OIG confiscated anything from (b) (6) vacated his position at Unity prior to being questioned about the USB that Mr. Bollinger reportedly provided to him. Given the highly sensitive nature of what

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might be on the USB, it is appropriate to exhaust every possible avenue to recover/account for the USB devices Mr. Bollinger reportedly delivered to Capt. Ruff and (b) (6)

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
Severely flawed investigative effort into the allegation of sexual abuse	Ineffective/absent leadership, lack of training, and lack of oversight/loss of institutional control	<ol style="list-style-type: none"> 1. Staff should immediately report an allegation of abuse to the appropriate investigative authority and coordinate with (b) (6), (b) (3) law enforcement. 2. Designate and train at least one staff member at the facility level and at the Nashville Area Office who will log, track, and manage reports of (b) (6), (b) (3) abuse. 3. Coordinate an administrative inquiry or internal investigation. 4. IHS should create a guide/flowchart for decision making for any allegation of abuse. 5. IHS should create a guide/flowchart for decision making related to allegations in the absence of (b) (6), (b) (3) LE involvement. 6. The agency should coordinate with (b) (6), (b) (3) and law enforcement to determine safety plan needs. 7. Training for all staff for policies/procedures developed and implemented related to sexual abuse including thorough and complete documentation. 8. Training for senior leadership at Unity on policy as well as the complexity of the investigative process. 9. IHS will need to establish a process to determine the disposition of an abuse allegation. 10. IHS will need to establish a process for notification of all stakeholders as appropriate or mandated by statute (alleged victim, alleged perpetrator, licensing board, Governing Board, IHS, Joint Commission, Tribal leaders, Office of General Counsel (OGC), appropriate abuse registries, etc.) to advise of necessary information or action. 11. IHS will need to create an action plan to resolve outstanding issues (i.e. needs of alleged victim, employment status of alleged perpetrator, etc.).

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12. Severely flawed investigative effort into the allegation of sexual abuse.

Root Causes

Ineffective and absent leadership created a chaotic environment which provided the opportunity for the (b) (6), (b) (3) (A). Unity leadership failed to comprehend the significance of the cues that (b) (6), (b) (3) (A). Once a concern/allegation of sexual abuse existed, leadership at Unity failed to report the allegation of sexual abuse to the appropriate authorities. Unity leadership conducted an investigation into the concerns of sexual abuse. The Unity investigation of the events surrounding (b) (6), (b) (3) (A) and the allegations of sexual abuse were poorly executed and were conducted by individuals who were neither trained nor objective. The failure of the Governing Board and the Nashville Area Office leadership to understand the gravity of the events surrounding (b) (6), (b) (3) (A) and reinforced the prevalent chaotic environment at Unity. Unity staff has repeatedly maintained there was no concern of sexual abuse. Multiple examples of allegations and concerns of sexual abuse were documented in writing. There was clearly an allegation/concern of sexual abuse. The management at Unity investigated the allegation and concluded (b) (6), (b) (3) (A).

As previously mentioned, Unity staff received little or no education or training on the dynamics of (b) (6), (b) (3) (A) abuse. Unity staff failed to grasp the seriousness of (b) (6) actions toward (b) (6), (b) (3) (A) or objectively entertain the possibility (b) (6) behavior was abusive. Unity staff failed to document pertinent information related to their investigation of the sexual abuse concern.

The responsibility for the provision of care at Unity rests with the leadership at Unity, Director of Field Operations, Governing Board, and the Nashville Area Office Director. The failure to conduct a thorough, objective, and appropriate investigation into the events that surrounded (b) (6), (b) (3) (A) reflected culpability at every level of leadership within the agency including the Governing Board and the Nashville Area Office.

Recommended Remediation

1. Staff should immediately report an allegation of abuse to the appropriate investigative authority and coordinate with (b) (6), (b) (3) (A) law enforcement.

The initial response to a report is the most important time in the process. Decisions made at the onset require intentional thought and intentional action. Transparency and accommodation for (b) (6), (b) (3) (A) and/or law enforcement officials to conduct an investigation will create an environment for IHS to protect (b) (6), (b) (3) (A) who are alleged to be victims as well as staff who may be accused of wrongdoing.

2. Designate and train at least one staff member at the facility level and at the Nashville Area Office who will log, track, and manage reports of (b) (6), (b) (3) (A) abuse.

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The individual(s) who is first concerned or aware of an allegation of abuse is the individual responsible for making a report to the appropriate investigative authorities. (Current policy also requires a report be entered into the IHS Incident Reporting System.) The agency should designate at least one staff member at the facility level who will log, track, and manage reports of (b) (6), (b) (7)(C) abuse once an allegation is made known to the facility. (Current policy identifies the Unity CEO as the individual responsible for management of any situation involving an allegation of abuse involving an employee.) The initial responsibility of this staff member is to coordinate with the appropriate investigative authorities. This individual should ensure staff appropriately document and report all pertinent information surrounding any allegation of (b) (6), (b) (7)(C) abuse. The staff member should receive specialized training on Unity/IHS policies, investigative process, reporting requirements, and other legal aspects regarding allegations of (b) (6), (b) (7)(C) abuse. The Nashville Area Office should also identify at least one individual who will track reports of (b) (6), (b) (7)(C) abuse and oversee the reporting process to ensure all necessary components are addressed and completed in a timely manner. There should be frequent and meaningful communication between these two individuals when an allegation of (b) (6), (b) (7)(C) abuse occurs to promote transparency and accountability.

3. Coordinate an administrative inquiry or internal investigation.

Individuals assigned to conduct an administrative inquiry must be trained to collect forensically sound information from alleged victims, staff, and alleged perpetrators. There will be situations that allow for a complete investigation that does not involve interview of an alleged victim. There will also be situations when an interview of an alleged victim will be necessary. IHS (or an IHS contractor) will need to secure parental permission prior to any interview of an alleged victim who is a (b) (6), (b) (7)(A). Any employee or contracted individual must be able to demonstrate competency and experience in (b) (6), (b) (7)(C) abuse investigations.

Regardless of any external investigation, IHS will still have the responsibility to conduct their own inquiry/investigation to make determinations about what happened, whether abuse occurred, or whether policies were violated. Ideally, IHS will have access to other information or from external investigators that will decrease or eliminate the need to question alleged victims of abuse. It is important to understand that the internal inquiry/investigation must be managed in a way that protects the integrity of the external investigation. Issues related to the initial response to the (b) (6), (b) (7)(C) initial response to the alleged perpetrator, preservation of evidence, and documentation of events surrounding the incident and/or report of the incident require special attention. IHS will first need to explore the purpose and goal of any internal investigation or administrative inquiry. Is it appropriate to establish a goal of substantiation or unsubstantiation of the actual allegation of abuse? Is the goal simply to determine whether a policy was violated? Ultimately IHS has to demonstrate they have taken appropriate action to collect necessary information to make decisions related to both patient safety and the employment status of any employee who is alleged to be a perpetrator of abuse.

The internal investigative effort does not end once interviews are conducted. A review of all information will be necessary prior to making the final determination about the validity of an allegation. This process is not a subjective process based on whether one believes or does not believe an allegation or statement. No process is perfect, but decision making based solely on whether one believes or does not believe an allegation is fraught with error. There are objective standards by which information can be evaluated to assess validity (spontaneous disclosure, corroborating statements, richness of detail, etc.). Protecting the integrity of the investigative process at all levels must be a

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priority. This process requires specialized training, experience and objectivity to provide an objective, thorough, and well-grounded inquiry/investigation into an allegation of (b) (6), (b) (7)(C) abuse. The practice of assigning random IHS staff to conduct an inquiry into an allegation of abuse by an employee is not appropriate. Any IHS staff member or contractor must possess the experience, knowledge, and objectivity to conduct a proper inquiry.

4. IHS should create a guide/flowchart for decision making for any allegation of abuse.

IHS should create a guide/flowchart for decision making for any allegation of abuse. The guide/flowsheet should be easily accessible to all staff, and all staff should be trained on the information from the guide/flowsheet. The guide/flowsheet should provide staff with a tool on how to respond to an allegation of (b) (6), (b) (7)(C) abuse, who to contact, and how to protect the residents. The guide/flowsheet should also include what actions not to take which might threaten the safety of the residents and compromise the integrity of an investigation (i.e., do not interview an alleged victim or alleged perpetrator, do not access or tamper with evidence, etc.).

5. IHS should create a guide/flowchart for decision making related to allegations in the absence of (b) (6), (b) (7)(C) LE involvement.

IHS should create a guide/flowchart for decision making related to allegations of abuse when external investigators (b) (6), (b) (7)(C) LE) determine the referral does not meet criteria for their involvement. Again, it is imperative that Unity/IHS report to and coordinate with appropriate external investigative authorities prior to initiating activities related to an internal inquiry/investigation.

6. The agency should coordinate with (b) (6), (b) (7)(C) and law enforcement to determine safety plan needs.

The agency should coordinate with (b) (6), (b) (7)(C) and law enforcement to determine safety plan needs. Allegations of abuse involving staff members and/or residents will require immediate action to assess needs and create a safety plan for both the alleged victim and alleged perpetrator. This will include coordination of the (b) (6), (b) (7)(C) and law enforcement response to ensure access to information and opportunity to conduct interviews as needed. It is recommended that staff immediately report an allegation of sexual abuse against a staff member or resident to the appropriate (b) (6), (b) (7)(C) law enforcement investigative authority and work with the investigative authority to coordinate the initial (b) (6), (b) (7)(C) law enforcement response.

7. Training for all staff for policies/procedures developed and implemented related to (b) (6), (b) (7)(C) abuse including thorough and complete documentation.

The facility should provide training for all staff regarding all policies/procedures developed and implemented related to abuse. The training should be conducted upon hire (before first resident contact) and regularly (e.g., annually). The facility should maintain training records (either hard copy or electronic) for all staff and ensure all staff complete required training before the provision of care. Documentation in the facility should begin the moment a staff member has a concern of abuse and/or makes a report, or when a staff member is notified of an external investigation. Documenting an allegation of abuse of a resident by another resident or IHS staff member in the medical record of the alleged victim (and the alleged perpetrator in the event another resident is the alleged perpetrator) will require consultation with

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HHS/IHS officials as well as legal consultation. There are risks and advantages to such documentation. For example, a resident could be the target of a completely fabricated allegation and documentation of the allegation could potentially affect future placement options and/or employment opportunities if that medical record becomes available through a legal and appropriate release of information. On the contrary, an allegation could be completely legitimate while still being ultimately unsubstantiated and lack of documentation of the incident could result in risk of harm to others if there is no full disclosure of the resident's history. There are also risks and advantages for alleged victims. Release of the medical record may limit an alleged victim's power to control the information or the absence of the information may prevent recognition of the need for a victim to have access to trauma informed care or criminal injury compensation. In short, there are no easy answers to many of the questions, but a full and transparent discourse will allow for the most appropriate decisions possible.

8. Training for senior leadership at Unity on the complexity of the investigative process.

Although senior leadership will not directly conduct the investigative process they should be informed on the complexity of the investigative process. Unlike situations involving private families, healthcare facilities are obligated to demonstrate that all allegations of abuse are properly investigated. Healthcare facilities are also required to document the process to ensure patient safety. Coordination with mandatory investigative agencies must be explored, but in the absence of such cooperation, IHS will need to deploy and document a thorough and credible inquiry/investigative effort that includes but is not limited to assessment of the following:

- Statement(s) of alleged victim(s)
- Statements(s) of alleged perpetrator(s)
- Witness statements
- Information related to medical evaluation of an alleged victim of abuse
- Identification, collection, maintenance, storage, preservation, processing of evidence
- Evaluation of all information collected

9. IHS will need to establish a process to determine the disposition of an abuse allegation.

As noted earlier, external investigators may generate findings that provide resolution of questions related to disposition. For example, criminal charges may be entered, or (b) (6), (b) (3) (A) may take action to restrict an alleged perpetrator from having contact with (b) (6), (b) (3) (A). In the absence of such external factors, IHS will be responsible for making some determination with respect to employment status of an employee who is accused of abuse. An employee may well be cleared to return to an environment where services to (b) (6), (b) (3) (A) are provided. Options for transfer of an employee to an area of service that does not include an environment where services to (b) (6), (b) (3) (A) are being provided must also be considered. The absence of a finding of abuse is not sufficient to return an employee to an environment

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where (b) (6), (b) (3) (A) are being served. Employees who have demonstrated an inability or refusal to abide by policies designed to minimize the risk of abuse cannot be employed in environments where services to (b) (6), (b) (3) (A) are rendered.

10. IHS will need to establish a process for notification of all stakeholders (alleged victim, alleged perpetrator, licensing board, Governing Board, IHS, Joint Commission, Tribal leaders, Office of General Counsel (OGC), appropriate abuse registries, etc.)

IHS will need to formalize a process consistent with legal requirements and limitations to inform outside parties of necessary information related to any abuse inquiry.

11. IHS will need to create an action plan to resolve outstanding issues (i.e. needs of alleged victim, employment status of alleged perpetrator, etc.)

All investigative activities need to be completed in an orderly manner utilizing a standardized process that can be deployed systematically in the event of an allegation of abuse occurring within HHS/IHS programs. All investigative activities will require coordination with IHS, HHS, and OGC officials. Even if IHS employs specialized internal investigators, senior leadership is still responsible for the investigative process. At a minimum, senior leadership should oversee the investigation to stay informed of the progress and ensure all required actions and documentation are being performed thoroughly and accurately.

Taking prompt and effective remedial action on specific conclusions reached in an investigation is essential. IHS may not have knowledge of or access to the official determination made by (b) (6), (b) (3) (A) or law enforcement, but IHS will ultimately be responsible for timely action when there is an allegation of abuse that involves an employee.

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The following discussion examines the macro dynamics within the institutional culture to identify essential root causes and recommended remediation to address the root causes.

Root Cause Analysis Finding	Root Causes	Recommended Remediation
Director of Field Operations failed to provide meaningful supervision of Unity Healing Center	Ineffective/absent leadership	<ol style="list-style-type: none"> 1. Mortality and Morbidity Review (MMR) of (b) (6), (b) (3) (A) 2016, with senior management. 2. Training aimed at leadership development.

Root Causes

The root causes outlined above are summarized in broad categories related to communication, absent/ineffective leadership, lack of training, etc. When exploring the “root cause” of something, the task is to keep asking “why” until the true root cause of the issue is identified. Some “root causes” turn out to be simple process or system issues such as a lack of training, logistical issue, or perhaps a funding issue. Other “root causes” are much more complex. Staff chaos and conflict, communication issues, etc. can be firmly rooted in a root cause of ineffective leadership. When the root cause of a problem is determined to be a leadership issue, the question “why” becomes more difficult to answer. Leadership is often viewed from one of two perspectives: traits that make an ineffective (bad) leader and traits that make an effective (good) leader. Characteristics such as fear, impulsivity, arrogance, and dishonesty are frequently at the “root” of ineffective leaders.

Fearfulness in a leader is expressed in distrust of others and distrust of self. A fearful leader will consciously or subconsciously sabotage others to avoid being proven wrong or being outdone. A fearful leader will highlight their own perceived successes while minimizing the success of others.

Impulsive leaders are in a constant state of reactivity, overreacting to stimulus in the work environment and creating chaos that ultimately fuels more impulsivity. The impulsive leader is fueled by the energy that feeds an underlying need to be sought out for decision making that

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has the appearance of problem solving but is ultimately micromanaging that will become debilitating for staff. Impulsive leaders are often very busy but rarely productive.

Arrogance or superiority will manifest itself when leaders are not able to admit mistakes. Leaders who are conceited and arrogant not only believe they have the correct answer one hundred percent of the time they also believe that they are the only person capable of understanding a problem or finding the correct answer. Arrogant leaders will not relinquish decision making, and they will criticize the work of others to highlight their superiority. Insecurity and fear are at the root of arrogance.

Dishonesty in leadership is not as simple or apparent as it may appear. There are times when it is necessary and appropriate for a person in a position of leadership to withhold information. True transparency may not always be possible. The question of dishonesty as a leadership trait is best framed from a perspective of deception. Dishonest leaders communicate in a manner intended to deceive. It is not disingenuous for a leader to acknowledge the limitations of disclosure. It may be frustrating for staff or others, but it is not deceptive. Dishonest leaders seek to deceive. The short-term benefits of deception are particularly tempting. Whether to avoid detection of wrongdoing or to achieve unearned accolades, deception can become an easy “go to” when there are difficult issues to address. Deception may provide a temporary relief of anxiety, but it is only temporary. The long-term consequences of deception are erosion of public trust, erosion of self, and erosion of corporate culture that will ultimately result in collapse of the leadership structure.

Identification of leadership qualities is not an exercise in assessing behaviors or intelligence. Leadership is about character. It is important for leaders to participate in training designed to enhance or develop skills, but identification and selection of leaders who possess the underlying (root) characteristics of honesty, integrity, courage, genuineness, and composure will undoubtedly provide the foundation necessary for successful program development and management.

Leaders who approach decision making with thoughtfulness and emotional intelligence will allow themselves space and time to consider intended and unintended consequences of decisions. The ability to convey genuine emotion while holding powerful emotions in check and contemplating decisions define strength in leadership. The capacity to equally entertain multiple perspectives and possibilities is a rare but necessary quality for a successful leader.

The situation and issues at Unity were not hidden. There was no cover-up. It is this reality that presents one of the more difficult challenges in assessment. How could so many intelligent, committed, and highly trained professionals miss what was quite literally right in front of them? It may be as simple as recognizing that we tend to see what we are looking for. Our expectations of what should be happening may drive our interpretation of what is happening. (b) (6), (b) (3) (A)

There are numerous explanations for the failure of institutions to identify high risk situations or to acknowledge concerns of sexual abuse. Cover-up, apathy, incompetence, etc. are all possible explanations. What appeared to be fundamentally problematic within the leadership at Unity, the Governing Board, and the Nashville Area Office was a complete lack of willingness to

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genuinely entertain the possibility that it could have occurred combined with a degree of leadership indifference with respect to Unity Healing Center.

Recommended Remediation

1. MMR of (b) (6), (b) (3) (A) 2016, with senior management.

A Mortality and Morbidity Review (or similar process) of the (b) (6), (b) (3) (A) 2016, incident may seem an odd recommendation; however, the capacity of senior management to honestly, safely, and objectively evaluate and discuss what happened, what went wrong, what went right, and what changes are needed could be a powerful opportunity to not only learn from the event, but to also provide meaningful closure and move forward with a sense of renewed commitment and energy. This exercise will likely require facilitation by an outside professional. Participants should include senior management at Unity (CEO), the Director of Field Operations, Executive Officer, and the NAO Director. It is also appropriate to extend an invitation to participate to ER/LR staff, OGC staff, and OIG staff. As appropriate, the involvement of key staff members who were directly involved in the activities surrounding the incident may be beneficial. Given the history of the situation and the potential ongoing legal issues, current HIS leadership may determine that such a review is counterproductive. There is no correct answer with respect to this type of review. This recommendation may be beyond what is possible in the current environment.

2. Training aimed at leadership development.

A recommendation for leadership training is easy but it is important to understand that a lack of training is rarely the primary explanation to a crisis in leadership. A systems approach is necessary. The analogy between an organizational/leadership crisis and a family crisis that ultimately creates the need for a facility such as Unity Healing Center is irony at its deepest. An adolescent who completes a treatment program but then returns to a family environment full of chaos and dysfunction will likely experience relapse. A leader who completes a leadership training program and then returns to a system full of chaos and dysfunction will likely return to old habits and practices. Does the leader have the power to change the system or will the power of the system change the leader? Organizations and agencies are not a group of individuals but a system of interrelated components. Systems naturally seek homeostasis. Change, whether positive or negative, requires system disruption. It is a fine line between the system changing individuals and individuals changing the system. It is difficult for family units to recognize that altering (b) (6), (b) (3) (A) behavior first requires a change in the decisions and behaviors of the adults responsible for the family unit. In the same way, change in employee behavior first requires a change in the decisions (policies and guidelines) and behaviors of senior leadership. Basic family systems approach teaches that families will almost always identify the (b) (6), (b) (3) (A) as the problem that needs correcting. Organizational cultures tend to identify problematic employees as the problem that needs correction. These are the easiest, most convenient, and cheapest solutions, but they are rarely the correct solutions.

The current NAO Director appears to be employing a top down strategy for change. This is a promising intervention. Clear direction on vision, mission, expectations, and organizational values will provide a solid foundation for the system change that must occur. Senior executives who can effectively make the adjustment to the new leadership strategy at the Nashville Area Office will provide powerful

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support for the change to occur. Agreement and consistency across all areas of the organization is paramount. Recognizing strengths, requiring and supporting accountability, and empowering team members at every level is necessary. Leadership training under the umbrella of this top down change strategy can produce meaningful results. It is important to note that all training must be considered in this context of “buy-in” from senior leadership.

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
Governing Board	Ineffective/absent leadership and lack of oversight/loss of institutional control	<ol style="list-style-type: none"> 1. Clarification and written description of the role of the Governing Board. 2. Create and or formalize dashboard availability for the Governing Board. 3. Create/formalize the RCA process. 4. Assign Governing Board member(s) to specific projects to ensure follow-up and follow-through. 5. Develop/revise a system of documentation for Governing Board members to ensure accountability and transparency.

Root Causes

The root causes of ineffective/absent leadership and lack of oversight/loss of institutional control have been addressed above. The root causes in this context focus on the ineffectiveness of the Governing Board to provide the initiative to lead management and staff in questioning and challenging a defective investigative process surrounding the events of (b) (6), (b) (3) (A) 2016, involving (b) (6) and (b) (6), (b) (3) (A). The Governing Board apparently assigned senior leadership at Unity (Capt. Ruff and Tracey Grant) to conduct an RCA, but the RCA was incomplete and poorly executed. Many of the components of the RCA were inadequately addressed, and significant, conspicuous root causes were overlooked or omitted. There was no evidence the Governing Board followed up with the progress of the RCA or the implementation of the action plan. The Governing Board apparently failed to recognize the potential conflicts when they assigned the RCA, since the author(s) were part of the problem. The Governing Board sacrificed objectivity in the process in assigning the project to Capt. Ruff and Tracey Grant. The Governing Board failed to question or challenge the findings and failed to follow-up with the progress or implementation of the process.

Recommended Remediation

1. Clarification and written description of the role of the Governing Board.

Clarification of the role of the Governing Board as a supervising authority over Unity Healing Center needs to be clearly communicated to Unity staff and Governing Board members. The Director of Field Operations at the Nashville Area Office is currently identified as the supervising official for the Unity Chief Executive Officer. The Governing Board is currently responsible for oversight of Unity Healing Center. The relationships and organizational structure are not clearly defined. The Director of Field Operations is currently a member of

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the Governing Board. Whether participation on the Governing Board is connected to oversight of the Unity CEO is not clear. Who is the ultimate decision maker with respect to Unity Healing Center? Is it the Unity Chief Executive Officer, the Governing Board, the Director of Field Operations, or the Nashville Area Office Director who is also a member of the Governing Board?

2. Create/formalize dashboard availability for the Governing Board.

IHS/Unity should develop a dashboard with designated quality indicators for Unity Healing Center which would be available to the Governing Board. The quality indicators should include incidents and sentinel events (documentation issues as a quality indicator has already been discussed). The Governing Board should understand the purpose and significance of the indicators and take the initiative to question any data from the indicators.

3. Create/formalize the RCA process.

The RCA is a team process. The individuals who conduct the RCA should be assigned, and their roles clearly defined. Individuals assigned should be trained on how to conduct the RCA to identify any and all root causes and how to address those concerns. At least one member of the team should not be a staff member at the facility where the RCA is conducted to provide objectivity. Ideally, the team would comprise of both individuals who were and who were not involved in direct resident care or involved directly with the incident for which the RCA was being conducted. The team members should receive training on how to document in the RCA including dates, times, and signatures. The team should know how to develop interventions with specific goals and time frames to provide a mechanism for monitoring progress and evaluation. The Governing Board should be kept informed of the progress of the RCA, and the Governing Board should follow-up with the RCA team to ensure accountability.

4. Assign Governing Board member(s) to specific projects to ensure follow-up and follow-through.

In this review, it was often difficult and/or impossible to determine who was responsible for certain tasks or follow-up with those tasks. The development/revision of a process to ensure clear designations on who is responsible for a certain task and who is responsible on the Governing Board to follow-up on that task is essential to provide clarity and accountability especially when addressing significant incidents or sentinel events.

5. Develop/revise a system of documentation for Governing Board members to ensure accountability and transparency.

Reports for the progress of an assigned task or project may be given during the regular Governing Board meeting, and the information would be documented in the minutes of those meetings. The members of the Governing Board should have a system to document any information shared or provided outside of those meetings. The Governing Board should know how to document information including names, dates, and times to provide evidence for actions or decisions made and for the progression or digression toward an established goal to ensure accountability and transparency for the staff involved as well as the Governing Board. The members of the Governing Board

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should receive training on the importance of documentation as well as the process of documentation. The members of the Governing Board should be able to demonstrate their involvement in the oversight of the facility through clear and consistent documentation.

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
NAO Director	Ineffective/absent leadership and loss of institutional control	<ol style="list-style-type: none"> 1. Create/formalize dashboard availability for the NAO Director 2. Review and revise current structure to allow for open and active communication between the NAO Director and CEO positions.

Root Causes

The root causes identified under the NAO Director (Martha Ketcher) in the analysis were ineffective/absent leadership and loss of institutional control. These root causes have been previously discussed, and here, represent the systemic impairment prevalent throughout all levels of care providers and leadership. The NAO Director was the supervising official for the Director of Field Operations, a member of the Governing Board, and ultimately responsible for Unity Healing Center. The NAO Director had the responsibility for oversight of the facility as well as the care and safety of the residents. Documented evidence seemed to indicate the NAO Director was only peripherally involved with the (b) (6), (b) (3) (A) 2016 situation involving (b) (6) and (b) (6), (b) (3) (A). The Nashville Area Office Director was included on several emails, but there was no documentation available that Ms. Ketcher acted to provide support or guidance to Unity leadership or staff or to ensure the safety of the residents. Ms. Ketcher's activities related to the (b) (6), (b) (3) (A) 2016, incident involving Unity Healing Center are unknown. There was simply no documentation to indicate what, if anything, Ms. Ketcher did in response to the allegations of sexual abuse at Unity Healing Center.

Recommended Remediation

1. Create/formalize dashboard availability for the NAO Director

The creation of a dashboard of meaningful information/quality indicators should be readily available to the NAO Director. The dashboard recommended for the Governing Board is appropriate for the NAO Director as well. The dashboard should contain quality indicators which would alert any significant incidents or threats to resident care or safety.

2. Review and revise current structure to allow for open and active communication between the NAO Director and CEO positions.

Given the vast array of programs and areas that fall under the leadership of the Nashville Area Office, it is appropriate to evaluate the current structure for presentation and management of information to the NAO Director. IHS/Unity should review and revise the current

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management structure to allow for open and active communication. The NAO Director and CEO of Unity should utilize this communication to help develop a thriving, working relationship. The relationship should provide the NAO Director and CEO with open lines of communication which would not only provide information but would enhance rapport and trust in the relationship. The NAO Director would receive valuable feedback from the leadership and staff at Unity through the CEO, while the leadership and staff at Unity would receive guidance and support from the NAO Director. The leadership and staff at Unity would be reassured that if they faced a challenging situation, they would not be isolated or left on their own. This process is intended to support the current chain of command rather than replace it. It is appropriate for the Director of Field Operations to provide supervision for the CEO, but access to and communication with the NAO Director will help to create transparency and consistency within the various levels of leadership as well as empower the CEO to access additional support and guidance if needed.

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
ER/LR Staff and process	Ineffective/absent leadership, lack of training, lack of communication, ineffective documentation system, and lack of oversight/loss of institutional control	<ol style="list-style-type: none"> 1. Clearly identify who is responsible for oversight of the ER/LR process. 2. ER/LR referrals involving an employee alleged to be involved in any inappropriate or abusive interaction with another person must be logged and documented as reviewed by the NAO ER/LR supervisory official. 3. Create a structure/process to document the ER/LR process. 4. Train ER/LR staff on special issues related to vulnerable populations. 5. Seek clarification on legal issues related to reporting laws for ER/LR staff. 6. Develop policy for ER/LR staff for reporting of abuse allegations. 7. Explore enhanced process for ER/LR referral involving allegations of abuse to allow for increased protection of employee rights as well as increased protection for vulnerable populations.

Root Causes

Ineffective/absent leadership, lack of training, lack of communication, ineffective documentation system, and lack of oversight/loss of institutional control were overwhelmingly reflected in the ER/LR process. ER/LR staff (b) (6) appeared to work independent of any oversight. A document identified by Nashville Area Office Executive Officer Mark Skinner as a “January 2017 Workload Report” submitted to Mr. Skinner reflected the initiation of an ER/LR referral on (b) (6) for (b) (6), (b) (3) (A). Mr. Skinner was interviewed during this current review at which time he reported he did not have any independent memory of anything related to the ER/LR (b) (6). There was no documentation provided for this review regarding what Mr. Skinner did or did not do when he received the January 2017, ER/LR workload report. Although Mr. Skinner identified the report as a “January 2017” report, there were “Follow-up” entries on the report dated 2/8/17 and 2/9/17. There was nothing on the “January 2017” report that documented when it was actually created, sent to Mr. Skinner, or received by Mr. Skinner. There was no documentation provided to suggest Mr. Skinner initiated any action to address the referral on (b) (6). Mr. Skinner was provided information via a “January 2017” workload report from ER/LR specialist (b) (6) that there was an investigation at Unity involving

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(b) (6) and “possible inappropriate concerns with a (b) (6), (b) (3) (A)” This information should have triggered an alarm. Regardless of whether Mr. Skinner received this information in January or February 2017, it was not only sufficient enough to justify an inquiry by Mr. Skinner, it should have mandated an inquiry. Due to a lack of documentation, it is unknown if Mr. Skinner reviewed the workload report, failed to document his actions after a review of the workload report, did nothing, or simply failed to read the workload report.

The ER/LR staff failed to make a report to authorities. It was not clear if ER/LR staff were mandated reporters. It was not clear if ER/LR staff were obligated to counsel Unity staff of their mandated reporting obligation. There was no apparent communication between ER/LR staff and any supervisory or legal counsel to address that Capt. Ruff was investigating a situation at Unity which involved “possible inappropriate concerns with a (b) (6), (b) (3) (A)”

The ER/LR referral was made on 9/28/16. There was a note from ER/LR that a request for an update on the investigation by Capt. Ruff regarding (b) (6) was made on 2/8/17, over 4 months after the investigation was initiated. (Another report documented there was a request for an update on 12/23/17. This 12/23/17 date appeared to be a possible error given the fact it is not consistent with how other dates on the document were ordered. It appeared ER/LR may have made the first request for an update on 12/23/16 instead of 12/23/17.) Capt. Ruff’s investigation and subsequent ER/LR paperwork was received by ER/LR on 3/2/17. The packet submitted to ER/LR by Capt. Ruff on 3/2/17 lacked even the most basic information. There was no formality with respect to creation, dating, or signing of staff statements. There was no documentation about how the information in the packet was collected. There was no information that the alleged victim (b) (6), (b) (3) (A) or the alleged perpetrator (b) (6) had been interviewed. There was no documentation with respect to other evidence (e.g., the writing(s) found in (b) (6), (b) (3) (A) video surveillance footage, etc.). There were multiple copies of similar forms and statements. The packet appeared to have been created with no valid organizational scheme or thought process.

In short, Capt. Ruff not only began an investigation related to allegations of sexual abuse, but she openly communicated her activities to ER/LR specialist (b) (6) communicated, via the workload report, the information to Executive Officer, Mark Skinner at the Nashville Area Office. It appeared no one responded to the information, read the documentation, or acknowledged there was an allegation of sexual abuse. (b) (6) sent the information to another ER/LR specialist (b) (6) who also had no documented consultation with supervisory staff or legal staff despite the fact (b) (6) clearly described in writing in March 2017, that there was an allegation of sexual abuse of a (b) (6), (b) (3) (A) by (b) (6) at Unity Healing Center. The workload report should have also been submitted to the Regional Office responsible for management of HR issues. There was no documentation indicating what, if any, action was taken by anyone from the HR regional management office upon their receipt of the workload report.

Recommended Remediation

1. Clearly identify who is responsible for oversight of the ER/LR process.

The person identified should be clearly documented in writing to avoid any misunderstandings or assumptions. It is easy for staff to assume that someone else is responsible for an action or decision particularly if there are unfilled positions or staff turnover. Any deviation from the responsibility of assigned staff should be clearly documented to avoid further confusion.

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2. Any ER/LR referral involving an employee alleged to be involved in any inappropriate or abusive interaction with another person must be actively logged and documented as reviewed by the NAO ER/LR supervisory official.

This documentation should ensure that the ER/LR supervisory official is aware of the referral and the seriousness of the allegation. If there is a concern/allegation of (b) (6), (b) (7) abuse, the ER/LR supervisory official must also forward the information to the designated individual responsible for management of (b) (6), (b) (7) abuse allegations. The involvement of the individual responsible for management of abuse allegations is separate from the ER/LR process. This recommendation is designed to create redundancy in the system.

3. Create a structure/process to document the ER/LR process.

Expectations with respect to timely creation of the ER/LR referral should be delineated and available to supervisory staff. Senior management responsible for oversight of ER/LR activities will monitor referral and activity deadlines. Failure to meet deadlines will trigger an automatic consultation between the supervisor who initiated the ER/LR referral and the senior management official responsible for monitoring of the ER/LR process.

4. Train ER/LR staff on special issues related to (b) (6), (b) (3) (A) and other vulnerable populations.

ER/LR staff should be trained on issues related to reporting of all types of abuse (whether involving (b) (6), (b) (3) (A) or other vulnerable populations). ER/LR staff should be trained on the importance of documentation as well as the procedure of documentation for the ER/LR referral process.

5. Seek clarification on legal issues related to reporting laws for ER/LR staff.

It is important for IHS to seek legal clarification on whether ER/LR staff are mandatory reporters for abuse (b) (6), (b) (7) or adult). If it is determined there is no legal obligation for ER/LR staff to report, then IHS will need to assess whether they can achieve mandatory reporting status for ER/LR staff via policy. The question is not just whether ER/LR staff are mandated reporters under existing Federal law, but whether there is some statutory limitation or exemption regarding mandatory reporting of abuse allegations for ER/LR staff.

6. Develop policy with respect to expectations for ER/LR staff for reporting of abuse allegations.

Once legal questions have been addressed, IHS will need to create a policy that specifically outlines the expectations/limitations of mandatory reporting for ER/LR staff who fall under their oversight.

7. Explore enhanced process for ER/LR referral involving allegations of abuse to allow for increased protection of employee rights as well as increased protection for vulnerable populations.

Assessment of issues related to allegations of abuse requires highly specialized training. The sensitive nature of such allegations warrants a higher level of attention. Management of ER/LR referrals involving allegations of abuse must be achieved in a process that is designed to maximize protection for all involved. Referrals to ER/LR that involve allegations of abuse should involve timelines for completion of tasks

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and checklists/decision tree to ensure all required tasks have been completed. For example, any ER/LR specialist who receives a referral involving allegations of abuse must document/confirm that senior leadership is aware of the allegation and that a report has been made to the appropriate authorities.

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Root Cause Analysis Finding	Root Causes	Recommended Remediation
IHS/OGC legal staff/OIG/HHS	<p>Identification of root causes at this level, while possible, is likely not productive. The nature and size of the systems involved are truly definitive of a “macro” environment. IHS operates within the confines of HHS, and HHS is beholden to statutory and policy requirements that are far outside the control of IHS much less Unity Healing Center. The larger macro systems (OGC, OIG, and HHS) were not available for this review. Evaluation of the larger macro systems would require extensive time and resources. Addressing issues related to these macro systems is possible and can be achieved within the confines of existing structure.</p>	<ol style="list-style-type: none"> 1. Ensure there is a formal mechanism for transparent communication with OGC, OIG, and HHS. 2. Ensure there is a mechanism to communicate conflicting interests and needs. 3. Ensure there is written documentation up the chain of command within the Federal Government related to any situation in which IHS is being advised or required to act in a manner that is inconsistent with their directive to provide an environment free of abuse for residents in their care.

Root Causes

As with any facility, there are agencies and systems outside the influence and control of IHS and Unity Healing Center. Unity may not be able to change certain aspects of organizations or networks, but the facility does have control over how it responds and reacts to outside forces. Regardless of OGC, OIG, or HHS policy, functions, and/or recommendations, Unity has the ultimate primary goal and responsibility of resident safety and well-being. Although there may be challenges for the facility in dealing with these agencies, the

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recommended remediation must center around how Unity responds to those agencies. Unity cannot sacrifice the safety of the residents, because they were advised to do so by another federal agency or department.

The legal opinion (b) (6), (b) (5)

Senior management at the Nashville Area Office simply capitulated. The response was abdication rather than advocacy for the (b) (6), (b) (3) (A) rights and safety. Legal opinions are important and necessary, but the question of whether legal opinions should be the absolute standard on which all management decisions are determined warrants serious consideration.

Recommended Remediation

1. Ensure there is a formal mechanism for transparent communication with OGC, OIG, and HHS.

Unity/IHS should develop open, honest, and transparent communication lines with separate agencies or departments when issues arise. This communication must occur at the NAO Director level when addressing decisions by OGC, OIG, or HHS that involve resident safety. Investigations by OIG which have the potential to involve criminal charges will likely not be available to IHS or Unity for review; however, given that Unity has a mandate to demonstrate that a proper investigation was conducted and actions necessary for safety were implemented, it is imperative for Unity to coordinate with OIG as much as possible. Once this coordination is maximized, Unity/IHS must conduct a credible investigation and document its findings. Many state and federal agencies have similar challenges. Law enforcement investigations that may potentially conflict with civil proceedings is not uncommon. Coordination to ensure there is no interference with law enforcement is needed and appropriate, but criminal investigative activities are not a valid reason for failure to complete a timely and thorough investigation required for civil processes such as the Centers for Medicare and Medicaid Services (CMS), Joint Commission on Accreditation of Healthcare Organizations, and employment related matters. Unity/IHS must also demonstrate they have taken all necessary actions to minimize/reduce risks to resident safety. The Unity/IHS investigative process must be transparent for review by appropriate individuals who have legal access to such information (i.e. Governing Board, CMS, Joint Commission, etc.).

2. Ensure there is a mechanism to communicate conflicting interests and needs.

If an outside agency makes a recommendation or a decision which will put residents at risk, Unity/IHS should provide formal notice of their concerns of the risk and work with the agency or department to reach a safer alternative. For example, if OGC legal staff informs Unity/IHS to return an employee to work who acted outside the confines of policy or was guilty of abuse against a resident, Unity/IHS should initiate a conversation to examine other alternatives. Unity/IHS cannot put residents' safety at risk, even if advised to do so by another federal department or agency. Unity/IHS still has the responsibility to protect the residents under the care of the facility. Protection of employee rights is not a valid reason to employ individuals in positions in which resident safety is compromised. Failure of one level of management to act appropriately cannot be justification to prevent another level of management from taking appropriate action with respect to resident safety.

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3. Ensure there is written documentation up the chain of command within the Federal Government related to any situation in which IHS is being advised to act in a manner that is inconsistent with their directive to provide an environment free of abuse for residents in their care.

Any requirement to employ staff who present a danger to (b) (6), (b) (3) (A) will require Unity to enact other safety measures to ensure the safety of their residents. These additional safety actions and the associated costs of these actions must be communicated up the chain of command to the highest level possible so there is transparency and accountability at every level of the Federal Government. Unity must seek and expect other agencies or departments to provide written acknowledgement that they have been informed by Unity/IHS of situations that involve placing (b) (6), (b) (3) (A) or other vulnerable individuals at risk.

Section IX

Summary of Root Causes and Recommended Remediations

1. Boundary violation by staff member.

(b) (6) repeatedly violated the boundaries of (b) (6), (b) (3) (A). (b) (6) acknowledged this fact in his written statement and his behavior was observed by numerous employees at Unity Healing Center. (b) (6) was re-directed on numerous occasions and failed to adjust his behavior to come into compliance with Unity Healing Center policy.

Training on boundaries, trauma informed care and zero tolerance for behaviors that violate (b) (6), (b) (3) (A) boundaries is required.

2. Failure to report allegations of (b) (6), (b) (3) (A) sexual abuse.

Unity leadership (Chief Executive Officer Capt. Tiara Ruff, Clinical Director Tracey Grant, and Social Services Assistant Supervisor Cynthia Slee) were aware of and investigated allegations of sexual abuse of (b) (6), (b) (3) (A) 2016. Capt. Ruff, Ms. Grant, and Ms. Slee all failed to report the allegations to (b) (6), (b) (3) (A) or law enforcement. A Unity nurse, (b) (6), and therapist (b) (6) respectively) were also aware of allegations of sexual abuse of (b) (6), (b) (3) (A) or law enforcement.

Training, clinical supervision, and other recommendations described below are necessary, but the failure of Unity leadership to report the allegations of sexual abuse was not simply the result of a lack of knowledge or a lack of training. Unity leadership was ineffective on virtually every level. Root causes and recommended remediations related to the overall environment at Unity are discussed below.

3. Staff Conflict.

The degree of conflict among staff members at Unity was difficult to fully describe. The Executive Director was physically and emotionally absent from the facility. Numerous complaints were filed related to staff performance and staff interactions. The vision and mission of Unity Healing Center was a secondary concern as staff conflict and maladaptive dynamics consumed the time and energy of Unity leadership.

Evaluation of CEO performance and training to recognize and address staff conflict will allow Unity to focus on their mission. Identification of quality indicators designed to encourage competence and success will provide a structure for measurement of program success.

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4. Unwillingness of staff to acknowledge sexual abuse could occur in the facility.

Leadership at Unity quite literally described witnessing (b) (6) touching (b) (6), (b) (3) (A) or the area (b) (6), (b) (3) (A) while simultaneously insisting there was no possible sexual motivation for (b) (6) behavior. Other staff members adamantly explained that “knowing” (b) (6) was sufficient for a determination to be made that he was not capable of sexual abuse. The former Clinical Director (Tracey Grant) viewed (b) (6) entering (b) (6), (b) (3) (A) alone with (b) (6), (b) (3) (A) for approximately one minute and determined there was not sufficient time for anything sexual to have occurred resulting in her determination that sexual abuse could not have occurred.

Training on the dynamics of (b) (6), (b) (3) (A) abuse, clinical supervision and peer review will provide relevant data and meaningful feedback and promote objective evaluation of observations. Training and supervision will also increase awareness of personal biases that may interfere with objectivity.

5. Failure to recognize the high-risk interaction of (b) (6), (b) (3) (A)

Multiple staff members witnessed (b) (6) violations of (b) (6), (b) (3) (A) boundaries. The Governing Board was presented with a Root Cause Analysis finding of “Staff/(b) (6), (b) (3) (A) as a contributing factor in an (b) (6), (b) (3) (A), yet no member of the Governing Board summoned even one question or request for explanation or additional information.

Training designed to provide supervisory staff with concrete skills to identify, acknowledge, and address concerning staff behaviors will prepare supervisors to confront issues immediately and with clarity. Training to increase understanding of what it means to be respectful of boundaries will allow all staff to consider a deeper and broader perspective of boundaries. Respectfulness of boundaries is not limited to whether certain types of physical contact occur. Respectfulness involves awareness of power differentials in relationships and awareness of intentionality with respect to emotional and physical behavior and responses to residents.

6. Lack of Clinical Supervision.

There was no evidence of clinical supervision. Treatment professionals are presented with complex issues related to social, behavioral, biological, environmental, affective, and cognitive functioning. The ability to provide and receive objective feedback with respect to clinical work is foundational to the delivery of quality care. Clinical supervision at Unity Healing Center was non-existent. Competent clinical supervision would have provided numerous opportunities for meaningful assessment of the treatment environment and the forces operating that were supporting or impeding effective treatment delivery.

As noted earlier, clinical supervision will provide relevant data and meaningful feedback, and promote objective evaluation of observations. Supervision will also increase awareness of personal biases that may interfere with objectivity.

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7. Failure to create a (b) (6), (b) (3) (A) consistent with (b) (6), (b) (3) (A) to meet (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

Streamlining of assessment and treatment planning activities is needed to create a more effective tool to address (b) (6), (b) (3) (A). This may involve obtaining new tools or managing current tools more effectively. Connecting the symptoms (behaviors), (b) (6), (b) (3) (A) and interventions is fundamental to effective (b) (6), (b) (3) (A). Movement toward (b) (6), (b) (3) (A) service provision will create a more effective and comprehensive (b) (6), (b) (3) (A).

8. Lack of effective communication between the (b) (6), (b) (3) (A) /clinical staff, supervisory staff, and SSA staff.

Perhaps the most valuable information available was provided by the Social Services Assistants (SSAs) in their daily (b) (6). Information exchanges between the clinical (b) (6) and the SSAs appeared extremely sporadic and disjointed with no systematic or meaningful purpose. The SSAs are in a unique position to not only provide feedback regarding resident emotional and behavioral responses to treatment, but to also assist with delivery of meaningful interventions related to behavior, affect regulation, cognitive engagement, and even trauma processing. A therapist could recommend a specific activity for a resident (journaling, mindfulness, anger management, etc.) and the SSAs are in a position to encourage the activity or prompt the residents to utilize new skills and coping mechanisms. Residents will likely be with the SSAs when they encounter situations that trigger difficult emotional or behavioral responses. These are the opportunities for residents to employ new skills rather than automatic defense mechanisms (problematic coping skills which often appear as defiant or inappropriate behavior) and the SSAs are in the best position to facilitate or encourage residents to practice those new skills.

Meaningful participation of SSAs in treatment team meetings will allow for information to be shared to allow for targeted intervention of symptomatic behavior. The SSAs spend more time with the residents than any other staff member. Maximizing their observations and interactions with residents has the potential to substantially increase the effectiveness of treatment planning and intervention.

9. Lack of training on reporting concerns of (b) (6), (b) (3) (A) sexual abuse / (b) (6), (b) (3) (A) abuse for staff.

The new administration at Unity and the Nashville Area Office has highlighted the importance of training on how to recognize and report concerns of abuse. Prior to the arrival of new management, training on recognizing and reporting (b) (6), (b) (3) (A) abuse was non-existent.

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Unity/IHS will need to provide training at the time of hire as well as annual in-service training on recognizing and reporting concerns of (b) (6), (b) (7) (C) abuse. Additionally, quick reference sheets with pertinent information should be placed in common areas for easy access by staff. More advanced training on the complexities of (b) (6), (b) (7) (C) abuse in Indian Country is important for supervisory staff.

10. Lack of a system for appropriate management of documentation

Unity has a system/policy currently in place to address documentation issues. The current policy is not sustainable. The current policy requires daily audit of charts. This is actually reflective of the larger problematic issues of reactivity rather than careful and thoughtful planning. An all or nothing approach is rarely effective. A temporary daily audit to assess current compliance might be useful, but it is not a sustainable practice. Addressing deficient documentation immediately is key to achieving competence and staff compliance. Once compliance is achieved, chart audit should be limited to periodic review that involves review of a percentage of charts. A scheduled, periodic review of a random sample of charts will allow for assessment of overall compliance. Staff members noted to be out of compliance can be engaged in supportive corrective action to increase compliance. It will be important to create a system that allows for true random selection of charts for review. If non-compliance continues, supervisory staff will need to utilize a more structured corrective action plan to address individual staff issues. Ultimately compliance with documentation policy is not negotiable and staff who are unable or unwilling to be in compliance will need to be evaluated to determine goodness of fit at Unity.

It will be necessary to train staff on expectations with respect to documentation and monitor compliance with expectations.

11. Improper use/management/utilization of video surveillance resources.

The video surveillance system at Unity was being utilized for numerous purposes including, monitoring of staff behavior and performance, conflict resolution, investigation of staff complaints about other staff, and investigation of allegations of inappropriate sexual activity involving adult staff at Unity. There were numerous potential violations of staff and resident privacy rights. Current Unity leadership has developed a policy that specifically addresses the purpose of the video surveillance system, access to the system, and management of requests for video footage.

Unity will need to make adjustments to the current policy to ensure notification of the use of video surveillance to legal guardians and residents.

12. Severely flawed investigative effort into the allegation of sexual abuse.

Current leadership at Unity is committed to proper notification of external investigative authorities in the event of an allegation of abuse at Unity. Investigation of (b) (6), (b) (7) (C) abuse complaints is often complex and replete with situational factors that are not easily anticipated. There is not a single answer, approach, or policy that can account for every possible scenario. Transparency with respect to process is paramount. External investigators such as (b) (6), (b) (3) (A) and law enforcement must be notified and must have an opportunity to complete their investigative tasks prior to any internal investigation or administrative inquiry. Areas of potential concern involve situations

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when IHS is not privy to investigative information such as victim or alleged perpetrator statements. There is also the potential that a referral may not meet criteria for (b) (6), (b) (7) and/or law enforcement involvement. The recommendations in this report are designed to increase the likelihood that a potential offender will be identified long before an action that meets the legal or criminal definition of abuse occurs. For example, a staff member could enter a (b) (6), (b) (3) (A) room and engage in some type of “touching” or communication that is not in and of itself a crime but is still a violation of a known boundary. It is quite possible that a referral of this type would not initiate a (b) (6), (b) (7) or law enforcement response. But it is an issue that Unity would need to address. Unity will have to have a mechanism to collect all necessary information to make a determination regarding whether a staff member violated a non-negotiable Unity policy. The behavior or policy violation may not meet any definition of (b) (6), (b) (7) abuse, but it could potentially have employment implications.

The investigation/inquiry by Unity staff of the concerns related to (b) (6), (b) (3) (A) in (b) (6), (b) (3) (A) 2016 was poorly executed and conducted by individuals who had no training, no experience, and no objectivity. There was no report made to mandatory investigative authorities. It was clear that evidence was either destroyed or improperly handled. Witness and staff statements were not properly collected. Documentation related to questioning of (b) (6), (b) (3) (A) was missing or never created. Senior leadership at the Nashville Area Office failed to review documentation related to the investigation or failed to acknowledge or take action upon receipt of the documentation.

IHS will need to determine the most appropriate course of action to address collection of pertinent information when there is an allegation of abusive or inappropriate staff behavior. IHS could employ personnel to collect information or IHS could consider contracting with an individual who has experience in (b) (6), (b) (7) abuse investigations. Unity/IHS will also need to create a structure to track and monitor referrals to ensure senior leadership at the Nashville Area Office is actively aware of any investigative activity related to abuse or any allegation of inappropriate behavior that involves a staff member and a resident.

IHS/Unity also has the option to explore a formal working relationship with local (b) (6), (b) (7) and law enforcement officials that would allow the sharing of information necessary for the purposes of employment related decisions. Some situations may inherently allow for some information to be shared, but the potential for conflict and denials of information requests is inevitable.

IHS/Unity will also need to train staff to ensure proper documentation and maintenance of information and evidence to allow for transparency and evaluation by mandatory investigators or administrative inquiry.

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Section X

Recommendations

TRAINING

1. Training on Trauma Informed Care.
2. Training on boundaries, use of self in therapeutic relationships, and power differentials in relationships.
3. Training for all staff on issues related to physical contact with residents.
4. Training for all staff on the dynamics of all types of (b) (6), (b) (7) abuse. Training for all staff should include basic reporting information for (b) (6), (b) (7) abuse/neglect/(b) (6), (b) (7) sexual abuse. Development of a structured training curriculum for all relevant aspects of (b) (6), (b) (7) abuse.
5. Training for all staff on management of abuse allegations. This includes specific guidance on how to respond in the moment to a (b) (6), (b) (7) who may disclose information concerning for abuse.
6. Training for all staff for policies/procedures developed and implemented related to (b) (6), (b) (7) abuse including thorough and complete documentation. This is to address specific needs related to documenting what a (b) (6), (b) (7) may report as well as other information necessary for a complete inquiry/investigation.
7. Advanced training for clinical staff to include the different types of sexual abuse and the complexities of addressing (b) (6), (b) (7) sexual abuse in Indian Country.
8. Training for senior leadership at Unity on the complexity of the investigative process.
9. Training for all staff on the purpose of the video system and access (or lack thereof) to the system.
10. Training aimed a leadership development.
11. Train ER/LR staff on special issues related to (b) (6), (b) (7) (A) and other vulnerable populations.
12. Training for supervisory staff focused on identifying and managing staff conflict.
13. Guidance and training for supervisory staff to address concerns when staff behavior is inconsistent with policy and conduct expectations.
14. Training for supervisory staff on assessing the least drastic alternatives when considering staff intervention/discipline.

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15. Training for supervisory staff to inform the process on how to initiate and complete an ER/LR referral.
16. Create/formalize the Root Cause Analysis (RCA) process and provide training on how to properly conduct an RCA.
17. Training to review expectations for documentation for all staff involved in the documentation process.

CLINICAL SUPERVISION/PEER REVIEW

1. Ongoing clinical supervision for clinical staff to provide opportunity for clinical staff to explore interpersonal and intrapersonal experiences as they relate to provision of clinical services. Clinical supervision will also allow an opportunity to discuss treatment interventions, ethical issues, etc.
2. Ongoing group meetings with peers (peer review) for Social Services Assistants (SSAs) designed to allow for processing of experiences and observations.
3. MMR of (b) (6), (b) (3) (A) 2016, with senior management.

CREATION OF FLOWCHARTS/TEMPLATES TO GUIDE STAFF DECISION MAKING

1. Identify quality indicators to measure specific outputs and outcomes and create a dashboard so data can be accessed by supervisory staff and Governing Board.
2. Development of specific informational sheets designed as a “quick reference” on a variety of topics including the process for reporting (b) (6), (b) (3) abuse concerns which would be easily accessible to all staff.
3. IHS should create a guide/flowchart for decision making for any allegation of sexual abuse.
4. IHS should create a guide/flowchart for decision making related to abuse allegations in the absence of (b) (6), (b) (3) LE involvement.
5. Create/formalize dashboard related to outputs, outcomes, sentinel events, etc. for the Governing Board.
6. Create/formalize dashboard related to outputs, outcomes, sentinel events, etc. for the NAO Director
7. Create and/or revise process for monitoring documentation for supervisory staff.
8. Evaluate current system of documentation or explore options for EMR to assess for opportunities for streamlining/improvement of process.

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9. Develop a mandatory log (preferably electronic log generated by the system login process) to track access of video surveillance (who, why, when, and what was reviewed).
10. Streamlining of pre-admission evaluation and treatment planning.
11. Develop or implement more effective/relevant evaluation tools. Provision of trauma informed care will require specific assessment of trauma and trauma symptomatology.

FORMALIZED ADMINISTRATIVE INQUIRY/INTERNAL INVESTIGATIVE PROCESS

1. Create a process for a coordinated administrative inquiry or internal investigation.
2. Designate and train at least one staff member at the facility level and at the Nashville Area Office who will log, track, and manage reports of (b) (6), (b) (7) (C) abuse.
3. Establish a process to determine the disposition of an abuse allegation.
4. Establish a process for notification of all stakeholders (alleged victim, alleged perpetrator, licensing board, Governing Board, IHS, Joint Commission, Tribal leaders, Office of General Counsel (OGC), appropriate abuse registries, etc.)
5. Create an action plan to resolve outstanding issues (i.e. needs of alleged victim, employment status of alleged perpetrator, etc.)
6. Engage in a concerted effort to locate the two USB drives reportedly given to Capt. Ruff and (b) (6) for which there is no current accounting.

ENHANCED/INCREASED COMMUNICATION

1. Review and revise current structure to allow for open and active communication between the NAO Director and CEO position.
2. Ensure there is a formal mechanism for transparent communication with OGC, OIG, and HHS.
3. Ensure there is a mechanism to communicate conflicting interests and needs when there is disagreement among OGC, IHS, HHS and/or other departments.
4. Ensure there is written documentation up the chain of command within the Federal Government related to any situation in which IHS is being advised to act in a manner that is inconsistent with their directive to provide an environment free of abuse for residents in their care.

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ENHANCED ER/LR PROCESS

1. Clearly identify who is responsible for oversight of the ER/LR process.
2. Any ER/LR referral involving an employee alleged to be involved in any inappropriate or abusive interaction with another person must be actively logged and documented as having been reviewed by the NAO ER/LR supervisory official.
3. Create a structure/process to document the ER/LR process.
4. Seek clarification on legal issues related to reporting laws for ER/LR staff.
5. Develop policy with respect to expectations for ER/LR staff for reporting of abuse allegations.
6. Explore enhanced process for ER/LR referrals involving allegations of abuse to allow for increased protection of employee rights as well as increased protection for vulnerable populations. This should include specific training for ER/LR personnel who may be assigned referrals involving allegations of abuse.

DELINEATION OF OVERSIGHT ROLES AND RESPONSIBILITIES

1. Operationalize the role of the Governing Board. Provide clear expectations and information with respect to oversight responsibilities. Governing Board members must acknowledge and actively assume responsibility for operation and performance of Unity Healing Center.
2. Assign Governing Board member(s) to specific projects to ensure follow-up and follow-through.
3. Develop a system of documentation for Governing Board members to ensure accountability and transparency. This system should allow Governing Board members to demonstrate active review/monitoring of oversight activity.
4. Clarify responsibilities of Governing Board members. Include specific statements regarding expectations of members and the responsibility of the Governing Board to provide active and meaningful oversight of Unity Healing Center. Clarify and formalize participation on the Governing Board and duration of service with respect to Governing Board membership.
5. Ongoing, meaningful evaluation of CEO to assess competence and performance. It should be clear that direct oversight and evaluation of the Unity CEO is the purview of the Governing Board and/or the Director of Field Operations at the Nashville Area Office, or other designated person(s).
6. Establish a mission statement to focus the primary purpose and goal for the facility.

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SECTION XI

Policy Recommendations

The following discussion regarding the policies of Unity Healing Center will incorporate many of the aspects already discussed. This discussion is intended to focus on some of the key issues identified during this review. The facility may find it necessary to develop new policies or revise current policies as new interventions are implemented or new tools are adopted to meet the needs of the residents. Many of the policy recommendations were outlined in Section II. This section provides a more detailed description of the recommended policy additions/revisions.

1. The facility should develop/revise a comprehensive policy or policies on (b) (6), (b) (7) abuse/neglect/ (b) (6), (b) (7) sexual abuse. It may be necessary for the facility to develop/revise multiple policies to address all components directly or indirectly related to (b) (6), (b) (7) abuse/neglect/ (b) (6), (b) (7) sexual abuse. The policy/policies should provide established definitions of (b) (6), (b) (7) abuse, neglect and (b) (6), (b) (7) sexual abuse and include at a minimum the following seven components: prevention, screening, identification, training, protection, investigation, and reporting.
2. The policy on (b) (6), (b) (7) abuse/neglect/ (b) (6), (b) (7) sexual abuse should also address the specifics on any adopted recommendations for the investigative process from the discussion above. Staff should be able to refer to Unity's policy on (b) (6), (b) (7) abuse/neglect/ (b) (6), (b) (7) sexual abuse and know how to respond appropriately to any suspicion or allegation. Unity policy should be written in a way to avoid any lack of clarity. For example, "concerns of (b) (6), (b) (7) abuse" or "reasonable suspicion" of (b) (6), (b) (7) abuse are rather vague and open to interpretation. Current policy reads that only "an incident" of abuse or neglect must be reported. It is not appropriate for staff to determine that an incident did or did not occur. Current policy could be interpreted to indicate that only a known "incident" of abuse is to be reported. Current Unity policy revised 03/2020 reads: "All (b) (6), (b) (7) (A) have a right to be free from (b) (6), (b) (7) abuse and neglect. In order to provide patient safety, quality care, and to comply with established guidelines and/or existing laws mandatory reporting of (b) (6), (b) (7) abuse and neglect, any Unity Healing Center (UHC) staff member, contractor, or volunteer who has a reasonable suspicion or knowledge of or has been made aware of an incident of (b) (6), (b) (7) abuse and/or neglect that may have occurred before, during, or after treatment was received at UHC, will make a report to the appropriate investigative agency." Specific language requiring all "allegations" of (b) (6), (b) (7) abuse to be reported is clearer and provides for the safest environment for Unity residents and staff.
3. The facility should consider establishing a policy to work with their community partners to respond with efficiency and continuity to allegations of (b) (6), (b) (7) abuse/neglect/ (b) (6), (b) (7) sexual abuse. It appears federal statute clearly allows for federal agencies to create working relationships with local (b) (6), (b) (7) abuse investigative authorities in order to achieve the goal of mandated reporting. The policy should clearly establish what is expected of each agency and the roles they will play in addressing an allegation. The current policy specifically requires reporting to the local authorities, but a more formal arrangement that delineates expectations for all involved

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will provide additional clarity. For example, policy should outline the expected action in the event (b) (6), (b) (3) (A) or law enforcement present to Unity in response to a referral of abuse or neglect.

4. Prevention includes ensuring adequate staffing to meet the needs of individual residents. Adequate staffing refers not only to the number of staff on duty but also the types of qualified, trained and experienced staff available and on duty especially during the evening, night, weekends, and holiday shifts. Prevention also includes training of staff to increase awareness of abuse and neglect as well as the fact that abuse and neglect can happen in their facility.
5. Screening includes background checks, abuse registry checks and personal reference checks to be conducted prior to hire. IHS will likely have to consult with legal staff to assess options for documentation of investigations in personnel files. Documentation about whether an individual has been the subject of an investigation, the outcome of the investigation, and/or any required actions subsequent to the investigation must be recorded. It will be necessary for IHS to determine what options are available with respect to release of information about an investigation. The current federal government process of background checks and management of ER/LR referrals appears to enable the movement of problematic staff without the possibility of detection. For example, if an employee is accused of misconduct, but the accusation is ultimately unsubstantiated, it is not permissible for a potential manager to have access to information that a prior investigation was conducted. Background screenings are conducted by a separate department, and potential managers are provided only with a statement that the employee passed or did not pass the background screening process. An employee could be investigated multiple times for an allegation of sexual abuse without the knowledge of potential managers. The ER/LR process and the process of background screening are two systems that must change in order for IHS to successfully vet employees prior to assigning them to work with (b) (6), (b) (3) (A) or vulnerable populations. Protection of employee rights and protection of (b) (6), (b) (3) (A) cannot be competing interests. Both can be achieved. It will require thoughtful consideration and change for the federal government to create a process that protects all involved.
6. Identification involves having responsible staff trained to recognize the signs/symptoms of abuse or neglect as well as resident-resident and staff-resident interactions which should raise concerns. Although abuse and/or neglect may not always be preventable, early detection and intervention can help to limit the scope and negative impact of abuse or neglect.
7. Training should be conducted upon hire before a staff member's first resident contact and continued regularly throughout employment (i.e., annually). Training should include all aspects of (b) (6), (b) (7) (C) abuse/neglect/(b) (6), (b) (7) (C) sexual abuse, and the facility should maintain documentation of training for all staff. Much of the training should include all staff, but some staff should receive specialized training which was discussed in previous recommended remediation. The facility is responsible to ensure all staff receives mandatory training and to maintain documentation of that training either electronically or on a hard copy located in the personnel file. The facility may also need to review job descriptions in the personnel files if any new requirements for a specific position are established such as training requirements.

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8. Protection refers to the facility's response to any allegation of abuse or neglect. It answers the question, "How can the facility protect the resident (alleged victim) as well as the other residents from further abuse or neglect?" This should be the first and immediate response by a staff member and the facility when there is an allegation or suspicion of abuse or neglect.
9. Administrative inquiry or investigation is the process the facility initiates when there is a suspicion or allegation of abuse and neglect to determine the validity of the allegation. This process was discussed in the Root Cause Analysis Finding section entitled, "Severely flawed investigative effort into the allegation of sexual abuse." There are needs related to both the external investigation by mandated investigative authorities as well as the internal administrative inquiry designed to promote patient safety and decrease the risk of abuse or exploitation.
10. Reporting includes informing senior leadership at Unity as well as (b) (6), (b) (7)(C) law enforcement and other required authorities. Reporting was discussed in the Root Cause Analysis Finding sections entitled, "Lack of training on reporting concerns of (b) (6), (b) (7)(C) sexual abuse/(b) (6), (b) (7)(C) abuse for staff" and "Severely flawed investigative effort into the allegation of sexual abuse."
11. The facility should develop/revise a policy to address performance or behavioral concerns for staff. The policy should provide guidance for supervisory staff to assess the least drastic alternatives to address those concerns. The policy should refer to or include a decision tree to determine what levels of intervention are available, and how to assess the appropriate level of intervention to be deployed. The policy should help supervisory staff address staff concerns consistently which would promote trust and confidence among staff.
12. The facility should develop/revise a policy to address how to respond to a staff member accused of an allegation of (b) (6), (b) (7)(C) abuse/neglect/(b) (6), (b) (7)(C) sexual abuse. When there has been a determination that a staff member acted inappropriately or abusively, it will be necessary for the facility and/or IHS (through the existing ER/LR structure presumably) management to make a determination whether the situation demands termination of employment or some other remedy (i.e., return to previous job duties or transfer to a different job more suited to the employee's talents). If there is a determination that a staff member has been guilty of abuse, then it is likely there is an existing mechanism to prevent the identified staff member from continued employment within the IHS system. Avoiding transfer or "passing around" within the agency of problem providers or other staff must be a priority. For the protection of the residents, there must be a process with transparency and accountability for staff who have displayed high-risk behaviors and endangered the safety and well-being of a resident(s). Review of state laws with respect to abuse registries will be important. Creation and implementation of policy related to search of abuse registries prior to employment may be necessary.
13. Policy related to documentation should address how to appropriately document within a resident's medical record including timeframes for the entry and signing of progress notes. The policy, or a subsequent policy, should include an established process

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for documenting incidents, adverse resident events, and sentinel events. Documentation should paint a clear picture of what happened and how the facility responded to an event. The facility may need to consult with legal staff to determine what information needs to be included in a resident's medical record involving a specific incident, adverse event or sentinel event and what information should be documented in a separate area or system. The current documentation policy revised 01/25/19 appears comprehensive. The policy requires a daily chart audit by the clinical supervisor or designee. This is an ambitious goal. Numerous documentation issues have been noted in this review and by other reviewers. While it is imperative for Unity Healing Center to dramatically improve performance with respect to documentation, a policy requiring daily chart audits, while ideal, may not be sustainable. It is recommended Unity consider a policy that progresses from a daily chart audit to a random chart audit. Upon successful demonstration of documentation competence, the intensity of chart audits can be tailored as needed based on random weekly or monthly review of charts.

14. The facility should develop/revise a policy to address clinical supervision. The policy should identify the individual responsible for ensuring clinical supervision is performed regularly (as defined by the policy) and is instrumental for clinical staff as a process to reflect and evaluate their experiences in the provision of clinical services. The policy should provide guidelines for the frequency of clinical supervision, clear objectives, delineation of the process, and required documentation for clinical supervision.
15. The facility should develop/revise a policy to address peer review for SSAs. The policy should state the purpose, frequency, process, and documentation of peer review. The policy should identify the individual responsible for ensuring peer review is performed regularly (as defined by the policy) and provides an opportunity for all SSAs to share and process their experiences with resident-resident and resident-staff interactions.
16. The facility should develop/revise a policy to address treatment team meetings to include SSAs. The policy should ensure the observations and experiences of SSAs with residents are incorporated into the treatment team discussions for the provision of care and treatment plan development and revision. Due to fiscal and scheduling constraints, the participation of SSA's in every treatment team meeting is not feasible or sustainable. The goal is twofold; to ensure information from the SSAs is available and presented and to ensure the SSAs have an opportunity to benefit from the process of treatment team discussion regarding resident treatment. In-person participation in treatment team meetings a minimum of 2 times yearly for each SSA is an appropriate goal. Development of a process for SSAs to add relevant topics regarding resident treatment to the treatment team agenda when needed (or as requested by the SSA) is appropriate. The SSA supervisor should be responsible for informing SSAs of treatment team schedules and agendas to ensure SSAs are aware of opportunities for their participation in treatment team meetings. The SSA supervisor should also be responsible for reporting relevant treatment team information back to the SSAs.

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17. Current policy with respect to Resident Assessment revised 03/2020 does not include any assessment related to trauma. Trauma assessment at intake should be a priority. Assessment of trauma and trauma symptomatology is imperative for effective treatment planning.
18. The facility should develop/revise a policy to address trauma informed care. The policy should define trauma informed care, and how this approach will be implemented into a resident's treatment program. The policy should state training requirements on trauma informed care for all staff and specialized training requirements for clinical staff.
19. The facility should develop/revise a policy to address Quality Assurance Performance Improvement (QAPI) regarding any new quality indicators (such as documentation) identified to be measured, analyzed, and tracked as a result of this review. The policy should identify the method and frequency of data collection, the process of analyzing the data, the development of interventions, and the evaluation of the outcomes. The policy should describe how the facility will report this information to the Governing Board and identify the individual responsible to oversee the process.
20. Unity Healing Center created policy for Video Surveillance in 02/2020. The policy appears comprehensive and responsive to the issues addressed in the Root Cause Analysis Finding section entitled, "Improper use/management/utilization of video surveillance resources." It is recommended Unity also include policy to address issues related to consent and notification of the use of video surveillance to residents and legal guardians.
21. Unity Code of Ethical Behavior revised 02/20 appears to address issues related to staff-resident interactions. It is not possible to create a policy to address every possible scenario, but the current policy of Ethical Behavior is clear and comprehensive.

Section XII

Commentary on issues related to analysis of macro systems, specific personnel behaviors, and motivations

(b) (6), (b) (3) (A)

[Redacted text block]

Responsibility for the situation that unfolded at Unity in 2016 is shared among a large group of professionals. It is important and appropriate to hold individuals accountable. At the same time there must be recognition that this same pattern has played out in numerous settings. Many “external” evaluators are quick to review a situation and assign blame. It is a disservice to humanity if we continue to act as though professionals callously ignore obvious warning signs, or intentionally work to protect alleged sex offenders. Pretending that those who fail to report, fail to recognize and response to concerning behavior, or who fail to believe when a [Redacted] makes a statement concerning for sexual abuse, are monsters who do not care about [Redacted] does not move us forward in protecting [Redacted]. All it does is allow us to remain in our fantasy world that sexual abuse can’t happen right in front of us. It allows us to continue the delusional thinking that sex offenders are uncivilized and revolting perversions of humanity that are obvious and can be seen with little difficulty. It allows us to continue to shun our own contribution to the larger problem of failing to believe and failing to protect [Redacted]. What if a judge, a chief justice, a doctor, a social worker, a parent, a grandparent, a custodian, a faith leader, a police officer could potentially be a sex offender? What if this is a behavior so secretive and so hidden that it is unseen or perhaps concealed in actions that are woven into the nature of who we are? For the vast majority of humans, actions such as horseplay, hugs, gestures of affection and comfort, and caretaking are innocent and intimately tied to our ability to connect with others. For a sex offender they are opportunities to invade the space of another and decrease sensitivity to touch. In our collective effort to maintain our fantasy and delusion we have demonized individuals who commit

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sexual crimes. In doing so, we have made it impossible to acknowledge that someone we love, someone we respect, someone who appears kind, or someone who is polite could possibly be guilty of sexual assault. Our fantasy is that only a monster could sexually abuse a (b) (6), (b) (3). Our delusion is that we would see and heroically intervene if it happened in front of us. Perhaps most difficult of all to acknowledge is the reality that we have made sexual assault the unforgiveable crime, while we have simultaneously romanticized sexual violence, normalized sexual aggression, and created a culture that objectifies and devalues women. We have repeatedly failed to believe those who report sexual victimization. We have created a culture that refuses to recognize that individuals who sexually offend are the same individuals who have desirable qualities which appear inconsistent with a sexual offender. We have used media to normalize and acknowledge the sexual indiscretions of others but also criminalized it to the degree that those who do engage in sexual misconduct can never admit it publicly for fear of ostracization and/or prosecution as well as substantial personal loss. There is no straightforward solution but continuing to simply assign blame to the easiest targets without recognizing the underlying issues is futile.

Personnel behaviors and motivations are difficult to assess and maybe even more difficult to manage through policies, rules, and disciplinary actions. It is by developing a culture of awareness and objectivity within the community of Unity Healing Center that promotes the wholeness of the residents as well as the staff that will have a positive effective in influencing and directing personnel behaviors and motivations.

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Section XIII

Summary

Between (b) (6), (b) (3) (A) 2016, and (b) (6), (b) (3) (A) 2017, no less than 3 members of Unity management knew and failed to report specific allegations of sexual abuse of (b) (6), (b) (3) (A) by (b) (6). At least 2 ER/LR staff were aware of allegations of sexual abuse of (b) (6), (b) (3) (A) by (b) (6). At least one senior management official in the Nashville Area Office received documentation that there was an investigation related to (b) (6) and possible inappropriate concerns with a (b) (6), (b) (3) (A). Via their role on the Governing Board, the Nashville Area Office Director along with numerous other senior management officials and professionals knew there was an issue involving (b) (6) and a (b) (6), (b) (3) (A) concerning some type of boundary issue. As noted in earlier analysis, there was no indication of a cover-up or that anyone was trying to hide what was happening. The problem was all too typical of what happens every day. Adults saw (b) (6) acting inappropriately toward a (b) (6), (b) (3) (A) and they blamed the (b) (6), (b) (3) (A). The (b) (6), (b) (3) (A) acted like a traumatized (b) (6), (b) (3) (A) who was behaving inappropriately acted like a victim. Well-educated medical and mental health professionals along with other professionals took it upon themselves to investigate despite a lack of training, understanding, or objectivity. Once the allegation became known and was referred for external investigation, everything stopped in deference to a criminal investigation. The lack of criminal prosecution was then viewed as equivalent to some gold standard by which all other decisions should be made. Moving forward, everyone involved is now held accountable except for the alleged perpetrator. The alleged victim moves on in life and is left with the emotional remnants of all (b) (6), (b) (3) (A) did to survive the debacle.

This review explored medical records, facility documentation, and personnel files, made observations at Unity Healing Center, and conducted interviews with current and former staff at Unity Healing Center and senior management at IHS to examine allegations of staff (b) (6), (b) (3) (A) sexual abuse in (b) (6), (b) (3) (A) 2016. The purpose of this review was not to determine the validity of the allegations but to assess the facility's response to those allegations.

In this part of the review, fundamental root causes were identified based on the root cause analysis findings from the analysis portion of the review. These root causes were explained, and remediation for the root causes were recommended to not simply fix an apparent problem but to address the underlying systemic issues behind those problems. The list of root causes and recommended remediations was intended to comprehensively address the underlying issues. As IHS/Unity Healing Center considers the root causes and recommendations, they may identify other local or systemic issues or other avenues of remediation to be implemented. The goal for this review and any recommendations for change is to promote the health and safety of the culture at Unity Healing Center. This includes the health and safety of the residents as well as the health and safety of the staff and leadership at Unity Healing Center.

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Milam Consulting

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APPENDIX

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Fact Statement #2

DATE OF REPORT-02/08/20

(0)

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #3

(b) (6), (b) (3) (A)

(b) (3) (A), (b) (6)

(b) (6), (b) (3) (A)

(b) (3) (A), (b) (6)

Fact Statement #4

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #5

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #6

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #7

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #8

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #9

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #10

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #11

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #12

(b) (3) (A), (b) (6)

Fact Statement #13

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #14

9/27/2016

On Thursday (b) (6), (b) (3) (A) 16 I received a report from (b) (6) that (b) (6) had come to speak with her with about some (b) (6), (b) (3) (A) during the conversation (b) (6) had mentioned to her that he was concerned about (b) (6), (b) (3) (A) with (b) (6), (b) (3) (A) and staff member (b) (6). As (b) (6) was always hanging all over him and he did not seem to tell (b) (6), (b) (3) (A) to stop as he had done with (b) (6), (b) (3) (A) when (b) (6), (b) (3) (A) had displayed (b) (6), (b) (3) (A) with him. After speaking to (b) (6) I went and spoke with (b) (6) about his report, (b) (6) told me the same information that he had told (b) (6), he did stress that he did not feel that (b) (6) was doing anything to encourage (b) (6) to hang on him but it was concerning to him as (b) (6), (b) (3) (A) does have (b) (6), (b) (3) (A) and he himself has struggled with (b) (6), (b) (3) (A) himself, his concern was that he did not think (b) (6) knew how to handle the (b) (6), (b) (3) (A) (b) (6) said that (b) (6), (b) (3) (A) 16 was the incident that concerned him.

Writer was asked by Tracet Grant my supervisor to review the cameras looking at the interaction between (b) (6), (b) (3) (A) (b) (6), (b) (3) (A). I along with Tracy Grant review the tape from the day in question, my observations was that (b) (6), (b) (3) (A) was very clingy to (b) (6), (b) (3) (A) appeared to have a hard time not trying to hold on to his arm and standing very close to him, at one point (b) (6), (b) (3) (A) was picking at his arm with (b) (6), (b) (3) (A) fingers it appeared as (b) (6), (b) (3) (A) was pulling hair on his arm he then did the same thing to (b) (6), (b) (3) (A) arm. And (b) (6), (b) (3) (A) at one point poked him in the stomach several times he then done the same thing to (b) (6), (b) (3) (A) stomach poking it a couple of times. (b) (6) was showing the (b) (6), (b) (3) (A) something on his cell phone several of the (b) (6), (b) (3) (A) were looking at his phone (b) (6), (b) (3) (A) grabbed his phone and (b) (6) did not immediately get it back from (b) (6), (b) (3) (A) kept looking at his phone for about maybe 30 seconds then (b) (6) got it back. (b) (6) at one point went into (b) (6), (b) (3) (A) for about 1 and 1/2 minutes (b) (6), (b) (3) (A) went in the room after him they both came out of the room in under 1 minute. When they were back outside the room (b) (6), (b) (3) (A) continued to try and hang on to (b) (6) arm. During the interaction in the hallway they were never alone as other (b) (6), (b) (3) (A) and staff there as well.

Cynthia Slee



Supervisory Social Service Assistant

Fact Statement #15

(b) (6), (b) (3) (A)

Fact Statement #16

(b) (3) (A), (b) (6)

(b) (6), (b) (3) (A)

Fact Statement #17

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #18

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #19

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #20

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #21

(b) (6), (b) (3) (A)

Fact Statement #22

On Saturday, (b) (6), (b) (3) (A) 2016, at (b) (6), (b) (3) (A) approached me and said that (b) (6), (b) (3) (A) needed to talk to (b) (6), (b) (3) (A) or someone about (b) (6), (b) (3) (A). I asked (b) (6), (b) (3) (A) what about, and (b) (6), (b) (3) (A) seemed hesitant to answer. I told (b) (6), (b) (3) (A) that if something was going on, (b) (6), (b) (3) (A) needed to tell me. (b) (6), (b) (3) (A) said that (b) (6), (b) (3) (A) was worried that (b) (6), (b) (3) (A) would be mad at (b) (6), (b) (3) (A) and I said that if it was something serious, it didn't matter and (b) (6), (b) (3) (A) needed to tell me. (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A) I told (b) (6), (b) (3) (A) that (b) (6), (b) (3) (A) did the right thing and that we needed to grab (b) (6), (b) (3) (A) and share the information with (b) (6), (b) (3) (A). I interrupted a conversation that (b) (6), (b) (3) (A) was having in the hallway with another (b) (6), (b) (3) (A) and went into the (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) with her and (b) (6), (b) (3) (A). I asked (b) (6), (b) (3) (A) if (b) (6), (b) (3) (A) would share what (b) (6), (b) (3) (A) just told me but (b) (6), (b) (3) (A) was quiet, so I told (b) (6), (b) (3) (A) I told (b) (6), (b) (3) (A) what (b) (6), (b) (3) (A) had just shared with me and some of the things that (b) (6), (b) (3) (A) had shared with me the previous night. I told her that (b) (6), (b) (3) (A) was currently in (b) (6), (b) (3) (A) and that (b) (6), (b) (3) (A) said that it had happened the previous night. I asked (b) (6), (b) (3) (A) whether she and Cynthia had told (b) (6), (b) (3) (A) that (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A) She said that while that was the initial plan, they had thought about it a more and changed their mind because it would be a bad idea. And I said that I think (b) (6), (b) (3) (A) I then left the (b) (6), (b) (3) (A) and Tawna went to (b) (6), (b) (3) (A) and I went to inform (b) (6), (b) (3) (A) of the situation. I called (b) (6), (b) (3) (A) approximately at 1630 and left her a voicemail while (b) (6), (b) (3) (A) called Cynthia and left her a voicemail. I then called Tracy approximately at 1635 and got a hold of her, and she said to call Tiara Ruff next. I called Ti and left her a voicemail while (b) (6), (b) (3) (A) called other staff to find coverage. I had gotten a hold of (b) (6), (b) (3) (A) approximately at 1650 and she agreed to come in. When (b) (6), (b) (3) (A) informed me that she had left her house and was close, approximately at 1700, (b) (6), (b) (3) (A) took (b) (6), (b) (3) (A). I kept all of (b) (6), (b) (3) (A) with me in the (b) (6), (b) (3) (A) until (b) (6), (b) (3) (A) joined us. When (b) (6), (b) (3) (A) came in (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) and requested to speak with me in private. I went into (b) (6), (b) (3) (A) to talk with me (b) (6), (b) (3) (A) asked me where (b) (6), (b) (3) (A) was and I said that (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

Fact Statement #23

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #24

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #25

1-D -
(b) (6), (b) (3) (A) 2016:

Yesterday while waiting for another (b) (6), (b) (3) (A) to finish their (b) (6), (b) (3) (A) and I sat alone on a couch outside of SCC's testing room. I inquired about the weekend and (b) (6), (b) (3) (A) said, (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A) reported the incident to staff on Saturday evening (b) (6)

The (b) (6), (b) (3) (A) stated that (b) (6), (b) (3) (A) felt protective of (b) (6), (b) (3) (A) with the (b) (6), (b) (3) (A) intimidated that (b) (6) has brought beads and candy for (b) (6), (b) (3) (A). He hangs around in the hallways and pokes (b) (6), (b) (3) (A)

When the (b) (6), (b) (3) (A) were switching (b) (6), (b) (3) (A) on two separate occasions (b) (6), (b) (3) (A) was in the (b) (6), (b) (3) (A) and (b) (6) were in the bathroom with the door shut.

Upon returning to Unity this writer reported the incident by writing up the conversation for supervisor, Tracey Grant.

(b) (6), (b) (3) (A) 2016

This morning at approximately 9:30 a.m. I spoke with (b) (6), (b) (3) (A) to follow up on comments made yesterday.

I asked (b) (6), (b) (3) (A) to come down to the (b) (6), (b) (3) (A). I explained that some of the conversation we had yesterday was concerning to me and that we needed to follow up on it. I ask (b) (6), (b) (3) (A) would be comfortable retelling this information to SSA supervisor, Cynthia Slee. (b) (6), (b) (3) (A) agreed and Cynthia was invited to join us in the (b) (6), (b) (3) (A)

Cynthia joined the meeting in the (b) (6), (b) (3) (A) and I started off the meeting by stating that there was a conversation (b) (6), (b) (3) (A) and I had yesterday that we needed to follow up on. There were concerns that (b) (6), (b) (3) (A) had that need to be shared. Cynthia Slee asked (b) (6), (b) (3) (A) to, "tell me about that." (b) (6), (b) (3) (A) replied, "(b) (6), (b) (3) (A) and (b) (6)

(b) (6), (b) (3) (A) stated that (b) (6) brings (b) (6), (b) (3) (A) beads and candy. (b) (6), (b) (3) (A) has also allegedly reported this information to (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A) stated that (b) (6), (b) (3) (A) reported Cynthia and (b) (6) were scared of (b) (6), (b) (3) (A). A phone call was made to the (b) (6), (b) (3) (A) about the situation between (b) (6), (b) (3) (A) and (b) (6). (b) (6), (b) (3) (A) reported that now everyone was convinced that their relationship is a friendship and it is just because (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A) stated that (b) (6), (b) (3) (A) had felt uncomfortable for the past two to three weeks with (b) (6) relationship with (b) (6), (b) (3) (A). (b) (6), (b) (3) (A) stated that before he left for a business trip (b) (6) that he asked (b) (6), (b) (3) (A) what (b) (6), (b) (3) (A) thought about their relationship. He gave her options, (b) (6), (b) (3) (A) (b) (6), (b) (3) (A). He rated the relationship a level 5 which was between a (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A) stated that on several occasions (b) (6) has poked (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) witnessed the poking. When asked to elaborate on when and where (b) (6), (b) (3) (A) stated it happened "all the time."

(b) (6), (b) (3) (A) reported that while moving their (b) (6), (b) (3) (A) (b) (6) and (b) (6), (b) (3) (A) were in (b) (6), (b) (3) (A) with the door shut on two separate occasions for approximately 4-5 minutes. (b) (6), (b) (3) (A) allegedly reported that they "held each other."

In the week of (b) (6) absence to (b) (6) (b) (6), (b) (3) (A) reported to this writer that (b) (6) had been checking up on (b) (6), (b) (3) (A) stated that he sent a text to a male staff member to ask if (b) (6), (b) (3) (A) been behaving and to tell (b) (6), (b) (3) (A) that he'd bring his belt if (b) (6), (b) (3) (A) wasn't.

(b) (6)

Fact Statement #26

Writer was asked by (b) (6) to join a meeting with (b) (6), (b) (3) (A) as the (b) (6), (b) (3) (A) wanted to talk with us about something. I joined them in the (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) told us that (b) (6) was having concerns about (b) (6), (b) (3) (A) and the interaction (b) (6), (b) (3) (A) had observed with (b) (6) (b) (6) reported that (b) (6) felt the need to watch out for (b) (6), (b) (3) (A) safety when (b) (6) was around (b) (6) as they were too close to one another and it made (b) (6) feel uncomfortable. Especially in the last couple of weeks and right before (b) (6) went on a work trip (b) (6) reported to (b) (6), (b) (3) (A) that (b) (6) had asked (b) (6), (b) (3) (A) their relationship and had given (b) (6), (b) (3) (A) some choices (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) reported that (b) (6), (b) (3) (A) had told him (b) (6), (b) (3) (A) but then had changed it (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) reported that (b) (6), (b) (3) (A) told (b) (6) that (b) (6) had rated their relationship as a 5 being (b) (6), (b) (3) (A) and (b) (6), (b) (3) (A) reported that (b) (6) brought (b) (6), (b) (3) (A) things like Beads and Candy. (b) (6), (b) (3) (A) reported that (b) (6), (b) (3) (A) had observed (b) (6) touching (b) (6), (b) (3) (A) touching them by poking them, (b) (6), (b) (3) (A) reported seeing this made (b) (6), (b) (3) (A) very uncomfortable. (b) (6), (b) (3) (A) reported that on the Friday that (b) (6), (b) (3) (A) occurred that (b) (6) and (b) (6), (b) (3) (A) went into (b) (6), (b) (3) (A) together and shut the door on 2 occasions. (b) (6), (b) (3) (A) reported that they were in the (b) (6), (b) (3) (A) with the door closed for about 4 or 5 minutes, while (b) (6), (b) (3) (A) was in (b) (6), (b) (3) (A) putting (b) (6), (b) (3) (A) things away. (b) (6), (b) (3) (A) reported that later on that night that (b) (6), (b) (3) (A) had told (b) (6), (b) (3) (A) that when they were in (b) (6), (b) (3) (A) they were touching and hugging each other. (b) (6), (b) (3) (A) told (b) (6), (b) (3) (A) that the note that I (Cynthia) had found was for (b) (6) (b) (6) also reported that (b) (6), (b) (3) (A) had told (b) (6), (b) (3) (A) (b) (6) aid if (b) (6), (b) (3) (A) wanted to send him a note to not give it to a staff member to put it in his mail box out front and he would get it. (b) (6), (b) (3) (A) said (b) (6), (b) (3) (A) was not aware of (b) (6) ever giving (b) (6), (b) (3) (A) note or was not aware of (b) (6), (b) (3) (A) writing him any more notes or putting them in his mail box. (b) (6), (b) (3) (A) reported that (b) (6), (b) (3) (A) told (b) (6), (b) (3) (A) that I and (b) (6) were scared of (b) (6), (b) (3) (A) and that (b) (6), (b) (3) (A) had convinced everyone that it was just a (b) (6), (b) (3) (A) thing between them.

Cynthia Slee ,Supervisory Social Service Assistant

Fact Statement #27

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #28

MEETING: UHC Governing Board

September 27th, 2016

(b) (6)

Tiara Ruff

STAFF ATTENDING: See Attached Sign In Sheet

ACTION POINTS:	ACTION TAKEN:	FOLLOW-UP:	STAFF RESPONSIBLE:
MEETING CALLED TO ORDER	Motion by Dr. Claymore to call to order UHC Governing Board Meeting Motion Second by Mrs. Martha Ketcher. Motion Carried: Meeting called to order at 10:12 am EST.		
CONFLICT OF INTEREST FORM AND PRIVACY ACT FORMS	Dr. Claymore requests that those that are attending this UHC Governing Board Call/Meeting to please sign these forms. They are located on the I-Drive. Please print them off; sign them and e-mail or fax them to (b) (6)	Sign and Send	All Members of GB (b) (6)
REVIEW OF AGENDA	CAPT Tiara Ruff asks if the participants would look over the GB agenda and if anyone would like to make any changes to the agenda. Motion by Dr. Claymore to approve agenda. Second the motion by Dr. Toedt. Motion carried.	Agenda Approved	
REVIEW OF PREVIOUS MINUTES (12-12-2014)	Dr. Finke asks if there are any addendums to the minutes regarding UHC's shut-down in December of 2014; if there was a GB meeting that regarded this specific issue. CAPT Ruff replied that there were several management calls but there was no official GB meeting regarding the closure of UHC. CAPT Ruff also explains that a RCA was done on the reason for the closure; which concluded that it was due to low staff. Motion by Dr. Claymore to table the approval of the GB minutes from 12-12-2014 until members receives more information regarding the closure of UHC and the RCA that was done on this issue. Motion Seconded by Dr. Toedt. Motion Carried. Dr. Finke suggests that this be an Action Item for the next UHC Governing Board Meeting.	Get the RCA added to the 12-12-14 Governing Board Minutes for approval. This will need to be sanitized and put on the I-Drive.	CAPT Tiara Ruff Tracey Grant

<p>OLD BUSINESS</p>	<p>REVISION TO REVISED BY-LAWS OF GOVERNING BOARD</p> <p>The By-Laws for Governing Board were revised on September 2016. The policy needs to be amended regarding Non-Voting members. It states that 2-3 Tribal Representatives that are placed on the Governing Board by the NAO Director, Mrs. Martha Ketcher are not able to vote.</p> <p>Dr. Claymore suggests that Mrs. Ketcher ask Health Directors at USET if they are willing to sit on Unity's GB, and also to look at which Tribes Unity services the most to fill a GB position.</p> <p>The Governing Board also needs the following representation:</p> <ul style="list-style-type: none"> -Nurse Consultant -CEO (Non-Voting Member) <p>Dr. Toedt would also like to start having UHC GB meeting quarterly; need to look into what the JCAHO standard for that would be.</p> <p>Motion by CAPT Ruff to table this revision of GB Policy & Procedures until next Governing Board Meeting.</p> <p>Motion Second by Dr. Toedt. Motion Carried</p> <p>Dr. Toedt would like for this to be an Action Item to be brought back to the next UHC Governing Board Meeting.</p>	<p>Tabled</p>	<p>All Members of GB</p>
<p>NEW BUSINESS</p>	<p>REPORT FROM TIARA RUFF</p> <p>See Attached Report from CAPT Tiara Ruff</p>		<p>Tiara Ruff</p>
	<p>REPORT ON THE DISCIPLINARY PROCEDURE</p> <p>Successful: The resident has done everything that is expected of them.</p> <p>CWSA: The resident has done most of everything that was expected but left due to different circumstances.</p> <p>Medical: The resident has medical problems that prohibit them from joining in most of the activities that are required of them at Unity. If a resident has to have surgery, an injury that cannot be treated here, etc.</p> <p>ACA: The resident is determined to leave Unity, has no desire to comply with Unity rules and refuses to join in groups, rec, etc.</p> <p>Death: Self-explanatory (Have never had this category and hope to not ever).</p> <p>Dr. Taylor asks if our categories are standard in residential programs or other RYTCs.</p> <p>CAPT Ruff replied that during RYTC calls this has been discussed and they would all like to be</p>		<p>Tracey Grant</p>

	<p>on the same page with this issue. The RYTC are all inconsistent and are having monthly calls to try to be more consistent with this and other issues regarding RYTC issues.</p> <p>Dr. Finke suggests that Unity looks at standard metrics in residential centers throughout IHS and private facility.</p> <p>◀ He also requests that this be an Action Item for the next UHC Governing Board Meeting.</p>		
	<p>CLINICAL PRIVILEGING AND CREDENTIALING</p> <p>Discussion regarding the policy for credentialing and whether there needs to be a policy and procedure regarding credentialing. Several members of UHC Governing Board would like to review the privileging and credentialing of staff for clinical services.</p> <p>Motion by Mr. Finke to table privileging and credentialing.</p> <p>Motion seconded by Dr. Toedt.</p> <p>▶ Dr. Toedt requests that this be an Action Item for the next UHC Governing Board Meeting.</p>	Tabled	
	<p>PERSONNEL STAFFING/CAPACITY ISSUES</p> <ol style="list-style-type: none"> 1. Mental Health Specialist is still vacant 2. 2 Mental Health Therapists have questions on the applicants. 3. Recreation Specialist: Working with (b) (6) ◦ Classify again 4. Administrative Officer: Have made a selection but due to technical difficulties Tiara cannot chose the applicant. Dr. Claymore will help her with this. 5. Cultural Position: Have hired this position and should start on 10/02/16 6. Contract Employees: I-Administrative Assistant, I-Cook, I-Housekeeper 7. We are aware of 3 verbal resignations for SSAs. 8. 1 SSA applicant has still not gotten his fingerprints; has been contacted numerous times but cannot be reached. May have to re-advertise, <p>STANDING LEVELS</p> <ol style="list-style-type: none"> 1. Due to NC Medical Regulation Unity can only take 8 residents based on the current amount of SSAs that we have at this time. 2. SSAs are critical, CMS requirements for youth ages 9-12 is 9 residents to 4 staff; a minimum of 3 staff for all waking hours. For youth ages 13-17 is 9 residents to 5 staff and 4 staff for over-night. 		
	<p>UNITY SURVEY</p> <p>Dr. Claymore, (b) (6) and (b) (6) sent out a survey (Survey Monkey) through e-mail to Tribal Health Directors, Tribal Leaders, School Counselors, etc. We will also be presenting this survey at USET in October that will be held in Cherokee for more input regarding their knowledge of Unity. Savannah has been following up with phone calls to the different tribes and is now compiling the information that she has received.</p>		<p>Dr. Claymore (b) (6) (b) (6)</p>

	<p>UNITY EMPLOYEE SURVEY</p> <p>CAPT Ruff explained the results of the employee survey.</p> <p>Mark Skinner replied that the questions present very little data and that nothing useful comes from this survey. He offered to help with Unity's next survey and proposed that Unity use Survey Monkey.</p> <p>Mr. Finke suggests that we take a look at other facility's surveys and compile a survey that will give better information that will show Unity's trends, problems and solutions to these problems.</p> <p>♦Mr. Skinner would like for this to be an Action Point for Next GB Meeting.</p> <p>RESIDENT SATISFACTION SURVEY</p> <p>Tracey Grant did not have a copy with her but she will put it into the I-Drive for GB member to review. Tracey states that she will look at other survey used in different facilities and re-new out survey and action points.</p>		
	<p>GETTING APT. IN BILL</p> <p>Contract Program Assistant has extensive training at other facilities and hospitals regarding information and requirement for NC coding and billing.</p> <p>CLARK DOCUMENTATION</p> <ul style="list-style-type: none"> -Level of electronic documentation -At this time we are scanning documents into the program that we are using -We have changed forms and counselors are getting the hang of using them and it is cutting down on time. -Does RYTCs need the full HR program? 		
	<p>SCHOOL/EDUCATION PROGRAM</p> <p>Unity is working with local schools to create a more value of our school and education program here at Unity (b) (6) has worked with different schools but the Swain County School system has been the most helpful. We would like to get more schools involved but the problem is that the resident will not be enrolled in their schools and this creates a problem for the schools numbers and funding. The school work here will be on-line education except for the residents that have special needs, special education.</p>		
	<p>QUALITY IMPROVEMENT ACTION CERTIFICATION</p> <p>JCAHO has until the 18th of December, 2016 to notify Unity when it will be here to do our inspection for recertification.</p>		

	<p>ADMINISTRATIVE REPORT:</p> <p>Nursing is now offering the Flu vaccine for Unity Staff and Residents</p> <p>CAPT Ruff shows a copy of the Staffing Plan – See Attached</p> <p>CAPT Ruff states that they are still working on a MOA with the Cherokee Indian Hospital. CAPT Ruff found a previous MOA that was with CIH and forwarded it to (b) (6) and they are currently working to get that finalized.</p> <p>♦Dr. Claymore would like to make this an Action Point for the next GB meeting.</p>		
	<p>DAILY SCHEDULE:</p> <p>(b) (6) asks what a day at Unity consists of for Unity residents. Tracey Grant answers with our daily schedule, I:I, groups, school, AA/NA meetings, recreational activities, cultural activities and lectures. Tracey states that it is a structured program schedule. (b) (6) responded that Unity seems to be right on track with daily activities.</p>		
	<p>RUFF MEMBERS IN PORTLAND:</p> <p>CAPT Ruff reports that they are going to form a periodic meeting.</p> <p>They also want to write Policies and By-Laws for this new committee.</p>		
	<p>GENERAL STAFF:</p> <p>CAPT Ruff reports that during Unity's general staff that we offer training for staff; CPR, HAZMAT, Blood Borne Pathogens, Mental Health Ist Aid, CFR-42 and HIPPA regulations.</p> <p>Would like to have more Trauma Informed Training, staff have had some but would like to have more in depth training. There are several Native American groups that offer this training and are willing to do this for us.</p> <p>What are the changes in the program regarding the impact of training? Why do you need training and has it been effective?</p> <p>♦Dr. Finke would like for this to be an Action Point for the next GB Meeting.</p>		
	<p>WEB-CIDENTS:</p> <p>CAPT Ruff informs GB that the recent Web-Cidents reports have been put into the I-Drive. She also states that she will do a more in depth report and also place it into the I-Drive.</p> <p>Some of the Web-Cidents include:</p> <ol style="list-style-type: none"> 1. Injury of residents due to Unity Recreation activities 2. Med Errors: Missed medication 3. In-Grown toe nails 4. Injuries to staff 		

	<p>CONTRACTING:</p> <p>CAPT Ruff states that with the increase of residents we will need to contract a Nurse Aide to help our Nurse with patient care.</p> <p>Dr. Claymore requests a list of the contractors that we use and Tiara stated she would send that to her directly on the I-Drive.</p> <p>In need of a Camera System and new Phone System.</p> <p>Dr. Finke asked what help from the NAO will be needed. Tiara states that (b) (6) is working on a Scope of Work for the Camera System since it is needed more for security of residents.</p> <p>Dr. Finke asks how Unity manages without cameras for the safety of our residents at this time.</p> <p>♦Dr. Finke would like to make this an Action Item for the next GB meeting.</p>		
	<p>NURSING REPORT:</p> <p>As stated earlier, will need more help as we get more residents. Our Nurse deals with the following here at UHC and also using the Cherokee Indian Hospital when needed for these services:</p> <ul style="list-style-type: none"> -Dental Appointment -Immunizations -Blood Draws -Male and Female Health -Dermatology -Acne -Constipation 		
	<p>RESIDENT EMERGENCY INTERVENTION:</p> <p>(b) (6), (b) (3) (A)</p> <p>Dr. Toedt suggested that a RCA be done regarding this incident and made himself available to be a part of this RCA since he will be here in Cherokee all week. Dr. Toedt also states that GB members should be made aware of these types of incidents as soon as possible.</p> <p>♦Dr. Finke would like to make this an Action Item to be discussed at a special called conference call to the GB members.</p>	<p>This RCA will be done this week and a report will be made on a special conference call to GB members.</p>	<p>Dr. Toedt CAPT Ruff Tracey Grant</p>

	<p>CALL FOR EXECUTIVE SESSION:</p> <p>Dr. Toedt requests that Governing Board now go into Executive Session. No minutes will be taken for this part of Governing Board.</p>		
	<p>ACTION ITEMS:</p> <ul style="list-style-type: none"> • Governing Board Minutes from 12-12-2014 to be revised with the RCA for UHC's closure. Due Date: Next GB meeting • Governing Board Policy and Procedures/By-Laws updated. Due date: Next GB • Standards for Discharge Status. Due date: January 2017 call • Credentialing and Privileging Policies and clarification on what is needed. Due date: Next GB meeting. • MOA with the Cherokee Indian Hospital. Due date: Next GB meeting. • Surveys for UHC employees and residents updated. Due date: Next GB meeting. • Camera System and how it is managing the safety of our residents at this time. Due date: Next GB meeting. 		

MEETING ADJOURNED: Motion to adjourn by Dr. Claymore
 Motion Second by Dr. Toedt
 Meeting Adjourned at 1:20 pm EST

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Fact Statement #29

Unity Healing Center – Timeline of Events – Concerns of Sexual Abuse Allegations, Quality of Services Corrective Action Plan, Personnel Actions, and Tribal Consultation

December 12, 2014: Unity Governing Body Meeting. Plan is to suspend admission beginning on 12/19/2014 due to staffing shortage leading to safety of care issues. Tiara Ruff, CEO to complete Root Cause Analysis on concerning low staffing levels. Unity had 0 census from 12/17/14-4/12/15.

June 2, 2015: Tiara Ruff completes Unity Healing Center Root Cause Analysis Review and Quality Assessment and Performance Improvement 2015. Recommendations focused on improved HR process, Marketing of Unity through USET, and repairs/renovation to existing facility.

August 22, 2016: Site Visit to Desert Visions/Nevada Skies. Tracey Grant, Clinical Supervisor, Dr. Claymore, DFO, Melanie Tomko, NA Business Office Manager, Alyshia Baker, NA Coder meet with Desert Vision CEO, Nevada Skies, Health System Administrator, Clinical Director, Medical Provider, Nurse Supervisor, and Dr. Rose Weahkee, Phoenix Area DFO to look at ways to improve issues of low census, billing, and a more effective treatment model at Unity. CAPT Ruff, CEO Unity was available by phone for part of the meetings.

(b) (6), (b) (3) (A) 2016: Inappropriate behavior, boundaries, and interactions, leading to a non-sexual relationship between **(b) (6)** and a **(b) (6), (b) (3) (A)** at IHS-operated Unity Healing Center located in Cherokee, NC. Confirmation is from reports from staff, resident complaints, and video surveillance.

(b) (6), (b) (3) (A) 2016: **(b) (6)** is alone in the bathroom with **(b) (6), (b) (3) (A)** for several minutes. Bathroom renovations were occurring and **(b) (6), (b) (3) (A)** had been moved into a new **(b) (6), (b) (3) (A)**. **(b) (6)** reported that **(b) (6), (b) (3) (A)** came to him stating that the outlet had given **(b) (6)** a shock and he was checking out the outlet. Tracey Grant, Clinical Supervisor, Cynthia Slee, SSA Supervisor, and Allen Bollinger, Nashville Area OEHF (who was onsite for the renovations) viewed the video surveillance tape confirming that **(b) (6)** and **(b) (6), (b) (3) (A)** entered the bathroom together and were in there for several minutes. Following the incident Tracey Grant, Clinical Supervisor meets with **(b) (6)** and discusses appropriate boundaries.

(b) (6), (b) (3) (A) 2016: **(b) (6), (b) (3) (A)** is questioned by SSA supervisor Cynthia Slee and SA therapist **(b) (6)** regarding a letter that Cynthia Slee has taken from the **(b) (6), (b) (3) (A)**.

(b) (6), (b) (3) (A) is questioned if the letter is to the **(b) (6)**. **(b) (6), (b) (3) (A)** denied it was to **(b) (6)** and becomes upset. **(b) (6), (b) (3) (A)**

(b) (6), (b) (3) (A) later tells **(b) (6), (b) (3) (A)** who reports it to staff the next day.

(b) (6), (b) (3) (A) 2016: **(b) (6), (b) (3) (A)**

(b) (6), (b) (3) (A) 2016: Unity Governing Body meeting is held. During the meeting it is reported to GB that there has been a **(b) (6), (b) (3) (A)**. CAPT Ruff reports that **(b) (6), (b) (3) (A)** and has led to a non-sexual relationship with the **(b) (6)**. **(b) (6), (b) (3) (A)** is addressing it with the **(b) (6), (b) (3) (A)** and the **(b) (6)**. **(b) (6)** does not have any contact with the **(b) (6), (b) (3) (A)**. An action item of completing a Root Cause Analysis (RCA) is assigned.

Unity Healing Center, Cherokee, NC Timeline of Events 2016-2019

September 28, 2016: CAPT Ruff provided a directive to (b) (6) via email restricting him from the main building until further notice.

September 28, 2016: (b) (6), (b) (3) (A) meets with (b) (6), (b) (3) (A) regarding (b) (6), (b) (3) (A) concern that a (b) (6), (b) (3) (A) was read by staff and being "misinterpreted". (b) (6), (b) (3) (A) reported that the information was disseminated to rest of staff and (b) (6), (b) (3) (A)

September 29, 2016: (b) (6), (b) (3) (A) meets with CAPT Tiara Ruff, CEO at the (b) (6), (b) (3) (A) request. (b) (6), (b) (3) (A) reports (b) (6), (b) (3) (A) concerns that the counselors and SSAs are saying about (b) (6), (b) (3) (A) CAPT Ruff talks to the (b) (6), (b) (3) (A) about (b) (6), (b) (3) (A) and (b) (6), (b) (3) (A) CAPT Ruff (b) (6), (b) (3) (A) and reports that (b) (6), (b) (3) (A)

September 30, 2016: RCA call held which included Unity Staff (CAPT Ruff, CEO, Tracey Grant, Clinical Supervisor, Cynthia Slee, SSA Supervisor) and Nashville Area Office staff (Dr. Toedt, CMO, Dr. Taylor, Nashville Area Behavioral Health Consultant, Dr. Claymore, DFO). The focus of the RCA was a review the incident of (b) (6), (b) (3) (A) Action items included updated policies related to (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) Staff training in (b) (6), (b) (3) (A) ERLR referral for staff boundary issue (b) (6), and a NAO Mock Survey scheduled for 10/24-25/2016.

October 13, 2016 (b) (6) TDY to Mashpee to help with maintenance duties at the Mashpee Service Unit. His TDY was through November 1, 2016. (b) (6), (b) (3) (A)

March 12, 2017: (b) (6) observed on video surveillance in his office on a non-duty day with a non-government employee adult female caressing and giving her a hug.

May 9, 2017: CEO Tiara Ruff sent an email to Dr. Claymore (Deciding Official) and IHS Nashville Employee Relations Labor Relations Sta (b) (6) stated she proposed

(b) (6), (b) (5) (b) (6), (b) (5) (b) (6) signed acknowledging receipt 5/9/17 (b) (6) Proposal was based on September 2016

administrative findings of inappropriate relationship with (b) (6) (b) (6)

May 12, 2017: Anonymous report to the Eastern Band of Cherokee Indians (EBCI) Public Health and Human Services, Department of Human Services, Cherokee, NC, regarding sexual relationship between

(b) (6), (b) (3) (A) Reporter stated they had heard about an incident on 2016. (b) (6), (b) (3) (A)

(b) (6), (b) (5), (b) (3) (A)

May 16, 2017: Tracey Grant received a phone message from (b) (6) at Eastern Band of Cherokee Indians (EBCI) Public Health and Human Services, Department of Human Services, Cherokee, NC.

Handwritten note: "I was told this info from" with an arrow pointing to the first paragraph.

(b) (6) reported she received a report that (b) (6), (b) (3) (A) had been involved in a sexual relationship with a (b) (6) that worked at Unity. It was an anonymous report received May 12, 2017. Ms. Grant contacted her supervisor CEO Capt. Tiara Ruff asking for guidance on how to respond.

May 16, 2017: CEO Capt. Tiara Ruff and Tracey Grant contacted Vickie Claymore, Director of Field Operations, via phone. They were directed to contact OGC (b) (6), (b) (5) guidance.

May 16, 2017: Ms. Grant contacted (b) (6) OGC requesting guidance and help with a (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A), (b) (5)

May 17, 2017: Dr. Claymore received a written response to the proposal for removal via UPS from (b) (6) (b) (6) His response included the (b) (6) 2016 administrative findings of (b) (6) (b) (6) and (b) (6), (b) (3) (A) 2017 of (b) (6)

May 17, 2017: (b) (6), (b) (5)

(b) (6), (b) (5)

May 17, 2017: (b) (6), (b) (3) (A) IHS/OGC sent an email to Martha Ketcher, AD to inform her that Tracey Grant had informed (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A), (b) (5)

(b) (6), (b) (3) (A), (b) (5) and copied Lisa Gyorda. IHS/OGC (b) (6) were also copied on the email.

May 17, 2017: (b) (6) IHS/OGC sent an email to Tracey Grant. Copied on the email was IHS/OGC (b) (6) recaps an earlier conversation with Tracey.

(b) (6), (b) (5)

May 18, 2017: As recommending by (b) (6) OGC Tracey Grant, Clinical Supervisor contacts (b) (6), (b) (7)(C)

(b) (6), (b) (5), (b) (7)(C)

May 18, 2017: (b) (6) (IHS/OGC) sent an email to Tracey Grant to confirmed what Tracey had reported in her phone conversation with OGC.

(b) (6), (b) (3) (A), (b) (5)

May 18, 2017: (b) (6), (b) (3) (A), (b) (5)

(b) (6), (b) (5)

May 18, 2017: Lisa Commins, Director Division of Personnel Security and Ethics sent an email stating OIG had been (b) (6), (b) (3) (A)

May 19, 2017 (b) (6) was placed on administrative leave.

May 22, 2017: Dr. Claymore contacts (b) (6) via email to seek guidance on moving forward with the proposed (b) (6), (b) (5)

(b) (6), (b) (5)

May 22, 2017: (b) (6) OGC in an email to (b) (6) OGC, Lisa Gvorda, IHS/HR. (b) (6)

(b) (6), (b) (5)

May 23, 2017 Martha Ketcher, AD verbally informed Vickie Claymore, DFO that she had received an email from (b) (6) tha (b) (5)

May 24, 2017: Tracey Grant received letter from EBCI Health and Human Service requesting any and all information related to the alleged incidents that took place involving the (b) (6), (b) (3) (A) suspected of being abused by (b) (6) Tracey forwarded the letter to Unity CEO, Tiara Ruff, Nashville Area Office (Martha Ketcher, AD; Vickie Claymore, DFO) and IHS/OGC (b) (6)

(b) (6) OGC) replies that OGC (b) (5)
(b) (5)

June 2, 2017: Unity receives Subpoena for records from ECBI Cherokee Court requesting. Records requested include personnel records of (b) (6), (b) (5), video surveillance records (b) (6), (b) (5), (b) (6), (b) (5) contact information, staffing logs and any information regarding (b) (6), (b) (5) duties and contact with any (b) (6), (b) (3) (A) of Unity Healing. Also received (b) (6), (b) (5) (b) (6), (b) (3) (A), (b) (5) (b) (6), (b) (3) (A), (b) (5) CAPT Ruff forwarded the information to (b) (6) OGC, Martha Ketcher, AD and Dr. Claymore, DFO.

June 8, 2017: Tracey Grant, Clinical Supervisor received a Cease and Desist Document Removal or Destruction letter from the ECB (b) (6). It stated that it had come to the attention of the prosecutor that employees of Unity Healing may be destroying or removing evidence of a potential crime and a current investigation while those documents are under subpoena. The letter was sent via email from Tracey Grant to (b) (6)

(b) (6)

June 9, 2017: (b) (6) OGC sends an email to Tracey Grant, Clinical Supervisor, Tiara Ruff, CEO Unity, (b) (6) OGC, Martha Ketcher, AD, and Dr. Claymore, DFO confirming that she had consulted (b) (5)

(b) (5)

confirmed (b) (5)

(b) (6) OGC has also

(b) (5)

Tracey Grant and Tiara Ruff are to (b) (5)

June 13, 2017: (b) (6) (b) (5)

(b) (6), (b) (5)

The email went to CAPT Ruff, CEO, Tracey Grant, Clinical Supervisor, Martha Ketcher, AD and Dr. Claymore, DFO. Copied on the email were OGC staff (b) (6). CAPT Ruff replied she would distribute the document to staff today (June 13, 2017).

June 30, 2017 Office of the Inspector General (OIG) issued a search warrant for Unity Healing Center. The search was conducted by OIG and EBCI law enforcement. (b) (6), (b) (7)(C) lead the investigation. The OIG team searched offices, (b) (6), (b) (3) (A) administrative records, and surveillance tapes. They conducted interviews of staff.

July 7, 2017: RADM Chris Buchanan is provided an update on the status of the OIG investigation at his request via email. CAPT Ruff provided a brief summary via email which was provided to RADM Buchanan by Martha Ketcher, AD.

July 7, 2017: Email string from (b) (6), (b) (5) to Dr. Claymore, DFO. Indicating that

(b) (6), (b) (5)

July 11, 2017: Sent inquiry to (b) (6) (b) (5)

(b) (6), (b) (5)

(b) (6), (b) (5)

July 11, 2017: Tracey Grant, Clinical Supervisor sends inquiry to (b) (6)

(b) (6), (b) (5), (b) (7)(C)

July 20, 2017: Unity received three-year Joint Commission re-accreditation.

August 4, 2017: Dr. Claymore received an email string from Martha Ketcher, AD. (b) (6)

(b) (6) had received an (b) (6) (b) (5) (b) (7)(C)

(b) (6), (b) (5), (b) (7)(C)

September 1, 2017 Received response from (b) (6) (b) (5)

(b) (6), (b) (5)

September 11, 2017: Dr. Claymore received call from Tracey Grant, Clinical Supervisor (b) (6), (b) (3) (A)

(b) (5), (b) (6)

Dr. Claymore sent email to (b) (6)

(b) (6), (b) (5)

December 4, 2017: Joint Commission Alerts Tiara Ruff, CEO Unity that they have received a complaint. It is reported that there are "numerous safety issues, violations and documentation violations at the facility." It references that OIG came to Unity on 6/30/17 and that the facility remains under investigation for concerns of (b) (6), (b) (5)

(b) (6), (b) (5)

December 15, 2017: CAPT Ruff, CEO Unity (b) (6)

(b) (6)

January 5, 2018: CAPT Ruff received a notice from Joint Commission that they accepted the organization's response and would not take any further action at that time. Joint Commission noted that should they receive additional information that may be relevant to these issues in the future, a determination will be made at that point if further evaluation is needed.

January 27, 2018: CAPT Ruff Submits the Corrective Action Plan to address the issues identified by Governing Body.

February 1, 2018: (b) (6) receives letter from the NC Psychology Board stating a complaint was filed against her by former employ (b) (6). (b) (6) One of his allegations is that (b) (6) failed to report suspected sexual misconduct between a (b) (6), (b) (3) (A) and a (b) (6), (b) (3) (A) at the facility (b) (6). He state (b) (6) assisted in an "Internal Investigation" despite federal, state and Unity Healing Centers' own internal policy to report to the local

March 6, 2018: Received email from Lisa Gyorda (US/HC) providing that (b) (6), (b) (5)

(b) (6), (b) (5)

March 6, 2018: RADM Kevin Meeks contacts Dr. Claymore, DFO to ensure aware of the Legal Analysis and that there will be follow up with CC Officer, CAPT Ruff, CEO Unity.

March 6, 2018: Dr. Claymore sent email to Lisa Gyorda with CC to Dr. Bruce Finke, Acting AD asking for

(b) (6), (b) (5)
(b) (6), (b) (5)

Lisa Gyorda responded that she is reviewing questions but I did not receive anything back directly from her responding to the questions.

March 21, 2018 (b) (6), (b) (5)

(b) (6), (b) (5)

(b) (6), (b) (5) Dr. Finke concurred with the recommendation.

March 21, 2018: Vickie Claymore, DFO reached out to (b) (6) regarding (b) (6), (b) (5)

(b) (6), (b) (5) CC Liaison's Brandon Taylor and (b) (6)

were copied on the email. Dr. Claymore followed up with a call (b) (6) regarding the (b) (6)

(b) (6) LCDR had concerns that the OIG investigation had not been completed.

March 28, 2018: Tiana Ruff worked with Nashville IHS ERLR and provided a memo to (b) (6)

(b) (6), (b) (5) There were not any restrictions listed in the memo.

April 8, 2018: (b) (6) detailed to Unity as (b) (6)

(b) (6) to be detailed to another position due to continued management and operating difficulties at Unity.

(b) (6) requested annual leave and medical leave while an appropriate detail could be agreed upon

by management, CC Liaison, and (b) (6) (b) (6)

(b) (6)

Unity Healing Center, Cherokee, NC Timeline of Events 2016-2019

May 15, 2018: (b) (6), (b) (5) provided draft (b) (6), (b) (5) (b) (6) responded that he had accepted another position and to work with (b) (6) CAPT Taylor had also accepted another position and would be leaving as well.

May 21, 2018: Follow up with (b) (6) and sent (b) (6) (b) (6)

May 29, 2018: Sent email to (b) (6), (b) (5) (b) (6), (b) (5) I was working with (b) (6). (b) (5) (b) (6), (b) (5)

June 2, 2018: Email from (b) (6), (b) (5) reported "We (b) (6), (b) (5) were advise (b) (6), (b) (5)

(b) (6), (b) (5)

June 8, 2018: Received email from (b) (6)

He had talked with (b) (6)

(b) (6), (b) (5) (b) (6) was going to speak to (b) (6) (b) (5)

(b) (6), (b) (5)

June 11, 2018 (b) (6) email stating she will get process of finding (b) (6) (b) (6)

(b) (6) agrees with moving forward with announcing the (b) (6)

August 27, 2018: Dr. Claymore sends email to (b) (6) inquiring on the final (b) (6)

(b) (6) Send email to (b) (6) inquiring on the completion of (b) (6)

Received email back from (b) (6) confirming detail will be August 29, 2018-October 28, 2018. Memo signed by (b) (6)

(b) (6) assigned her as the (b) (6) It was for a period not to exceed 60 days with the option to extend up to 120 days. All expenses incident to this TDY to be paid by Pine Ridge Service Unit. Copied on the memo was (b) (6) (b) (6)

(b) (6)

August 28, 2018: (b) (6) received and signed for (b) (6) It was given to her by (b) (6)

(b) (6) and copies were sent to (b) (6) and Dr. Claymore.

September 4, 2018: Admission dates were delayed due to low census. It was felt having one patient was not therapeutic so the admission was delayed until we could have at least two admissions.

Admissions started again October 2, 2018. During that time (b) (6) worked with staff on policy and procedures, reviewing schedule and treatment elements, and catching up on records.

September 22, 2018: (b) (6) Nashville Area Business Officer Manager detailed to Unity

(b) (6) detail ended and she returned to her position as (b) (6)

(b) (6)

October 16, 2018: Email sent to (b) (6)

(b) (6)

(b) (6) responded on

Unity Healing Center, Cherokee, NC Timeline of Events 2016-2019

October 17, 2018 that (b) (6) was doing a good job at (b) (6) and wanted to extend the TDY. He stated (b) (6) was interested in bringing her on full time and he was working with the (b) (6) to get it finalized. It was pending final approval from Pine Ridge.

October 31, 2018: (b) (6)

(b) (6)

November 20, 2018: Selection made for new CEO Unity.

November 29, 2018: (b) (3) (A)

(b) (5), (b) (3) (A)

December 11, 2018 Email sent to (b) (6) regarding update on the extension since I hadn't received anything since the October 17, 2018 email from (b) (6) responded in email stating Pine Ridge had extended the TDY and was currently working on (b) (6) (b) (6) to Pine Ridge. He was going to follow up with the (b) (6)

January 22, 2019: Unity Governing Board meeting held related to draft Joint Commission corrective action plan. Concerns raised by governing board regarding the administrative inquiry and any subsequent steps that needed to occur after (b) (6) returned to work.

January 28, 2019: Beverly Cotton, Area Director, requests to convene meeting with Area Office staff and Acting Unity CEO to further discuss draft corrective action plan. Decision is made to request review and assistance with the corrective action plan from IHS Office of Quality for review before it is submitted to Joint Commission.

January 29, 2019: Corrective action plan submitted to Joint Commission.

February 18, 2019: Corrective action plan accepted by Joint Commission. No further follow up required by Joint Commission. Acting Unity CEO notifies Nashville Area Office leadership of concerns that staff fail to meet directives and follow corrective action plan. Clinical supervisor not following through on actions.

February 14, 2019: Sent email to (b) (6) again inquiring about the transfer. Dr. Finke and Allen Bollinger, Nashville Area CC Liaison copied on the email.

February 21, 2019: Unity Governing Board Special Called Meeting held to address concerns the corrective action plan was not being followed and implemented by (b) (6) failure to follow directives from the (b) (6) Executive Session called to order to address personnel concerns and recommendations for the Acting Unity CEO to take for (b) (6) and (b) (6)

Unity Healing Center, Cherokee, NC Timeline of Events 2016-2019

February 22, 2019: Call held between Beverly Cotton, Area Director, and (b) (6), (b) (7)(C) with IHS HQ Office of Management Services Director, Athena Elliott, to inquire about the active OIG investigation at Unity, as well as address concerns with the length of time it is taking to hear back from OIG which has

(b) (6), (b) (5) (b) (6), (b) (7)(C), (b) (5) (b) (6), (b) (5) (b) (6), (b) (7)(C) offers to be available for any questions and guidance.

February 28, 2019: Site visit conducted to Unity by Director of Field Operations, Vickie Claymore; Acting Area Deputy Director, Bruce Finke; and Area Director, Beverly Cotton. Allen Bollinger, Facilities Director, also attends site visit. Leadership team meets with Unity staff and communicates plans to take action to improve the quality of services over the course of the next year. Leadership asks for commitment to change from staff. Review of facility conducted and plans for renovations to buildings and parking lot. Decision made that no resources will be devoted to Unity facility until after tribal consultation is conducted.

Nashville Area Office holds call with IHS National Chief Medical Officer and Office of Quality to brainstorm solutions for potential upcoming staff shortages at Unity if personnel actions are taken. Nashville Area Office informs IHS HQ that she will be ending (b) (6) who was detailed to Pine Ridge and asking her to return to the Nashville Area Office for a permanent reassignment.

February 28, 2019: Email from Nashville Area Director to Great Plains Area Director and other relevant staff ending (b) (6) detail to Pine Ridge Service Unit and returning to Nashville Area Office.

March 1, 2019: Additional staffing from HQ is not feasible to detail to Unity. Nashville Area Office leadership (b) (5)

(b) (5)

March 6, 2019: Unity status provided to USET Health Committee during USET Impact Week, identifying issues with quality and personnel challenges.

March 12, 2019: (b) (6) submitted his resignation effective March 13, 2019.

March 19, 2019: (b) (6) signs for TDY Assignment as a (b) (6) (b) (6) at the Nashville Area Office. TDY effective 3/20/2019 and will be for a period not to exceed 180 days.

March 20, 2019: IHS Nashville completes draft of 1 year action plan to improve quality of services and management competencies at Unity (b) (5)

(b) (5)

March 21, 2019: IHS Public Affairs contacted by Wall Street Journal related to 2016 sexual abuse allegations at Unity.

April 1, 2019: New CEO for Unity EOD.

Fact Statement #30

ROOT CAUSE ANALYSIS AND ACTION PLAN FRAMEWORK TEMPLATE

The Joint Commission Root Cause Analysis and Action Plan tool has 24 analysis questions. The following framework is intended to provide a template for answering the analysis questions and aid organizing the steps in a root cause analysis. All possibilities and questions should be fully considered in seeking “root cause(s)” and opportunities for risk reduction. Not all questions will apply in every case and there may be findings that emerge during the course of the analysis. Be sure however to enter a response in the “Root Cause Analysis Findings” field for each question #. For each finding continue to ask “Why?” and drill down further to uncover why parts of the process occurred or didn’t occur when they should have. Significant findings that are not identified as root causes themselves have “roots”.

As an aid to avoid “loose ends,” the two columns on the right are provided to be checked off for later reference:

- “Root cause” should be answered “Yes” or “No” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a “Why?” question such as “Why did it contribute to the likelihood of the event?” or “Why did it contribute to the severity of the event?” Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- “Plan of action” should be answered “Yes” for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan.

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

Unity Healing Center, Cherokee, NC Timeline of Events 2016-2019

February 22, 2019: Call held between Beverly Cotton, Area Director, and (b) (6), (b) (7)(C) with IHS HQ Office of Management Services Director, Athena Elliott, to inquire about the active OIG investigation at Unity, as well as address concerns with the length of time it is taking to hear back from OIG which has

(b) (6), (b) (5) (b) (6), (b) (7)(C), (b) (5) (b) (6), (b) (5) (b) (6), (b) (7)(C) offers to be available for any questions and guidance.

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Nashville Area Office holds call with IHS National Chief Medical Officer and Office of Quality to brainstorm solutions for potential upcoming staff shortages at Unity if personnel actions are taken. Nashville Area Office informs IHS HQ that she will be ending (b) (6) who was detailed to Pine Ridge and asking her to return to the Nashville Area Office for a permanent reassignment.

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March 1, 2019: Additional staffing from HQ is not feasible to detail to Unity. Nashville Area Office leadership (b) (5)

(b) (5)

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March 12, 2019: (b) (6) submitted his resignation effective March 13, 2019.

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(b) (5)

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As an aid to avoid “loose ends,” the two columns on the right are provided to be checked off for later reference:

- “Root cause” should be answered “Yes” or “No” for each finding. A root cause is typically a finding related to a process or system that has a potential for redesign to reduce risk. If a particular finding is relevant to the event is not a root cause, be sure that it is addressed later in the analysis with a “Why?” question such as “Why did it contribute to the likelihood of the event” or “Why did it contribute to the severity of the event?” Each finding that is identified as a root cause should be considered for an action and addressed in the action plan.
- “Plan of action” should be answered “Yes” for any finding that can reasonably be considered for a risk reduction strategy. Each item checked in this column should be addressed later in the action plan.

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

Fact Statement #31

Ruff, Tiara R (IHS/NAS/UHC)

From: Ruff, Tiara R (IHS/NAS/UHC)
Sent: Wednesday, September 28, 2016 12:21 PM
To: (b) (6)
Subject: Main building upper & Lower Floors

Importance: High

(b) (6)

This is your official directive that I am restricting you from the main building upper and lower floors
Until further notice.

Please communicate with me if there is a problem in the main building and we can work together
To figure out a time you can enter the building when the (b) (6) leave the center.

Thank you



Tiara R. Ruff

Executive Director

CAPT USPHS

Unity Healing Center(YRTC)/NAIHS

PO Box 201, 448 Sequoyah Trail Drive

Cherokee NC 28719

☎ (828) 497.3958 x203

☎ (828) 497.6826

✉ tiara.ruff@ihs.gov



Cell: (b) (6)

"Not what we gain, but what we give measures the worth of the life we live." - Unk
"The growth and development of people is the highest calling of Leadership." - Harvey S. Firestone

Security Reminder: Do not send or attach personally identifiable information (PII), such as SSN, DOB, through unencrypted e-mail

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Fact Statement #32

9/28/16

Writer spoke with (b) (6) this morning when he called into work. I asked him if he had any knowledge about (b) (6) texting anyone and asking about the (b) (3) (A), (b) (6) while he was in (b) (6) (b) (6) said yes that (b) (6) had texted him and asked him how things were going at the facility, and how the (b) (3) (A), (b) (6) were doing. (b) (6) was asked if (b) (6) had singled out any (b) (3) (A), (b) (6) in particular (b) (6) said no he had asked about all the (b) (3) (A), (b) (6) I asked (b) (3) (A), (b) (6) in the text if (b) (6) had threatened to get the belt after the (b) (3) (A), (b) (6) if they didn't behave while he was gone (b) (6) said absolutely not. But he was joking with the (b) (3) (A), (b) (6) after the text and may have said "you know (b) (6) he will get after you if you don't behave". But they were just laughing and joking as they always do. I asked (b) (6) if he still had the text he said no that he did not save it. (b) (6) did state he did not feel (b) (6) had done anything wrong regarding this text he took it as (b) (6) was concerned about the center and all the (b) (3) (A), (b) (6)

Cynthia Slee



Supervisory Social Service Assistant

Fact Statement #33

Date Received:	9/28/2016	High Incident
Location:	Unity	
Incident report filed against / Employee Name / Title	(b) (6)	
BUE:	N	
Incident:		
Performance / Conduct:	C	
Supervisor Name / Title:	Tiara Ruff, Executive Director	
Support Review:		
Notes:	09/28/16 - T Ruff placed (b) (6) on restriction from the main Unity facility and began investigation on possible inappropriate concerns with a (b) (6), (b) (3) (A) and began her investigation.	
Follow up dates:	02/08/17 - Sent email to his supervisor requesting update on this issue.	

5

Date Received:	8/31/2016	High Incident
Location:	Unity	
Incident report filed against / Employee Name / Title	(b) (6)	(b) (6)
BUE:	N	
Incident:	(b) (6)	
Performance / Conduct:	C	
Supervisor Name / Title:	(b) (6)	
Support Review:		
Notes:	(b) (6)	
Follow up dates:	(b) (6)	

6

Date Received:	12/22/2015	(b) (6)
Location:	(b) (6)	
Incident report filed against / Employee Name / Title	(b) (6)	
BUE:	N	
Incident:	12/22/15 - (b) (6)	
Performance / Conduct:	P	
Supervisor Name / Title:	(b) (6)	
Support Review:	WK	
Notes:	(b) (6)	
Follow up dates:	(b) (6)	
Closed case:	(b) (6)	

WORKLOAD REPORT JAN 2017
 IN MARK SKINNER FILE

1	
Date Received:	10/4/2016 (b) (6)
Location:	(b) (6)
Incident report filed against / Employee Name	(b) (6)
BUE:	
Incident:	
Performance / Conduct:	P
Supervisor Name / Title:	(b) (6)
Support Review:	
Notes:	(b) (6), (b) (5)
Follow up dates:	

2	
Date Received:	12/12/2016
Location:	(b) (6)
Incident report filed against / Employee Name	(b) (6)
BUE:	
Incident:	(b) (6)
Performance / Conduct:	C
Supervisor Name / Title:	(b) (6)
Support Review:	
Notes:	(b) (6)
Follow up dates:	

3	
Date Received:	1/3/2016
Location:	(b) (6)
Incident report filed against / Employee Name	(b) (6)
BUE:	
Incident:	(b) (6)
Performance / Conduct:	C
Supervisor Name / Title:	(b) (6)
Support Review:	
Notes:	(b) (6)
Follow up dates:	

4	
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Fact Statement #34

ER Tracking Nashville (006201) Data - Read-Only - Excel

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05/11/17

No	A	B	C	D	E	F	G	H	I	J	K	L	M	N
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)		(b) (6)						(b) (6)
							N							(b) (6), (b) (5)
5	Unity Healing Center	9/28/2016	(b) (6)	(b) (6)			N							(b) (6), (b) (5)
6	Unity Healing Center	3/12/2017	(b) (6)	(b) (6)			N/A		5/9/2017					(b) (6), (b) (5)
7	Unity Healing Center	3/13/2017	(b) (6)	(b) (6)			N/A							(b) (6), (b) (5)
8	Nashville Area	5/2/2017	(b) (6)	(b) (6)			Y		5/12/2017	5/24/2017				(b) (6)
9	Catawba		(b) (6)	(b) (6)			N/A		5/15/2017	5/15/2017				(b) (6)

Sheet1

Ready

Fact Statement #35

On September 29th, 2016,

I asked (b) (6), (b) (3) (A) to come with me to my office at (b) (6), (b) (3) (A) request to speak with me.

(b) (6), (b) (3) (A) reported: (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

Later this day, (b) (6), (b) (3) (A)

Viana Sutt
Director
09/29/2016.

On September 29th, 2016,

I asked (b) (6), (b) (3) (A) to come with me to my office at (b) (6), (b) (3) (A) request to speak with me.

(b) (6), (b) (3) (A)
reported: (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

Virginia Bull
Director Unity HC
09/29/2016.

Fact Statement #36

On September 29th, 2016,

I asked (b) (6), (b) (3) (A) to come with me to my office at (b) (6), (b) request to speak with me.

(b) (6), (b) (3) reported: (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

Virginia Bull
Director Unity AC
09/29/2016.

On September 29th, 2016,

I asked (b) (6), (b) (3) (A) to come with me to my office at (b) (6), (b) (3) (A) request to speak with me.

(b) (6), (b) (3) (A) reported: (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

Later this day, (b) (6), (b) (3) (A)

Viana Sutt
Director
09/29/2016.

Fact Statement #37

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

(b) (3) (A), (b) (6)

Fact Statement #38

Unity Healing Center – Timeline of Events – Concerns of Sexual Abuse Allegations, Quality of Services Corrective Action Plan, Personnel Actions, and Tribal Consultation

December 12, 2014: Unity Governing Body Meeting. Plan is to suspend admission beginning on 12/19/2014 due to staffing shortage leading to safety of care issues. Tiara Ruff, CEO to complete Root Cause Analysis on concerning low staffing levels. Unity had 0 census from 12/17/14-4/12/15.

June 2, 2015: Tiara Ruff completes Unity Healing Center Root Cause Analysis Review and Quality Assessment and Performance Improvement 2015. Recommendations focused on improved HR process, Marketing of Unity through USET, and repairs/renovation to existing facility.

August 22, 2016: Site Visit to Desert Visions/Nevada Skies. Tracey Grant, Clinical Supervisor, Dr. Claymore, DFO, Melanie Tomko, NA Business Office Manager, Alyshia Baker, NA Coder meet with Desert Vision CEO, Nevada Skies, Health System Administrator, Clinical Director, Medical Provider, Nurse Supervisor, and Dr. Rose Weahkee, Phoenix Area DFO to look at ways to improve issues of low census, billing, and a more effective treatment model at Unity. CAPT Ruff, CEO Unity was available by phone for part of the meetings.

(b) (6), (b) (3) (A) 2016: Inappropriate behavior, boundaries, and interactions, leading to a non-sexual relationship between **(b) (6)** and a **(b) (6), (b) (3) (A)** at IHS-operated Unity Healing Center located in Cherokee, NC. Confirmation is from reports from staff, resident complaints, and video surveillance.

(b) (6), (b) (3) (A) 2016: **(b) (6)** is alone in the bathroom with **(b) (6), (b) (3) (A)** for several minutes. Bathroom renovations were occurring and **(b) (6), (b) (3) (A)** had been moved into a new **(b) (6), (b) (3) (A)**. **(b) (6)** reported that **(b) (6), (b) (3) (A)** came to him stating that the outlet had given **(b) (6)** a shock and he was checking out the outlet. Tracey Grant, Clinical Supervisor, Cynthia Slee, SSA Supervisor, and Allen Bollinger, Nashville Area OEHF (who was onsite for the renovations) viewed the video surveillance tape confirming that **(b) (6)** and **(b) (6), (b) (3) (A)** entered the bathroom together and were in there for several minutes. Following the incident Tracey Grant, Clinical Supervisor meets with **(b) (6)** and discusses appropriate boundaries.

(b) (6), (b) (3) (A) 2016: **(b) (6), (b) (3) (A)** is questioned by SSA supervisor Cynthia Slee and SA therapist **(b) (6)** regarding a letter that Cynthia Slee has taken from the **(b) (6), (b) (3) (A)**. **(b) (6), (b) (3) (A)** is questioned if the letter is to the **(b) (6)**. **(b) (6), (b) (3) (A)** denied it was to **(b) (6)** and becomes upset. **(b) (6), (b) (3) (A)**

(b) (6), (b) (3) (A) later tells **(b) (6), (b) (3) (A)** who reports it to staff the next day.

(b) (6), (b) (3) (A) 2016: **(b) (6), (b) (3) (A)**

(b) (6), (b) (3) (A) 2016: Unity Governing Body meeting is held. During the meeting it is reported to GB that there has been a **(b) (6), (b) (3) (A)**. CAPT Ruff reports that **(b) (6), (b) (3) (A)** and has led to a non-sexual relationship with the **(b) (6)**. **(b) (6), (b) (3) (A)** is addressing it with the **(b) (6), (b) (3) (A)** and the **(b) (6)**. **(b) (6)** does not have any contact with the **(b) (6), (b) (3) (A)**. An action item of completing a Root Cause Analysis (RCA) is assigned.

Unity Healing Center, Cherokee, NC Timeline of Events 2016-2019

September 28, 2016: CAPT Ruff provided a directive to (b) (6) via email restricting him from the main building until further notice.

September 28, 2016: (b) (6), (b) (3) (A) meets with (b) (6), (b) (3) (A) regarding (b) (6), (b) (3) (A) concern that a (b) (6), (b) (3) (A) was read by staff and being "misinterpreted". (b) (6), (b) (3) (A) reported that the information was disseminated to rest of staff and (b) (6), (b) (3) (A)

September 29, 2016: (b) (6), (b) (3) (A) meets with CAPT Tiara Ruff, CEO at the (b) (6), (b) (3) (A) request. (b) (6), (b) (3) (A) reports (b) (6), (b) (3) (A) concerns that the counselors and SSAs are saying about (b) (6), (b) (3) (A) CAPT Ruff talks to the (b) (6), (b) (3) (A) about (b) (6), (b) (3) (A) and (b) (6), (b) (3) (A) CAPT Ruff (b) (6), (b) (3) (A) and reports that (b) (6), (b) (3) (A)

September 30, 2016: RCA call held which included Unity Staff (CAPT Ruff, CEO, Tracey Grant, Clinical Supervisor, Cynthia Slee, SSA Supervisor) and Nashville Area Office staff (Dr. Toedt, CMO, Dr. Taylor, Nashville Area Behavioral Health Consultant, Dr. Claymore, DFO). The focus of the RCA was a review the incident of (b) (6), (b) (3) (A) Action items included updated policies related to (b) (6), (b) (3) (A) (b) (6), (b) (3) (A) Staff training in (b) (6), (b) (3) (A) ERLR referral for staff boundary issue (b) (6), and a NAO Mock Survey scheduled for 10/24-25/2016.

October 13, 2016 (b) (6) TDY to Mashpee to help with maintenance duties at the Mashpee Service Unit. His TDY was through November 1, 2016. (b) (6), (b) (3) (A)

March 12, 2017: (b) (6) observed on video surveillance in his office on a non-duty day with a non-government employee adult female caressing and giving her a hug.

May 9, 2017: CEO Tiara Ruff sent an email to Dr. Claymore (Deciding Official) and IHS Nashville Employee Relations Labor Relations Sta (b) (6) stated she proposed

(b) (6), (b) (5) (b) (6), (b) (5) (b) (6) signed acknowledging receipt 5/9/17 (b) (6) Proposal was based on September 2016

administrative findings of inappropriate relationship with (b) (6) (b) (6)

May 12, 2017: Anonymous report to the Eastern Band of Cherokee Indians (EBCI) Public Health and Human Services, Department of Human Services, Cherokee, NC, regarding sexual relationship between

(b) (6), (b) (3) (A) Reporter stated they had heard about an incident on 2016. (b) (6), (b) (3) (A)

(b) (6), (b) (5), (b) (3) (A)

May 16, 2017: Tracey Grant received a phone message from (b) (6) at Eastern Band of Cherokee Indians (EBCI) Public Health and Human Services, Department of Human Services, Cherokee, NC.

Handwritten note: "I was told this info from" with an arrow pointing to the first paragraph.

(b) (6) reported she received a report that (b) (6), (b) (3) (A) had been involved in a sexual relationship with a (b) (6) that worked at Unity. It was an anonymous report received May 12, 2017. Ms. Grant contacted her supervisor CEO Capt. Tiara Ruff asking for guidance on how to respond.

May 16, 2017: CEO Capt. Tiara Ruff and Tracey Grant contacted Vickie Claymore, Director of Field Operations, via phone. They were directed to contact OGC (b) (6), (b) (5) guidance.

May 16, 2017: Ms. Grant contacted (b) (6) OGC requesting guidance and help with a (b) (6), (b) (3) (A) (b) (6), (b) (3) (A), (b) (5)

May 17, 2017: Dr. Claymore received a written response to the proposal for removal via UPS from (b) (6) (b) (6) His response included the (b) (6) 2016 administrative findings of (b) (6) (b) (6) and (b) (6), (b) (3) (A) 2017 of (b) (6)

May 17, 2017: (b) (6), (b) (5) (b) (6), (b) (5)

May 17, 2017: (b) (6), (b) (3) (A) IHS/OGC sent an email to Martha Ketcher, AD to inform her that Tracey Grant had informed (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A), (b) (5) (b) (6), (b) (3) (A), (b) (5) and copied Lisa Gyorda. IHS/OGC (b) (6) were also copied on the email.

May 17, 2017: (b) (6) IHS/OGC sent an email to Tracey Grant. Copied on the email was IHS/OGC (b) (6) recaps an earlier conversation with Tracey.

(b) (6), (b) (5)

May 18, 2017: As recommending by (b) (6) OGC Tracey Grant, Clinical Supervisor contacts (b) (6), (b) (7)(C) (b) (6), (b) (5), (b) (7)(C)

May 18, 2017: (b) (6) (IHS/OGC) sent an email to Tracey Grant to confirmed what Tracey had reported in her phone conversation with OGC.

(b) (6), (b) (3) (A), (b) (5)

May 18, 2017: (b) (6), (b) (3) (A), (b) (5)

(b) (6), (b) (5)

May 18, 2017: Lisa Commins, Director Division of Personnel Security and Ethics sent an email stating OIG had been (b) (6), (b) (3) (A)

May 19, 2017 (b) (6) was placed on administrative leave.

May 22, 2017: Dr. Claymore contacts (b) (6) via email to seek guidance on moving forward with the proposed (b) (6), (b) (5)

(b) (6), (b) (5)

May 22, 2017: (b) (6) OGC in an email to (b) (6) OGC, Lisa Gvorda, IHS/HR. (b) (6)

(b) (6), (b) (5)

May 23, 2017 Martha Ketcher, AD verbally informed Vickie Claymore, DFO that she had received an email from (b) (6) tha (b) (5)

May 24, 2017: Tracey Grant received letter from EBCI Health and Human Service requesting any and all information related to the alleged incidents that took place involving the (b) (6), (b) (3) (A) suspected of being abused by (b) (6) Tracey forwarded the letter to Unity CEO, Tiara Ruff, Nashville Area Office (Martha Ketcher, AD; Vickie Claymore, DFO) and IHS/OGC (b) (6)

(b) (6) OGC replies that OGC (b) (5)
(b) (5)

June 2, 2017: Unity receives Subpoena for records from ECBI Cherokee Court requesting. Records requested include personnel records of (b) (6), (b) (5), video surveillance records (b) (6), (b) (5), (b) (6), (b) (5) contact information, staffing logs and any information regarding (b) (6), (b) (5) duties and contact with any (b) (6), (b) (3) (A) of Unity Healing. Also received (b) (6), (b) (5) (b) (6), (b) (3) (A), (b) (5) (b) (6), (b) (3) (A), (b) (5) CAPT Ruff forwarded the information to (b) (6) OGC, Martha Ketcher, AD and Dr. Claymore, DFO.

June 8, 2017: Tracey Grant, Clinical Supervisor received a Cease and Desist Document Removal or Destruction letter from the ECB (b) (6). It stated that it had come to the attention of the prosecutor that employees of Unity Healing may be destroying or removing evidence of a potential crime and a current investigation while those documents are under subpoena. The letter was sent via email from Tracey Grant to (b) (6)

(b) (6)

June 9, 2017: (b) (6) OGC sends an email to Tracey Grant, Clinical Supervisor, Tiara Ruff, CEO Unity, (b) (6) OGC, Martha Ketcher, AD, and Dr. Claymore, DFO confirming that she had consulted (b) (5)

(b) (5)

(b) (6) OGC has also

confirmed (b) (5)

(b) (5) Tracey Grant and Tiara Ruff are to (b) (5)

June 13, 2017: (b) (6) (b) (5)

(b) (6), (b) (5) The email went to CAPT Ruff, CEO, Tracey Grant, Clinical Supervisor, Martha Ketcher, AD and Dr. Claymore, DFO. Copied on the email were OGC staff (b) (6) CAPT Ruff replied she would distribute the document to staff today (June 13, 2017).

June 30, 2017 Office of the Inspector General (OIG) issued a search warrant for Unity Healing Center. The search was conducted by OIG and EBCI law enforcement. (b) (6), (b) (7)(C) lead the investigation. The OIG team searched offices, (b) (6), (b) (3) (A) administrative records, and surveillance tapes. They conducted interviews of staff.

July 7, 2017: RADM Chris Buchanan is provided an update on the status of the OIG investigation at his request via email. CAPT Ruff provided a brief summary via email which was provided to RADM Buchanan by Martha Ketcher, AD.

July 7, 2017: Email string from (b) (6), (b) (5) to Dr. Claymore, DFO. Indicating that

(b) (6), (b) (5)

July 11, 2017: Sent inquiry to (b) (6) (b) (5)

(b) (6), (b) (5)

(b) (6), (b) (5)

July 11, 2017: Tracey Grant, Clinical Supervisor sends inquiry to (b) (6)

(b) (6), (b) (5), (b) (7)(C)

July 20, 2017: Unity received three-year Joint Commission re-accreditation.

August 4, 2017: Dr. Claymore received an email string from Martha Ketcher, AD. (b) (6)

(b) (6) had received an (b) (6) (b) (5) (b) (7)(C)

(b) (6), (b) (5), (b) (7)(C)

September 1, 2017 Received response from (b) (6) (b) (5)

(b) (6), (b) (5)

September 11, 2017: Dr. Claymore received call from Tracey Grant, Clinical Supervisor (b) (6), (b) (3) (A)

(b) (5), (b) (6)

Dr. Claymore sent email to (b) (6)

(b) (6), (b) (5)

December 4, 2017: Joint Commission Alerts Tiara Ruff, CEO Unity that they have received a complaint. It is reported that there are "numerous safety issues, violations and documentation violations at the facility." It references that OIG came to Unity on 6/30/17 and that the facility remains under investigation for concerns of (b) (6), (b) (5)

(b) (6), (b) (5)

December 15, 2017: CAPT Ruff, CEO Unity (b) (6)

(b) (6)

January 5, 2018: CAPT Ruff received a notice from Joint Commission that they accepted the organization's response and would not take any further action at that time. Joint Commission noted that should they receive additional information that may be relevant to these issues in the future, a determination will be made at that point if further evaluation is needed.

January 27, 2018: CAPT Ruff Submits the Corrective Action Plan to address the issues identified by Governing Body.

February 1, 2018: (b) (6) receives letter from the NC Psychology Board stating a complaint was filed against her by former employ (b) (6). One of his allegations is that (b) (6) failed to report suspected sexual misconduct between a (b) (6), (b) (3) (A) and a (b) (6), (b) (3) (A) at the facility (b) (6). He stated (b) (6) assisted in an "Internal Investigation" despite federal, state and Unity Healing Centers' own internal policy to report to the local (b) (6).

March 6, 2018: Received email from Lisa Gyorda (UHS/UO) regarding (b) (6), (b) (5).

(b) (6), (b) (5)

March 6, 2018: RADM Kevin Meeks contacts Dr. Claymore, DFO to ensure aware of the Legal Analysis and that there will be follow up with CC Officer, CAPT Ruff, CEO Unity.

March 6, 2018: Dr. Claymore sent email to Lisa Gyorda with CC to Dr. Bruce Finke, Acting AD asking for

(b) (6), (b) (5)
(b) (6), (b) (5)

Lisa Gyorda responded that she is reviewing questions but I did not receive anything back directly from her responding to the questions.

March 21, 2018: (b) (6), (b) (5)

(b) (6), (b) (5)

(b) (6), (b) (5) Dr. Finke concurred with the recommendation.

March 21, 2018: Vickie Claymore, DFO reached out to (b) (6) regarding (b) (6), (b) (5)

(b) (6), (b) (5) CC Liaison's Brandon Taylor and (b) (6)

were copied on the email. Dr. Claymore followed up with a call (b) (6) regarding the (b) (6)

(b) (6) LCDR had concerns that the OIG investigation had not been completed.

March 29, 2018: Tiera Ruff worked with Nashville IHS ERLR and provided a memo (b) (6)

(b) (6), (b) (5) There were not any restrictions listed in the memo.

April 8, 2018: (b) (6) detailed to Unity at (b) (6)

(b) (6) to be detailed to another position due to continued management and operating difficulties at Unity.

(b) (6) requested annual leave and medical leave while an appropriate detail could be agreed upon

by management, CC Liaison, and (b) (6) (b) (6)

(b) (6) (b) (6)

Unity Healing Center, Cherokee, NC Timeline of Events 2016-2019

May 15, 2018: (b) (6), (b) (5) provided draft (b) (6), (b) (5) (b) (6) responded that he had accepted another position and to work with (b) (6) CAPT Taylor had also accepted another position and would be leaving as well.

May 21, 2018: Follow up with (b) (6) and sent (b) (6) (b) (6)

May 29, 2018: Sent email to (b) (6), (b) (5) (b) (6), (b) (5) I was working with (b) (6). (b) (5) (b) (6), (b) (5)

June 2, 2018: Email from (b) (6), (b) (5) reported "We (b) (6), (b) (5) were advise (b) (6), (b) (5)

(b) (6), (b) (5)

June 8, 2018: Received email from (b) (6)

He had talked with (b) (6)

(b) (6), (b) (5)

(b) (6)

was going to speak to (b) (6) (b) (5)

(b) (6), (b) (5)

June 11, 2018 (b) (6) email stating she will get process of finding (b) (6) (b) (6)

(b) (6) agrees with moving forward with announcing the (b) (6)

August 27, 2018: Dr. Claymore sends email to (b) (6) inquiring on the final (b) (6)

(b) (6) Send email to (b) (6) inquiring on the completion of (b) (6) Received email back from (b) (6) confirming detail will be August

29, 2018-October 28, 2018. Memo signed by (b) (6) assigned her as the

(b) (6) It was for a period not to exceed 60 days with the option to extend up to 120 days. All expenses incident to this TDY to be paid by Pine Ridge Service Unit. Copied on the memo was (b) (6) (b) (6)

(b) (6)

August 28, 2018: (b) (6) received and signed for (b) (6) It was given to her by (b) (6)

(b) (6) and copies were sent to (b) (6) and Dr. Claymore.

September 4, 2018: Admission dates were delayed due to low census. It was felt having one patient was not therapeutic so the admission was delayed until we could have at least two admissions.

Admissions started again October 2, 2018. During that time (b) (6) worked with staff on policy and procedures, reviewing schedule and treatment elements, and catching up on records.

September 22, 2018: (b) (6) Nashville Area Business Officer Manager detailed to Unity

(b) (6) detail ended and she returned to her position as (b) (6)

(b) (6)

October 16, 2018: Email sent to (b) (6)

(b) (6)

(b) (6) responded on

Unity Healing Center, Cherokee, NC Timeline of Events 2016-2019

October 17, 2018 that (b) (6) was doing a good job at (b) (6) and wanted to extend the TDY. He stated (b) (6) was interested in bringing her on full time and he was working with the (b) (6) to get it finalized. It was pending final approval from Pine Ridge.

October 31, 2018: (b) (6)

(b) (6)

November 20, 2018: Selection made for new CEO Unity.

November 29, 2018: (b) (3) (A)

(b) (5), (b) (3) (A)

December 11, 2018 Email sent to (b) (6) regarding update on the extension since I hadn't received anything since the October 17, 2018 email from (b) (6) responded in email stating Pine Ridge had extended the TDY and was currently working on (b) (6) (b) (6) to Pine Ridge. He was going to follow up with the (b) (6)

January 22, 2019: Unity Governing Board meeting held related to draft Joint Commission corrective action plan. Concerns raised by governing board regarding the administrative inquiry and any subsequent steps that needed to occur after (b) (6) returned to work.

January 28, 2019: Beverly Cotton, Area Director, requests to convene meeting with Area Office staff and Acting Unity CEO to further discuss draft corrective action plan. Decision is made to request review and assistance with the corrective action plan from IHS Office of Quality for review before it is submitted to Joint Commission.

January 29, 2019: Corrective action plan submitted to Joint Commission.

February 18, 2019: Corrective action plan accepted by Joint Commission. No further follow up required by Joint Commission. Acting Unity CEO notifies Nashville Area Office leadership of concerns that staff fail to meet directives and follow corrective action plan. Clinical supervisor not following through on actions.

February 14, 2019: Sent email to (b) (6) again inquiring about the transfer. Dr. Finke and Allen Bollinger, Nashville Area CC Liaison copied on the email.

February 21, 2019: Unity Governing Board Special Called Meeting held to address concerns the corrective action plan was not being followed and implemented by (b) (6) failure to follow directives from the (b) (6) Executive Session called to order to address personnel concerns and recommendations for the Acting Unity CEO to take for (b) (6) and (b) (6)

Unity Healing Center, Cherokee, NC Timeline of Events 2016-2019

February 22, 2019: Call held between Beverly Cotton, Area Director, and (b) (6), (b) (7)(C) with IHS HQ Office of Management Services Director, Athena Elliott, to inquire about the active OIG investigation at Unity, as well as address concerns with the length of time it is taking to hear back from OIG which has

(b) (6), (b) (5) (b) (6), (b) (7)(C), (b) (5) (b) (6), (b) (5) (b) (6), (b) (7)(C) offers to be available for any questions and guidance.

February 28, 2019: Site visit conducted to Unity by Director of Field Operations, Vickie Claymore; Acting Area Deputy Director, Bruce Finke; and Area Director, Beverly Cotton. Allen Bollinger, Facilities Director, also attends site visit. Leadership team meets with Unity staff and communicates plans to take action to improve the quality of services over the course of the next year. Leadership asks for commitment to change from staff. Review of facility conducted and plans for renovations to buildings and parking lot. Decision made that no resources will be devoted to Unity facility until after tribal consultation is conducted.

Nashville Area Office holds call with IHS National Chief Medical Officer and Office of Quality to brainstorm solutions for potential upcoming staff shortages at Unity if personnel actions are taken. Nashville Area Office informs IHS HQ that she will be ending (b) (6) who was detailed to Pine Ridge and asking her to return to the Nashville Area Office for a permanent reassignment.

February 28, 2019: Email from Nashville Area Director to Great Plains Area Director and other relevant staff ending (b) (6) detail to Pine Ridge Service Unit and returning to Nashville Area Office.

March 1, 2019: Additional staffing from HQ is not feasible to detail to Unity. Nashville Area Office leadership (b) (5)

(b) (5)

March 6, 2019: Unity status provided to USET Health Committee during USET Impact Week, identifying issues with quality and personnel challenges.

March 12, 2019: (b) (6) submitted his resignation effective March 13, 2019.

March 19, 2019: (b) (6) signs for TDY Assignment as a (b) (6) (b) (6) at the Nashville Area Office. TDY effective 3/20/2019 and will be for a period not to exceed 180 days.

March 20, 2019: IHS Nashville completes draft of 1 year action plan to improve quality of services and management competencies at Unity (b) (5)

(b) (5)

March 21, 2019: IHS Public Affairs contacted by Wall Street Journal related to 2016 sexual abuse allegations at Unity.

April 1, 2019: New CEO for Unity EOD.

Fact Statement #39

Date Received:	9/28/2016	High Incident
Location:	Unity	
Incident report filed against / Employee Name / Title	(b) (6)	
BUE:	N	
Incident:		
Performance / Conduct:	C	
Supervisor Name / Title:	Tiara Ruff, Executive Director	
Support Review:		
Notes:	09/28/16 - T Ruff placed (b) (6) on restriction from the main Unity facility and began investigation on possible inappropriate concerns with a (b) (6), (b) (3) (A) and began her investigation.	
Follow up dates:	02/08/17 - Sent email to his supervisor requesting update on this issue.	

5

Date Received:	8/31/2016	High Incident
Location:	Unity	
Incident report filed against / Employee Name / Title	(b) (6)	(b) (6)
BUE:	N	
Incident:	(b) (6)	
Performance / Conduct:	C	
Supervisor Name / Title:	(b) (6)	
Support Review:		
Notes:	(b) (6)	
Follow up dates:	(b) (6)	

6

Date Received:	12/22/2015	(b) (6)
Location:	(b) (6)	
Incident report filed against / Employee Name / Title	(b) (6)	
BUE:	N	
Incident:	(b) (6)	
Performance / Conduct:	P	
Supervisor Name / Title:	(b) (6)	
Support Review:	(b) (6)	
Notes:	(b) (6)	
Follow up dates:	(b) (6)	
Closed case:	(b) (6)	

WORKLOAD Report JAN 2017
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1	
Date Received:	10/4/2016 (b) (6)
Location:	(b) (6)
Incident report filed against / Employee Name	(b) (6)
BUE:	
Incident:	
Performance / Conduct:	P
Supervisor Name / Title:	(b) (6)
Support Review:	
Notes:	(b) (6)
Follow up dates:	
2	
Date Received:	12/12/2016
Location:	(b) (6)
Incident report filed against / Employee Name	(b) (6)
BUE:	
Incident:	(b) (6)
Performance / Conduct:	C
Supervisor Name / Title:	(b) (6)
Support Review:	
Notes:	(b) (6)
Follow up dates:	
3	
Date Received:	1/3/2016
Location:	(b) (6)
Incident report filed against / Employee Name	(b) (6)
BUE:	
Incident:	(b) (6)
Performance / Conduct:	C
Supervisor Name / Title:	(b) (6)
Support Review:	
Notes:	(b) (6)
Follow up dates:	
4	

Fact Statement #40

Ruff, Tiara R (IHS/NAS/AO)

From: (b) (6)
Sent: Wednesday, March 22, 2017 21:06
To: (b) (6) Ruff, Tiara R (IHS/NAS/UHC)
Subject: RE: Proposal

(b) (6) and Ti,

I agree with the recommendation (b) (6), (b) (5)

I also have one other concern with this documentation and the response of the other staff – she took a recorded item from a Unity surveillance camera and gave to someone outside of the Unity/Nashville area. That employee also did not report the incident to her immediate supervisor once she knew of this incident and only did after the fact of presenting the recording to the church.

I will begin working on the Proposal.

Thanks
(b) (6)

From: (b) (6)
Sent: Tuesday, March 21, 2017 2:10 PM
To: (b) (6) Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>
Subject: Re: Proposal

I reviewed the documents regarding the latest incident re this employee. I had also looked at the documentation of the (b) (6), (b) (3) (A) and had concerns because it involved a (b) (6), (b) (3) (A) who appears to be (b) (6), (b) (3) (A) who spent several minutes alone in the bathroom with the male employee. (b) (6), (b) (3) (A) stated they were hugging or something to that effect. I don't know how much credence can be given to the (b) (6), (b) (3) (A) that may have (b) (6), (b) (3) (A) but it appears there is something going on and has been observed by (b) (6), (b) (3) (A) (b) (6), (b) (3) (A)

In my opinion, this latest incident would cause a person to lean more toward a (b) (6), (b) (5) (b) (6), (b) (5) The latest occurred on government owned/leased property. Why was he there? On duty? The documentation does not state a reason for him being there. Did anyone observe the behavior? I don't understand where the church became involved but I don't believe it removes agency responsibility to review/investigate the incident and take disciplinary action if warranted.

From: (b) (6)
Sent: Thursday, March 16, 2017 5:13 PM
To: (b) (6)
Subject: RE: Proposal

(b) (6)

We should have the detail and support for your review by Monday, March 20.
Thanks

From: (b) (6)
Sent: Tuesday, March 07, 2017 11:46 AM
To: (b) (6)
Subject: Re: Proposal

I have a question. Why is this employee being (b) (6) He has previous (b) (6)

(b) (6), (b) (3) (A)

From: (b) (6)
Sent: Thursday, March 2, 2017 10:31 PM
To: (b) (6)
Subject: Proposal

(b) (6)

Happy march 2017,

(b) (6)

Please review this proposal and the supporting documents. Please let me know if I need any supporting changes to this (b) (6), (b) (5) This case has been open since September 2016 – I'm concerned about the time frames.

Thanks

(b) (6)

Fact Statement #41

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	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	(b) (6)		(b) (6)		(b) (6)	(b) (6)					(b) (6)				
5	(b) (6)			N							(b) (6), (b) (5)				
6	(b) (6)			N/A			5/9/2017				(b) (6), (b) (5)				
7	(b) (6)			N/A							(b) (6), (b) (5)				
8	(b) (6)			Y			5/12/2017	5/24/2017			(b) (6)				
9				N/A			5/15/2017	5/15/2017							

Proposal rescinded 4/5/18

Sheet1

Ready

ER Tracking Nashville 06062018.xlsx - Read-Only - Excel

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05/11/17

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)		(b) (6)	(b) (6)					(b) (6)
5	Unity Healing Center	9/28/2016	(b) (6)				N							(b) (6), (b) (5)
6	Unity Healing Center	3/12/2017	(b) (6)				N/A			5/9/2017				(b) (6), (b) (5)
7	Unity Healing Center	3/13/2017	(b) (6)				N/A							(b) (6), (b) (5)
8	Nashville Area	5/2/2017	(b) (6)				Y			5/12/2017	5/24/2017			(b) (6)
9	Catawba						N/A			5/15/2017	5/15/2017			

Ready

Fact Statement #42

Ruff, Tiara R (IHS/NAS/AO)

From: (b) (6)
Sent: Wednesday, March 22, 2017 21:06
To: (b) (6) Ruff, Tiara R (IHS/NAS/UHC)
Subject: RE: Proposal

(b) (6) and Ti,

I agree with the recommendation (b) (6)

I also have one other concern with this documentation and the response of the other staff – she took a recorded item from a Unity surveillance camera and gave to someone outside of the Unity/Nashville area. That employee also did not report the incident to her immediate supervisor once she knew of this incident and only did after the fact of presenting the recording to the church.

I will begin working on the Proposal.

Thanks

(b) (6)

From: (b) (6)
Sent: Tuesday, March 21, 2017 2:10 PM
To: (b) (6) Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>
Subject: Re: Proposal

I reviewed the documents regarding the latest incident re this employee. I had also looked at the documentation of the (b) (6), (b) (3) (A) and had concerns because it involved a (b) (6), (b) (3) (A) who appears to be (b) (6), (b) (3) (A) who spent several minutes alone in the bathroom with the male employee. (b) (6), (b) (3) (A) stated they were hugging or something to that effect. I don't know how much credence can be given to the (b) (6), (b) (3) (A) that may have (b) (6), (b) (3) (A) but it appears there is something going on and has been observed by (b) (6), (b) (3) (A) (b) (6), (b) (3) (A)

In my opinion, this latest incident would cause a person to lean more toward a (b) (6), (b) (5) (b) (6), (b) (5) The latest occurred on government owned/leased property. Why was he there? On duty? The documentation does not state a reason for him being there. Did anyone observe the behavior? I don't understand where the church became involved but I don't believe it removes agency responsibility to review/investigate the incident and take disciplinary action if warranted.

From: (b) (6)
Sent: Thursday, March 16, 2017 5:13 PM
To: (b) (6)
Subject: RE: Proposal

(b) (6)
We should have the detail and support for your review by Monday, March 20.
Thanks

From: (b) (6)
Sent: Tuesday, March 07, 2017 11:46 AM
To: (b) (6)
Subject: Re: Proposal

I have a question. Why is this employee being (b) (6) He has previous (b) (6)

(b) (6), (b) (3) (A)

From: (b) (6)
Sent: Thursday, March 2, 2017 10:31 PM
To: (b) (6)
Subject: Proposal

(b) (6)

Happy march 2017,

(b) (6)

Please review this proposal and the supporting documents. Please let me know if I need any supporting changes to this

(b) (6) This case has been open since September 2016 – I'm concerned about the time frames.

Thanks

(b) (6)

Fact Statement #43

	(b) (6)																	
4	(b) (6)	(b) (6)	(b) (6)	(b) (6)								(b) (6)						
5	(b) (6)											(b) (6), (b) (5)						
6	(b) (6)											(b) (6), (b) (5)						Proposal reschedule 4/5/18
7	(b) (6)											(b) (6), (b) (5)						
8	(b) (6)											(b) (6)						
9																		

File Home Insert Page Layout Formulas Data Review View Help Tell me what you want to do

Clipboard Font Alignment Number Styles Cells Editing

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)		(b) (6)	(b) (6)					(b) (6)
5	Unity Healing Center	9/28/2017	(b) (6)	(b) (6)			N							
6	Unity Healing Center	3/12/2017	(b) (6)	(b) (6)			N/A			5/9/2017				
7	Unity Healing Center	3/13/2017	(b) (6)	(b) (6)			N/A							
8	Nashville Area	5/2/2017	(b) (6)	(b) (6)			Y			5/12/2017	5/24/2017			
9	Catawba						N/A			5/15/2017	5/15/2017			

Fact Statement #44

Ruff, Tiara R (IHS/NAS/AO)

From: (b) (6)
Sent: Wednesday, March 22, 2017 21:06
To: (b) (6) Ruff, Tiara R (IHS/NAS/UHC)
Subject: RE: Proposal

(b) (6) and Ti,

I agree with the recommendation (b) (6), (b) (5)

I also have one other concern with this documentation and the response of the other staff – she took a recorded item from a Unity surveillance camera and gave to someone outside of the Unity/Nashville area. That employee also did not report the incident to her immediate supervisor once she knew of this incident and only did after the fact of presenting the recording to the church.

I will begin working on the Proposal.

Thanks
(b) (6)

From: (b) (6)
Sent: Tuesday, March 21, 2017 2:10 PM
To: (b) (6) Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>
Subject: Re: Proposal

I reviewed the documents regarding the latest incident re this employee. I had also looked at the documentation of the (b) (6), (b) (3) (A) and had concerns because it involved a (b) (6), (b) (3) (A) who appears to be (b) (6), (b) (3) (A) who spent several minutes alone in the bathroom with the male employee. (b) (6), (b) (3) (A) stated they were hugging or something to that effect. I don't know how much credence can be given to the (b) (6), (b) (3) (A) that may have (b) (6), (b) (3) (A) but it appears there is something going on and has been observed by (b) (6), (b) (3) (A) (b) (6), (b) (3) (A)

In my opinion, this latest incident would cause a person to lean more toward a (b) (6), (b) (5) (b) (6), (b) (5) The latest occurred on government owned/leased property. Why was he there? On duty? The documentation does not state a reason for him being there. Did anyone observe the behavior? I don't understand where the church became involved but I don't believe it removes agency responsibility to review/investigate the incident and take disciplinary action if warranted.

From: (b) (6)
Sent: Thursday, March 16, 2017 5:13 PM
To: (b) (6)
Subject: RE: Proposal

(b) (6)

We should have the detail and support for your review by Monday, March 20.
Thanks

From: (b) (6)
Sent: Tuesday, March 07, 2017 11:46 AM
To: (b) (6)
Subject: Re: Proposal

I have a question. Why is this employee being (b) (6) He has previous (b) (6)

(b) (6), (b) (3) (A)

From: (b) (6)
Sent: Thursday, March 2, 2017 10:31 PM
To: (b) (6)
Subject: Proposal

(b) (6)

Happy march 2017,

(b) (6)

Please review this proposal and the supporting documents. Please let me know if I need any supporting changes to this (b) (6), (b) (5) This case has been open since September 2016 – I'm concerned about the time frames.

Thanks

(b) (6)

Fact Statement #45

(b) (6)

(b) (6)

(b) (6)

Fact Statement #46

Ruff, Tiara R (IHS/NAS/AO)

From: (b) (6)
Sent: Wednesday, March 22, 2017 21:06
To: (b) (6) Ruff, Tiara R (IHS/NAS/UHC)
Subject: RE: Proposal

(b) (6) and Ti,

I agree with the recommendation (b) (6), (b) (5)

I also have one other concern with this documentation and the response of the other staff – she took a recorded item from a Unity surveillance camera and gave to someone outside of the Unity/Nashville area. That employee also did not report the incident to her immediate supervisor once she knew of this incident and only did after the fact of presenting the recording to the church.

I will begin working on the Proposal.

Thanks
(b) (6)

From: (b) (6)
Sent: Tuesday, March 21, 2017 2:10 PM
To: (b) (6) Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>
Subject: Re: Proposal

I reviewed the documents regarding the latest incident re this employee. I had also looked at the documentation of the (b) (6), (b) (3) (A) and had concerns because it involved a (b) (6), (b) (3) (A) who appears to be (b) (6), (b) (3) (A) who spent several minutes alone in the bathroom with the male employee. (b) (6), (b) (3) (A) stated they were hugging or something to that effect. I don't know how much credence can be given to the (b) (6), (b) (3) (A) that may have (b) (6), (b) (3) (A) but it appears there is something going on and has been observed by (b) (6), (b) (3) (A) (b) (6), (b) (3) (A)

In my opinion, this latest incident would cause a person to lean more toward a (b) (6), (b) (5) (b) (6), (b) (5) The latest occurred on government owned/leased property. Why was he there? On duty? The documentation does not state a reason for him being there. Did anyone observe the behavior? I don't understand where the church became involved but I don't believe it removes agency responsibility to review/investigate the incident and take disciplinary action if warranted.

From: (b) (6)
Sent: Thursday, March 16, 2017 5:13 PM
To: (b) (6)
Subject: RE: Proposal

(b) (6)

We should have the detail and support for your review by Monday, March 20.
Thanks

From: (b) (6)
Sent: Tuesday, March 07, 2017 11:46 AM
To: (b) (6)
Subject: Re: Proposal

I have a question. Why is this employee being (b) (6) He has previous (b) (6)

(b) (6), (b) (3) (A)

From: (b) (6)
Sent: Thursday, March 2, 2017 10:31 PM
To: (b) (6)
Subject: Proposal

(b) (6)

Happy march 2017,

(b) (6)

Please review this proposal and the supporting documents. Please let me know if I need any supporting changes to this (b) (6), (b) (5) This case has been open since September 2016 – I'm concerned about the time frames.

Thanks

(b) (6)

Fact Statement #47

5-12-17



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Nashville Area Indian Health Service
Unity healing Center,
Cherokee, NC 28719

March 28, 2017

(b) (6)
(b) (6)
(b) (6)

Dear (b) (6)

(b) (6)

(b) (6) (b) (6), (b) (3) (A)

[Redacted]

(b) (6) (b) (6), (b) (3) (A)

(b) (6)

(b) (6)

(b) (6)

You and your representative may review the material upon which this proposal is based by contacting (b) (6)

(b) (6)

(b) (6)

Please acknowledge receipt of this letter in the space provided on the enclosed copy and return the signed copy to me. Your signature does not mean that you agree with this letter, but merely shows that you received it.



CAPT Tiara Ruff
Director
Unity Healing Center

I acknowledge receipt of this advance notice of (b) (6) letter as indicated below:

(b) (6)

5-4-17
Date

Fact Statement #48

EP Tracking Nashville 08063018.xlsx - Read-Only - Excel

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Clipboard Font Alignment Number Styles Cells Editing

	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	(b) (6)		(b) (6)	(b) (6)	(b) (6)	(b) (6)					(b) (6)				
				N							(b) (6), (b) (5)				
	(b) (6)			N							(b) (6), (b) (5)				
6	(b) (6)			N/A			5/9/2017				(b) (6), (b) (5)		Proposal escinde 14/5/18		
											(b) (6), (b) (5)				
7	(b) (6)			N/A											
8	(b) (6)			Y			5/12/2017	5/24/2017			(b) (6)				
9				N/A			5/15/2017	5/15/2017							

Sheet1

Ready

ER Tracking Nashville 08/16/2018.xlsx - Read-Only - Excel

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Share Comments

05/11/17

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)		(b) (6)	(b) (6)					(b) (6)
5	Unity Healing Center	9/28/2016	(b) (6)	(b) (6)			N							(b) (6), (b) (5)
6	Unity Healing Center	3/12/2017	(b) (6)	(b) (6)			N/A			5/9/2017				(b) (6), (b) (5)
7	Unity Healing Center Nashville	3/13/2017	(b) (6)	(b) (6)			N/A							(b) (6), (b) (5)
8	Area	5/2/2017	(b) (6)	(b) (6)			Y			5/12/2017	5/24/2017			(b) (6)
9	Catawba						N/A			5/15/2017	5/15/2017			

Sheet1

Ready

100%

Fact Statement #49

Milam, Lisa

From: (b) (6)
Sent: Wednesday, April 26, 2017 10:58 PM
To: Ruff, Tiara R (IHS/NAS/UHC)
Subject: FW: review

Ti,

Here is the detail from (b) (6) -
Let's discuss.

Thanks

(b) (6)

From: (b) (6)
Sent: Thursday, April 20, 2017 11:11 AM
To: (b) (6)
Subject: Re: review

Regarding the (b) (6) incident: did I see in the documentation that the (b) (6), (b) (3) (A) saw the employee and (b) (6), (b) (3) (A) spend approximately 5 minutes alone in the bathroom? If so, I would include this as (b) (6)

(b) (6)
(b) (6) incident: Interviews of employees reveal discussions occurring in the community about the incident adversely reflects on federal employees and Unity.

From: (b) (6)
Sent: Wednesday, April 19, 2017 8:58 PM
To: (b) (6)
Subject: review

(b) (6)

I've attached the revised proposal letter for review.- included in this letter is the last incident in (b) (6) 2017.

Let me know if this is supportive detail.

Thanks

(b) (6)

Fact Statement #50

ER Tracking Nashville 09/02/2018.xlsx - Read-Only - Excel

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Clipboard Font Alignment Number Styles Cells Editing

	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	(b) (6)		(b) (6)	(b) (6)	(b) (6)						(b) (6)				
5											(b) (6), (b) (5)				
6				N/A			5/9/2017				(b) (6), (b) (5)				
7				N/A							(b) (6), (b) (5)				
8				Y			5/12/2017	5/24/2017			(b) (6)				
9				N/A			5/15/2017	5/15/2017							

Proposal rescinded 4/5/18

Sheet1

Ready

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NG (b) (6) (b) (6) 05/11/17

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)		(b) (6)(b) (6)						(b) (6)
5	Unity Healing Center	9/28/2014		(b) (6)			N							(b) (6), (b) (5)
6	Unity Healing Center	3/12/2017		(b) (6)			N/A		5/9/2017					(b) (6), (b) (5)
7	Unity Healing Center	3/13/2017		(b) (6)			N/A							(b) (6), (b) (5)
8	Nashville Area	5/2/2017		(b) (6)			Y		5/12/2017	5/24/2017				(b) (6)
9	Catawba						N/A		5/15/2017	5/15/2017				

Sheet1

Ready

Fact Statement #51

Tracking Nashville 04/06/2018 - Read-Only - Excel

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Share Comments

05/11/17

	A	B	C	D	E	F	G	H	I	J	K	L	M
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)		(b) (6)	(b) (6)				(b) (6)
							N						(b) (6), (b) (5)
5	Unity Healing Center	9/28/2017		(b) (6)			N						(b) (6), (b) (5)
6	Unity Healing Center	3/12/2017		(b) (6)			N/A			5/9/2017			(b) (6), (b) (5)
7	Unity Healing Center	3/13/2017		(b) (6)			N/A						(b) (6), (b) (5)
8	Nashville Area	5/2/2017		(b) (6)			Y			5/12/2017	5/24/2017		(b) (6)
9	Catawba						N/A			5/15/2017	5/15/2017		

Sheet1

Ready

100%

Fact Statement #52

Bollinger, Allen (IHS/NAS/AO)

From: Bollinger, Allen (IHS/NAS/AO)
Sent: Friday, May 12, 2017 10:10 AM
To: (b) (6)
Subject: Response for additional informaton.

(b) (6)

I am responding to your request for additional documentation concerning the incident where you were stated to be alone with the (b) (6), (b) (3) (A) in the bathroom.

The day in question was a fairly busy day that started off with myself inspecting the first two resident bathrooms being renovated. Minor items were found that needed to be corrected. The contractor immediately addressed these concerns, and I deemed the first two bathrooms complete and ready for occupancy. In order for the contractor to proceed with renovating the next two bathrooms the female residents needed to be relocated from the male end of the hall to the female end of the hall. There were only female residents at Unity during this time. I assisted with cleaning the bedroom carpets to remove construction dust and assisted with relocating furniture. Once this was complete the residents were able to relocate their belongings to the other bedrooms.

During the time that the residents were completing their relocation, I checked in with the HVAC Retro-commissioning contractor located in the basement adjacent to the server room whom was trying to solve issues with installing the new JACE (web based HVAC interface).

I was not present to witness any time that (b) (6) would have possibly been alone with the (b) (6), (b) (3) (A) in question. But, when I had finished checking with the HVAC contractor, (b) (6) immediately brought it to my attention that the (b) (6), (b) (3) (A) in question had stated that the light switch in (b) (6), (b) (3) (A) newly renovated bathroom had shocked (b) (6), (b) (3) (A). He stated that he had checked the switch but could not find anything wrong and wanted me to look as well. I went into the bathroom with (b) (6) to inspect the light switch and found there to be no fault with any of the electrical devices in the bathroom and determined that if the (b) (6), (b) (3) (A) indeed did get shocked it was most likely from static electricity. After inspecting the bathroom both of us left the room.

If any additional information is needed I can be contacted using my information below.
Thank You,
Allen Bollinger

Allen F. Bollinger, P.E., CHFM, C.E.M.
CDR, United States Public Health Service Facilities Engineer / Realty Officer
Nashville Area Indian Health Service Office of Environmental Health & Engineering
711 Stewarts Ferry Pike
Nashville, TN 37214

TEL: (615) 467-1514
CELL: (b) (6)
FAX: (615) 467-1586
allen.bollinger@ihs.gov

Fact Statement #53

(b) (6) Report

Complete the **(b) (6)** Report using the form below.

General Information

Report Date: * 5/12/2017 12:47:00 PM
Report Taken: * Phone
Intake Worker: * **(b) (6)**
Case Name: **(b) (6), (b) (3)**
Report #: **(b) (6)**

Reporter Information

Full Name:
Relationship:
Address:
City / State / Zip Code:
Phone #:
Organization:
How does the reporter wish to be notified.

(b) (6)

Individuals Associated with Report

Name*	Gender	Birthdate	Role*	Perpetrator/ Victim*	Employment/School	Current Whereabouts	Whereabouts (Other)	Comments
-------	--------	-----------	-------	-------------------------	-------------------	------------------------	------------------------	----------

(b) (6)	Male		Parent/Caretaker	Perpetrator				
----------------	------	--	------------------	-------------	--	--	--	--

Community Where Family Resides:
Record Anonymous Individuals?
Anonymous Individuals:
Directions to the Home:

(b) (6), (b) (3) (A) VICTIM

Collateral information - Document names and contact information of any other individuals that have firsthand knowledge of the alleged maltreatment or information supporting the concerns (who else may be worried about the **(b) (6)**)

Full Name (Last, First, MI)*	Address (City, State, Zip Code)	Phone	Relationship
------------------------------	---------------------------------	-------	--------------

Rating - On a scale of 0 to 10, ten means the children are completely safe without Family Safety intervening and zero means the **(b) (6)** could be seriously harmed, maybe even hospitalized or worse, where do we rate this current situation?

Rating:

Response to Investigation - Describe how family will respond to an inquiry regarding maltreatment and any significant risk of harm to investigators.

Response to Investigation:

Has family been involved with **(b) (6)** before:

Status:

preventive intervention:

Report Assigned To:

(b) (6)

Social Worker:

(b) (6)

Social Worker Signature:

(b) (6)

Supervisor

(b) (6)

Supervisor Signature

(b) (6)

(b) (6) Report Narrative

Complete the narrative section of this **(b) (6)** Report using the fields below.

Specific Behaviors/Events - Describe specific behaviors or events; include where and when incident(s) occurred, effects of maltreatment on the **(b) (6)** events leading up to the maltreatment, any previous maltreatment, effects and impact of maltreatment on the **(b) (6)**

(b) (6), (b) (3) (A)

Behaviors/Events:

Injuries - Describe nature and extent of any injury or condition resulting from maltreatment. Be as specific as possible as to size, shape, color of any injuries, etc.

Extent Injuries

(b) (6) Functioning - Vulnerability of **(b) (6)** due to age, disability or circumstance; Indicators of **(b) (6)** wellbeing; location of **(b) (6)** in relation to maltreatment and alleged perpetrator; access to help.

(b) (6), (b) (3) (A)

(b) (6) Functioning:

Adult Functioning - Describe indicators of functioning including any involvement in domestic violence, substance abuse, mental health issues, employment, stressors and general methods of coping.

Adult Functioning:

(b) (6)

Parenting Approaches - Describe roles and responsibilities of parents, attitudes/perceptions of **(b) (6)** and specific disciplinary practices/approaches.

Parenting Approach:

Family/Parent Strengths - Ways that they've seen or heard of the **(b) (6)** being protected in the past, either by the legal guardians or others around the **(b) (6)** taking effort to detail the specific people and actions that helped the **(b) (6)** remain safe/well-cared for in the past.

Family Strengths:

Additional Information - Any other information the reporter believes might be helpful in establishing the need for protective services or court intervention including but not limited to including unusual stressors, living conditions, household composition or outside influence, conditions of the home, and family supports.

Additional Information:

[Redacted]

Fact Statement #54

5/16/17

May 16, 2017

CAPT Ti Ruff,

I received a phone message at 9:07am this morning from (b) (6) an employee with Cherokee Family Safety (Tribal Social Services) at (b) (6) I had been expecting a call from them regarding a request for admission, however, the matter she wished to discuss was quite different. I returned the call at approximately 9:50am. (b) (6) (b) (3) (A)

(b) (6) (b) (3) (A)
(b) (6), (b) (3) (A) I told her I could not discuss such a matter with her at the moment, but would discuss the issue with my supervisor and try to respond in some way to her today. I asked if she could tell me who made the report and when. She stated she could not tell me who made the report – it was made anonymously, but that the report was received on Friday, May 12, 2017.

I am asking for guidance in how to respond to (b) (6) as the report, at face value, involves a report of (b) (6), (b) (3) (A)

Thank you,



Tracey Grant
UHC Clinical Supervisor

Fact Statement #55

Claymore, Vickie (IHS/NAS/AO)

From: Grant, Tracey S (IHS/NAS/UHC)
Sent: Thursday, May 18, 2017 4:30 PM
To: (b) (6) Ruff, Tiara R (IHS/NAS/UHC)
Cc: (b) (6)
(b) (6) Claymore, Vickie (IHS/NAS/AO); Ketcher, Martha A (IHS/NAS/AO)
Subject: RE: investigation

Hi (b) (6)

Yes, confirmed. Thank you again for your assistance. I am out of the office on training until Monday as well. I will check email sporadically and am available by cell phone.

Thank you,

Tracey

From: (b) (6)
Sent: Thursday, May 18, 2017 5:07 PM
To: Grant, Tracey S (IHS/NAS/UHC) <Tracey.Grant@ihs.gov>; Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>

(b) (6)

Subject: investigation

Hi Tracey,

Thank you very much for following up.

(b) (6), (b) (3) (A), (b) (5)

I want to also reiterate our advice about (b) (5)

(b) (5)

Finally, I will be out of the office tomorrow, so please contact my colleagues cc'd above, (b) (6) on anything that needs to be discussed tomorrow. We are all fully briefed on the issues and are here to assist should you need us.

Thank you,

(b) (6)

We just learned new information from IHS. (b) (6), (b) (5)

(b) (6), (b) (3) (A), (b) (5)

(b) (6), (b) (5)

Meanwhile, my understanding (b) (6), (b) (5)

(b) (6), (b) (3) (A), (b) (5)

I am seeking guidance on what impact this (b) (6), (b) (5)

(b) (6), (b) (5)

Thank you, and please contact me if I can provide additional information.

(b) (6)

Attorney

U.S. Department of Health and Human Services

(b) (6)

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From: (b) (6), (b) (5)

Sent: Friday, May 19, 2017 10:18 AM

To: (b) (6)

(b) (6)

Subject: RE: Incident at IHS

(b) (6)

(b) (6), (b) (5)

I'm copying (b) (6) in our office on this, inasmuch as (b) (6) has been involved in advising I.H.S. and it's best to keep everyone in the loop.

(b) (6)

Assistant Deputy Associate General Counsel
Claims and Employment Law Branch

(b) (6)

CONFIDENTIALITY STATEMENT: The information contained in this electronic message is privileged and confidential and intended for the use of the individual(s) or entity named above. If you are not the intended recipient or the employee or the agent responsible for delivering this message to the intended recipient, you are hereby notified that any disclosure, dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender and then delete this email.

From: (b) (6)

Sent: Friday, May 19, 2017 9:33 AM

To: (b) (6)

(b) (6)

Subject: FW: Incident at IHS
Importance: High

(b) (6) we need clarification of (b) (6) advice (see below). (b) (6), (b) (5)

(b) (6), (b) (5)

(b) (6)

Principal Senior Attorney
U.S. Department of Health & Human Services

(b) (6)

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From: (b) (6)

Sent: Thursday, May 18, 2017 6:06 PM

To: (b) (6)
(b) (6)

(b) (6) have been in touch this morning with Lisa Gvorda (b) (6) (b) (5)
(b) (6), (b) (5)
one topic. I'll keep you posted.

On: 18 May 2017 17:47, (b) (6) wrote:

Hi (b) (6)

We wanted to inform you of a situation at IHS that may require us to ask for your assistance from several of your branches. We have already been getting some assistance from (b) (6) as it pertains to the employment law aspect of it, which we appreciate.

(b) (6), (b) (3) (A), (b) (5)

We are likely going to request your assistance for the following areas:

- Release of records to social services or law enforcement. Employee's personnel records; (b) (6), (b) (3) (A)
- (b) (6), (b) (3) (A)
- Employment action against the (b) (6), (b) (5)
- (b) (6), (b) (5)
- Other legal questions that arise

I have cc'd my colleagues who I've been working on this with, should they have anything to add. Again, for now we are just letting you know so that you are aware of these facts should we need to get specific advice in some of these areas, as I understand they may reach across several of your Divisions.

We appreciate in advance any help you can provide on this sensitive issue. Please let us know if you have any questions at this time.

Thank you,

(b) (6)

(b) (6)

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Claymore, Vickie (IHS/NAS/AO)

From: (b) (6)
Sent: Monday, May 22, 2017 9:10 AM
To: Claymore, Vickie (IHS/NAS/AO)
Subject: RE: investigation

Sure I will call you now. Thank you so much.

From: Claymore, Vickie (IHS/NAS/AO)
Sent: Monday, May 22, 2017 10:09 AM
To: (b) (6)
(b) (6)
Subject: RE: investigation

Yes I am. Will you be calling my office?

Vickie Claymore, Ph.D.
Director, Field Operations, Nashville IHS
(615) 467-1623

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From: (b) (6)
Sent: Monday, May 22, 2017 9:08 AM
To: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
(b) (6)
Subject: RE: investigation

Hi Dr. Claymore,

Are you available for a quick call now to discuss? I want to be sure I have all of the facts.

Thank you,

(b) (6)
Attorney
U.S. Department of Health and Human Services

(b) (6)

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Attorney
U.S. Department of Health and Human Services

(b) (6)

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From: Claymore, Vickie (IHS/NAS/AO)
Sent: Monday, May 22, 2017 10:00 AM
To: (b) (6)
Subject: RE: investigation

Good Morning. I am the deciding official on the (b) (6), (b) (3) (A) I am working on it now.

(b) (5)

Thank you
Vickie Claymore, Ph.D.
Director, Field Operations, Nashville IHS
(615) 467-1623

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From: Grant, Tracey S (IHS/NAS/UHC)
Sent: Thursday, May 18, 2017 4:30 PM
To: (b) (6) Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>
(b) (6)
(b) (6) Claymore, Vickie (IHS/NAS/AO)
<Vickie.Claymore@ihs.gov>; Ketcher, Martha A (IHS/NAS/AO) <Martha.Ketcher@ihs.gov>
Subject: RE: investigation

Hi (b) (6)

Yes, confirmed. Thank you again for your assistance. I am out of the office on training until Monday as well. I will check email sporadically and am available by cell phone.

Thank you,

Tracey

From: (b) (6)
Sent: Thursday, May 18, 2017 5:07 PM
To: Grant, Tracey S (IHS/NAS/UHC) <Tracey.Grant@ihs.gov>; Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>
(b) (6)
Subject: investigation

Hi Tracey,

Thank you very much for following up.

(b) (6), (b) (3) (A), (b) (5)

(b) (6), (b) (3) (A), (b) (5)

I want to also reiterate our advice (b) (5)

(b) (5)

Finally, I will be out of the office tomorrow, so please contact my colleagues cc'd above, (b) (6) on anything that needs to be discussed tomorrow. We are all fully briefed on the issues and are here to assist should you need us.

Thank you,

(b) (6)

Attorney

U.S. Department of Health and Human Services

(b) (6)

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Fact Statement #56

ER Tracking Nashville DB002018.xlsx - Read-Only - Excel

File Home Insert Page Layout Formulas Data Review View Help Tell me what you want to do

Clipboard Font Alignment Number Styles Cells Editing

	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
4	(b) (6)		(b) (6)	(b) (6)(b) (6)							(b) (6)				
5	(b) (6)										(b) (6), (b) (5)				
6	(b) (6)										(b) (6), (b) (5)				
7	(b) (6)										(b) (6), (b) (5)				
8	(b) (6)						5/12/2017	5/24/2017			(b) (6)				
9							5/15/2017	5/15/2017							

Proposal rescinded 4/9/18

Sheet1

Ready

ER Tracking Nashville 01/06/2018.xlsx - Read-Only - Excel

File Home Insert Page Layout Formulas Data Review View Help Tell me what you want to do

Clipboard Font Alignment Number Styles

Calibri 11

Normal Bold Good Neutral Calculation Input Note

Insert Delete Format Fill Clear Find & Select

05/11/17

	A	B	C	D	E	F	G	H	I	J	K	L	M
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)		(b) (6)	(b) (6)				(b) (6)
5	Unity Healing Center	9/28/2017	(b) (6)				N						(b) (6), (b) (5)
6	Unity Healing Center	3/12/2017	(b) (6)				N/A			5/9/2017			(b) (6), (b) (5)
7	Unity Healing Center	3/13/2017	(b) (6)				N/A						(b) (6), (b) (5)
8	Nashville Area	5/2/2017	(b) (6)				Y			5/12/2017	5/24/2017		(b) (6)
9	Catawba						N/A			5/15/2017	5/15/2017		

Sheet1

Ready

100%

Fact Statement #57

Milam, Lisa

From: (b) (6)
Sent: Wednesday, June 7, 2017 2:14 PM
To: (b) (6), (b) (7)(C)
Cc: (b) (6), (b) (7)(C); (b) (6)
(b) (6); Grant, Tracey S (IHS/NAS/UHC); Ruff, Tiara R (IHS/NAS/UHC)
Subject: RE: Unity Healing Center allegation

(b) (6), (b) (7)(C) my colleague, (b) (6) is going to send a subpoena and court order that the Tribe recently served on IHS. Take a look at it and let us know if you want to have a conference call. IHS is currently reviewing both.

(b) (6) (b) (6)

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From: (b) (6), (b) (7)(C)
Sent: Wednesday, June 07, 2017 3:08 PM
To: (b) (6)
(b) (6), (b) (7)(C); (b) (6)
(b) (6); Grant, Tracey S (IHS/NAS/UHC) <Tracey.Grant@ihs.gov>; Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>
Subject: RE: Unity Healing Center allegation
Importance: High

G 'Afternoon,

Since my last communication to the group on May 22nd, we (OIG) have been in receipt of additional complaint(s) via the OIG Hotline regarding the (b) (6), (b) (3) (A)

During my conversation with Ms. Grant, I was advised that surveillance footage of the alleged incident was retained and reviewed.

After reviewing the additional information that we have received, I would like to request a copy of the said footage and any others that may exist, as well as any records/documents that were or continue to be used during the internal administrative process.

Who specifically can I coordinate with to receive these items.

Regards,

(b) (6), (b) (7)(C)



From: (b) (6), (b) (7)(C)

Sent: Monday, May 22, 2017 4:41 PM

To: (b) (6)

(b) (6), (b) (7)(C)

(b) (6)

(b) (6)

(b) (6)

Subject: RE: Unity Healing Center allegation

Importance: High

Good Afternoon,

After speaking with Ms. Grant and Capt. Ruff at the UHC, I have determined that the OIG will not be opening a criminal investigation into this incident.

The actions do not constitute a criminal act, but more of an administrative work ethic violation by the employee.

Should you have any questions and/or concerns, please do not hesitate to contact (b) (6), (b) (7)(C) or myself.

Regards,

(b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)



From: (b) (6)

Sent: Friday, May 19, 2017 4:45 PM

To: (b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)

(b) (6)

(b) (6)

(b) (6)

Subject: RE: Unity Healing Center allegation

Okay. Thank you for your prompt reply.

(b) (6)

Principal Senior Attorney
U.S. Department of Health & Human Services

(b) (6)

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From: (b) (6), (b) (7)(C)

Sent: Friday, May 19, 2017 4:24 PM

To: (b) (6)

(b) (6), (b) (7)(C)

(b) (6)

(b) (6)

Subject: RE: Unity Healing Center allegation

It is hard to say at this point with the lack of information. I may be in a better position to advise after speaking with the HIS staff and Tribal Social Services.

From: (b) (6)

Sent: Friday, May 19, 2017 4:16 PM

To: (b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)

(b) (6)

(b) (6)

Subject: RE: Unity Healing Center allegation

(b) (7)(C), (b) (6)

can you tell me if the OIG will conduct its own investigation at Unity Healing Center? Thank you.

(b) (6)

Principal Senior Attorney

U.S. Department of Health & Human Services

(b) (6)

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From: (b) (6), (b) (7)(C)

Sent: Thursday, May 18, 2017 1:23 PM

To: (b) (6)

(b) (6), (b) (7)(C)

(b) (6)

(b) (6)

Subject: Re: Unity Healing Center allegation

Has anyone in OGC been able to obtain the specifics (i.e identities, statements, etc) from the social services yet?

(b) (6), (b) (7)(C)

Sent from my iPhone

On May 18, 2017, at 12:58, (b) (6)

Great, thank you. (b) (6), (b) (7)(C) please include my colleagues cc'd here to ensure we have coverage, as I will be out tomorrow should something arise.

Thank you,

(b) (6)

Attorney
U.S. Department of Health and Human Services

(b) (6)

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From: (b) (6), (b) (7)(C)
Sent: Thursday, May 18, 2017 12:02 PM
To: (b) (6)
Cc: (b) (6), (b) (7)(C)
Subject: Unity Healing Center allegation

(b) (6)

Thank you for taking my call today regarding the allegation of sexual abuse at the Unity Healing Center. I have passed this information on to my colleagues in the HHS-OIG Special Investigations Branch (SIB) in DC for follow up as (b) (6). It is my understanding that (b) (6), (b) (7)(C) will be following up with you on this matter.

Please feel free to contact either (b) (6), (b) (7) or I going forward with employee related complaints.

Thank you.

(b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)

<image001.jpg>

This E-mail may contain sensitive law enforcement and/or privileged information. If you are not the intended recipient (or have received this E-mail in error) please notify the sender immediately and destroy this E-mail. Any unauthorized copying, disclosure or distribution of the material in this E-mail is strictly forbidden.

Fact Statement #58

EASTERN BAND OF CHEROKEE INDIANS



File No

Name of Plaintiff(s):

**EASTERN BAND OF
CHEROKEE INDIANS**

VERSUS

(b) (6)

SUBPOENA

FILED

2017 JUN -2 PM

EBCI
CHEROKEE TRIBAL COURT
CHEROKEE, N.C.

To be heard on the June 9, 2017

2017 at 9:00 AM PM

Unity Healing
448 Wilbur Sequoyah Rd
Cherokee, N.C. 28719
828-497-9163

Appear and testify in the above entitled action in the Cherokee Tribal Court at the time and date indicated.
 Produce for the Court the following items and make such items available at the time and date indicated: (attach additional sheets if necessary)

Produce for the court the following items and make such items available to the Cherokee Indian Police Department CVU Division.

1. This includes but not limited to any and all personnel records related to **(b) (6)** who is employed at Unity.

2. Video or other surveillance records for **(b) (6)** 2016 involving **(b) (6)** and Unity employee, **(b) (6)**

3. Staff log and/or other sign in sheet for the period of time during which the victim **(b) (6)** was a **(b) (6)**

4. The Name(s) and address, and telephone number(s) of each employee of Unity from the date the victim, **(b) (6)** arrival at Unity until the date the victim, **(b) (6)** was released.

5. General personnel record concerning **(b) (6)** **(b) (6)** which are in the possession of Unity and/or the Indian Health Service as they pertain to the employee performance file, any record of adverse action, transfer or move to any facility operated by Unity or the Indian Health Service on or after **(b) (6)** 2016, any records of reduction in grade and removal actions, and relating to termination of **(b) (6)**

6. Provide information regarding **(b) (6)** duties and contact with any residents of Unity Healing.

Attention: Supervisor of records

Contact information of Attorney/Party requesting subpoena:

(b) (6)

EBCI Police Department
828-359-6621

- Clerk of Court
- Judge
- Assistant Clerk
- Requesting Attorney/Party
- Magistrate
- Prosecutor

RETURN OF SERVICE

certify that this Subpoena was received and served as follows:

- By delivering to the person named above a copy of the subpoena.
- By telephone communication with the person named above: Date: _____ Time: _____
- By registered/certified mail. (Attach return receipt)

Subpoena WAS NOT served for the following reason:

Date Received	Received By
Date of Return	Serving Officer

CTC-CR-001P, Rev. 04/02
© 2002 Cherokee Tribal Court

(b) (3) (A), (b) (6)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

Fact Statement #59

Milam, Lisa

From: (b) (6)
Sent: Wednesday, June 7, 2017 2:14 PM
To: (b) (6), (b) (7)(C)
Cc: (b) (6), (b) (7)(C) (b) (6)
(b) (6) Grant, Tracey S (IHS/NAS/UHC); Ruff, Tiara R (IHS/NAS/UHC)
Subject: RE: Unity Healing Center allegation

(b) (6), (b) (7)(C) my colleague, (b) (6) is going to send a subpoena and court order that the Tribe recently served on IHS. Take a look at it and let us know if you want to have a conference call. IHS is currently reviewing both.

(b) (6)

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From: (b) (6), (b) (7)(C)
Sent: Wednesday, June 07, 2017 3:08 PM
To: Johnson-Webb, Mechelle D (IHS/HQ) <Mechelle.Johnson-Webb@ihs.gov>
(b) (6), (b) (7)(C) (b) (6)
(b) (6) Grant, Tracey S (IHS/NAS/UHC) <Tracey.Grant@ihs.gov>; Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>
Subject: RE: Unity Healing Center allegation
Importance: High

G 'Afternoon,

Since my last communication to the group on May 22nd, we (OIG) have been in receipt of additional complaint(s) via the OIG Hotline regarding the (b) (6), (b) (3) (A)

During my conversation with Ms. Grant, I was advised that surveillance footage of the alleged incident was retained and reviewed.

After reviewing the additional information that we have received, I would like to request a copy of the said footage and any others that may exist, as well as any records/documents that were or continue to be used during the internal administrative process.

Who specifically can I coordinate with to receive these items.

Regards,

(b) (6), (b) (7)(C)



From: (b) (6), (b) (7)(C)

Sent: Monday, May 22, 2017 4:41 PM

To: (b) (6)

(b) (6), (b) (7)(C)

(b) (6)

(b) (6)

Subject: RE: Unity Healing Center allegation

Importance: High

Good Afternoon,

After speaking with Ms. Grant and Capt. Ruff at the UHC, I have determined that the OIG will not be opening a criminal investigation into this incident.

The actions do not constitute a criminal act, but more of an administrative work ethic violation by the employee.

Should you have any questions and/or concerns, please do not hesitate to contact (b) (6), (b) (7)(C) or myself.

Regards,

(b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)



From: (b) (6)

Sent: Friday, May 19, 2017 4:45 PM

To: (b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)

(b) (6)

(b) (6)

Subject: RE: Unity Healing Center allegation

Okay. Thank you for your prompt reply.

(b) (6)

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From: (b) (6), (b) (7)(C)

Sent: Friday, May 19, 2017 4:24 PM

To: (b) (6)

(b) (6), (b) (7)(C)

(b) (6)

(b) (6)

Subject: RE: Unity Healing Center allegation

It is hard to say at this point with the lack of information. I may be in a better position to advise after speaking with the HIS staff and Tribal Social Services.

From: (b) (6)

Sent: Friday, May 19, 2017 4:16 PM

To: (b) (6), (b) (7)(C)

Cc: (b) (6), (b) (7)(C) (b) (6)

(b) (6)

Subject: RE: Unity Healing Center allegation

(b) (6), (b) (7)(C) can you tell me if the OIG will conduct its own investigation at Unity Healing Center? Thank you.

(b) (6)

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From: (b) (6), (b) (7)(C)

Sent: Thursday, May 18, 2017 1:23 PM

To: (b) (6)

Cc: (b) (6), (b) (7)(C) (b) (6)

(b) (6)

Subject: Re: Unity Healing Center allegation

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(b) (6), (b) (7)(C)

Sent from my iPhone

On May 18, 2017, at 12:58, (b) (6) wrote:

Great, thank you. (b) (6), (b) (7)(C) please include my colleagues cc'd here to ensure we have coverage, as I will be out tomorrow should something arise.

Thank you,

(b) (6)

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From: (b) (6), (b) (7)(C)
Sent: Thursday, May 18, 2017 12:02 PM
To: (b) (6)
Cc: (b) (6), (b) (7)(C)
Subject: Unity Healing Center allegation

(b) (6)

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Please feel free to contact either (b) (6), (b) (7)(C) or I going forward with employee related complaints.

Thank you.

(b) (6), (b) (7)(C)

(b) (6), (b) (7)(C)

<image001.jpg>

This E-mail may contain sensitive law enforcement and/or privileged information. If you are not the intended recipient (or have received this E-mail in error) please notify the sender immediately and destroy this E-mail. Any unauthorized copying, disclosure or distribution of the material in this E-mail is strictly forbidden.

Fact Statement #60

June 8, 2017

Unity Healing
448 Wilbur Sequoya Road
Cherokee, N.C. 28719
828-497-9163

Attention: Unity Healing

RE: Cease and Desist Document Removal or Destruction

To whom it may concern:

It has come to our attention that employees of Unity Healing may be destroying or removing evidence of a potential crime and a current investigation while those documents are under subpoena.

The Tribal Prosecutor's Office hereby demands that Unity Healing and all employees thereof, cease and desist any further removal from any electronic database, or destruction of any of the documentation surrounding the materials listed within the subpoena and order for medical records properly served on 6-2-2017.

Any further handling of the above mentioned documentation must be in compliance with law and the subpoena or this office shall immediately take appropriate legal measures.

(b) (6)

(b) (6)

P.O. Box 455
Cherokee, NC 28719

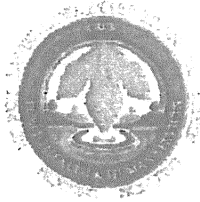
*Received on 04/08/2017 @ 8:30 AM
JOD/sant*

Fact Statement #61

(b) (6), (b) (3) (A), (b) (5)

(b) (6), (b) (3) (A), (b) (5)

(b) (6), (b) (3) (A), (b) (5)



EBCI Public Health and Human Services
Department of Human Services
FAMILY SAFETY PROGRAM

117 John Crowe Hill / Post Office Box 666, Cherokee, NC 28719
Tel (828) 359-1520 Fax (828) 359-0216

Tracey Grant, MA, LPA, CSAC, LCAS-A
Clinical Supervisor
Unity Healing Center
Cherokee, NC 28719

5-24-2017

The Director of the EBCI Public Health and Human Services Division has initiated a (b) (6) investigation relating to [REDACTED], DOB [REDACTED] who resided at Unity Healing Center on or about (b) (6), (b) (3) (A) 2016. Pursuant to your email today, the Division is requesting any and all information relating to the alleged incidents that took place involving [REDACTED], DOB [REDACTED]. The Cherokee Code provides that the Director may make a written demand for any information to assess the protective services report. This power is set out in Cherokee Code, Sec. 7B-302.3. - Access to Confidential Information, which states:

The director or a member of the ICWT may make a written demand for any information or reports, whether or not confidential, that may be relevant to the assessment or provision of protective services.

(1) Unless protected by the attorney-client privilege, any public or private agency or individual shall provide access to and copies of this confidential information and these records to the extent permitted by federal law and regulations.

On behalf of the Director, I am requesting the following information, documents and records, whether in writing or kept electronically, which are in the possession of Unity, its employees, contractors or which have been provided to employees of the Indian Health Service.

1. Any and all documents and records relating to [REDACTED], DOB [REDACTED]. These documents include, but are not limited to, any Unity Referral Form(s); any therapist/treatment records, notes or documents from the [REDACTED]; Releases of Information; names, addresses and contact information of any (b) (6), (b) (3) (A) of [REDACTED] any assessments and treatment recommendations from any Unity employee/contractor; names, addresses and contact information of therapists, medical professionals; any physician/ pharmacist medical records, including prescription records; any Wellness, Recovery and Action Plan(s), and any documentation relating to (b) (6), (b) (3) (A) release/discharge from Unity.
2. Any videotape or other surveillance record for (b) (6), (b) (3) (A) 2016 involving [REDACTED] and [REDACTED] interaction. Please provide the information on a CD/DVD.

3. Staff logs and/or other sign in sheets for the period of time during which [REDACTED] was a (b) (6), (b) (3) (A) at Unity.
4. The name, address, and telephone number for each employee of Unity from the date of [REDACTED] (name of victim) arrival at Unity until the date [REDACTED] was released/discharged from Unity. Please include a description of the scope of employment for each employee and if they are no longer an employee, the date they were released from employment with Unity.
5. Please provide any and all records of communication of any kind between [REDACTED] (our victim) and [REDACTED] (the perpetrator)
6. Please provide any and all documents written or composed by [REDACTED] (our victim) in your possession during [REDACTED] time at Unity.
7. Please provide each and every document, or other evidence that you know, or believe, to contain any information pertaining to, or be relevant to this (b) (6), (b) (3) (A) report.
8. Please provide each and every document or other evidence that you know contain communications that you had with the Indian Health Services, any agencies or representatives of the [REDACTED] Tribe relating to any contact between [REDACTED] and [REDACTED]
9. Please provide the general personnel record concerning [REDACTED] which are in the possession of Unity and/or the Indian Health Service as they pertain to the employee performance file, any records of adverse actions, transfer or move to any facility operated by Unity or the Indian Health Service on or after (b) (6), (b) (3) (A) 2016, any records of reduction in grade and removal actions, and relating to termination of [REDACTED]
10. If [REDACTED] is still an employee of Unity, please provide information regarding his duties and contact with any residents of Unity.

Thank you.

(b) (6)

(b) (6)

Fact Statement #62

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
 OFFICE OF INSPECTOR GENERAL
 OFFICE OF INVESTIGATIONS
 SPECIAL INVESTIGATIONS BRANCH



Receipt for Property Seized on 06/30/2017

SEARCH SITE: Unity Healing Center Cherokee, NC

CASE NO. H-17-0-1056-4

CASE AGENT: (b) (6), (b) (7)(C)

Item #	Room ID	Seizing Agent	Item Description	Box #
		(b) (6), (b) (7)(C)		
1	J		Employee handbook	1
2	R		Misc documents regarding reporting requirements	1
3	L		(b) (6), (b) (7)(C) patient records	1
4	H		Hand written notes from (b) (6), (b) (3) (A), (b) (7)(C) and bracelet	2
5	H		Documents pursuant to tribal subpoena	2
6	F		Personnel docs, training certs and other documents	3
7	D		(b) (6), (b) (7)(C) desktop image	4
8	O		(b) (6), (b) (7)(C) USB external image	4
9	I		(b) (6), (b) (7)(C) iPhone	4
10	H		(b) (6), (b) (7)(C) desktop image	4
11	O		Dell server image	4
XXXXX	XXX		XX	XXX
			End of inventory	

Received by: _____

Received From: _____

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF INVESTIGATIONS

SPECIAL INVESTIGATIONS BRANCH



Receipt for Property Seized on 06/30/2017 by consent

SEARCH SITE: Unity Healing Center Cherokee, NC

CASE NO. H-17-0-1056-4

CASE AGENT: (b) (6), (b) (7)(C)

Item #	Room ID	Seizing Agent	Item Description	Box #
1	D	(b) (6), (b) (7)(C)	Butler building - (b) (6), (b) (7)(C) office misc documents	1
2	B	(b) (6), (b) (7)(C)	Butler building - (b) (6), (b) (7)(C) cell	1
3	D	(b) (6), (b) (7)(C)	Butler building - (b) (6), (b) (7)(C) USB	1
4	B	(b) (6), (b) (7)(C)	Butler building - (b) (6), (b) (7)(C) USB	1
5	B	(b) (6), (b) (7)(C)	Butler building - (b) (6), (b) (7)(C) desktop image	1
6	D	(b) (6), (b) (7)(C)	Butler building - (b) (6), (b) (7)(C) desktop image	1
7	D	(b) (6), (b) (7)(C)	Butler building - (b) (6), (b) (7)(C) phone image	1
8	B	(b) (6), (b) (7)(C)	Butler building - (b) (6), (b) (7)(C) external USP	1
XXX	XXX	(b) (6), (b) (7)(C)	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXX
			End of inventory	

Received by: _____

Received From: _____



(b) (6), (b) (7)(C)



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL
SPECIAL INVESTIGATIONS BRANCH

(b) (6), (b) (7)(C)

UNITED STATES DISTRICT COURT

for the

Western District of North Carolina

FILED: ASHEVILLE, N.C.

JUN 30 2017

U.S. DISTRICT COURT W. DIST. OF N.C.

In the Matter of the Search of)
(Briefly describe the property to be searched)
or identify the person by name and address))
Unity Healing Center located at 448 Sequoyah Trail)
Drive, Cherokee, NC 28719)

Case No. 1:17-mj-89

SEARCH AND SEIZURE WARRANT

To: Any authorized law enforcement officer

An application by a federal law enforcement officer or an attorney for the government requests the search of the following person or property located in the Western District of North Carolina (identify the person or describe the property to be searched and give its location):

See Attachment A.

I find that the affidavit(s), or any recorded testimony, establish probable cause to search and seize the person or property described above, and that such search will reveal (identify the person or describe the property to be seized):

See Attachment B.

YOU ARE COMMANDED to execute this warrant on or before July 14 2017 (not to exceed 14 days) in the daytime 6:00 a.m. to 10:00 p.m. at any time in the day or night because good cause has been established.

Unless delayed notice is authorized below, you must give a copy of the warrant and a receipt for the property taken to the person from whom, or from whose premises, the property was taken, or leave the copy and receipt at the place where the property was taken.

The officer executing this warrant, or an officer present during the execution of the warrant, must prepare an inventory as required by law and promptly return this warrant and inventory to Any Western Dist. of NC Magistrate Judge (United States Magistrate Judge)

Pursuant to 18 U.S.C. § 3103a(b), I find that immediate notification may have an adverse result listed in 18 U.S.C. § 2705 (except for delay of trial), and authorize the officer executing this warrant to delay notice to the person who, or whose property, will be searched or seized (check the appropriate box)

for days (not to exceed 30) until, the facts justifying, the later specific date of

Date and time issued: June 30, 2017 at 4:37pm

Dennis L. Howell Judge's signature

City and state: Asheville, NC

Dennis L. Howell, U.S. Magistrate Judge Printed name and title

Western District of North Carolina



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF INVESTIGATIONS



ADVICE OF RIGHTS AND CONSENT TO SEARCH

Before I (we) search you or your premises, it is my (our) duty to advise you of your rights.

You have the right to refuse to permit me (us) to search you or enter and search your premises. If you voluntarily permit the search, any incriminating evidence that I (we) find may be used against you in court or other proceedings.

Prior to permitting me (us) to search, you have the right to require me (us) to secure a search warrant.

I have read the above statement and I understand its content.

(b) (6), (b) (7)(C)

The above statement was read to me by _____, and I understand my rights.

I consent to the search of the Butler Suple building
on the campus of the Army Medical Center
center in Chgo
extends to all floors
within the building.

(b) (6), (b) (7)(C)

Signature

6/30/2017

Date

(b) (6), (b) (7)(C)

6-30-17

Witness Signature and Date

(b) (6), (b) (7)(C)

06/30/17
Date

This document, including any attachments and information contained therein, is the property of the Office of Inspector General (OIG), United States Department of Health and Human Services (HHS), and is for OFFICIAL USE ONLY. The original and any copies of the report must be appropriately controlled and maintained. Disclosure to unauthorized persons without prior written approval of the Deputy Inspector General for Investigations or his/her designee is strictly prohibited and may subject the disclosing party to liability. Unauthorized persons may include, but are not limited to, individuals referenced in the report, contractors, and individuals outside the HHS. Public disclosure is determined by the Freedom of Information Act (Title 5, U.S.C., Section 552) and the Privacy Act (Title 5, U.S.C., Section 552a).

Fact Statement #63

ER Tracking Nashville 0002018.xlsx - Read Only - Excel

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Clipboard Font Alignment Number Styles Cells Editing

05/11/17

	A	B	C	D	E	F	G	H	I	J	K	L	M
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)		(b) (6)	(b) (6)				(b) (6)
5	Unity Healing Center	9/28/2016	(b) (6)			(b) (6)							(b) (6), (b) (5)
6	Unity Healing Center	3/12/2017	(b) (6)			(b) (6)	N/A			5/9/2017			(b) (6), (b) (5)
7	Unity Healing Center	3/13/2017	(b) (6)			(b) (6)	N/A						(b) (6), (b) (5)
8	Nashville Area	5/2/2017	(b) (6)				Y			5/12/2017	5/24/2017		(b) (6)
9	Catawba						N/A			5/15/2017	5/15/2017		

Sheet1

Ready

Milam Consulting

Fact Statement #64

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Clipboard Font Alignment Number Styles Cells Editing

	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
3	(b) (6)		(b) (6)		(b) (6)	(b) (6)					(b) (6)				
4											(b) (6), (b) (5)				
5	(b) (6)		(b) (6)								(b) (6), (b) (5)				
6	(b) (6)		(b) (6)	N/A			5/9/2017				(b) (6), (b) (5)	proposal scinde 4/5/18			
7	(b) (6)		(b) (6)	N/A							(b) (6), (b) (5)				
8	(b) (6)			Y			5/12/2017	5/24/2017			(b) (6)				
9				N/A			5/15/2017	5/15/2017							

Sheet1

Ready

ER Tracking Nashville 00000783.xlsx - Read-Only - Excel

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Clipboard Font Alignment Number Styles

Share Comments

05/11/17

		(b) (6)				(b) (6)											
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)	(b) (6)	(b) (6)									(b) (6)
5	Unity Healing Center	9/28/2017	(b) (6)			(b) (6)											(b) (6), (b) (5)
6	Unity Healing Center	3/12/2017	(b) (6)			(b) (6)	N/A			5/9/2017							(b) (6), (b) (5)
7	Unity Healing Center	3/13/2017	(b) (6)			(b) (6)	N/A										(b) (6), (b) (5)
8	Nashville Area	5/2/2017	(b) (6)				Y			5/12/2017	5/24/2017						(b) (6)
9	Catawba						N/A			5/15/2017	5/15/2017						(b) (6)

Sheet1

Ready

100%

Fact Statement #65

ER Tracking Nashville 00062018.xlsx - Read-Only - Excel

File Home Insert Page Layout Formulas Data Review View Help Tell me what you want to do

Clipboard Font Alignment Number Styles Cells Editing

	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R
6		(b) (6)													
4	(b) (6)		(b) (6)		(b) (6)	(b) (6)						(b) (6)			
5	(b) (6)		(b) (6)	N								(b) (6), (b) (5)			
7	(b) (6)		(b) (6)	N/A								(b) (6), (b) (5)			
8	(b) (6)		(b) (6)	N/A			5/9/2017					(b) (6), (b) (5)	Proposal escmde 5/5/18		
9				Y			5/12/2017	5/24/2017				(b) (6)			
				N/A			5/15/2017	5/15/2017							

Ready Sheet1 100%

ER Tracking Nashville 05/11/2017.xlsx - Read-Only - Excel

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Clipboard Font Alignment Number Styles

Share Comments

05/11/17

	A	B	C	D	E	F	G	H	I	J	K	L	M
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)		(b) (6)	(b) (6)				
5	Unity Healing Center	9/28/2017	(b) (6)			(b) (6)							(b) (6), (b) (5)
6	Unity Healing Center	3/12/2017	(b) (6)			(b) (6)	N/A			5/9/2017			(b) (6), (b) (5)
7	Unity Healing Center Nashville	3/13/2017	(b) (6)			(b) (6)	N/A						(b) (6), (b) (5)
8	Area	5/2/2017	(b) (6)				Y			5/12/2017	5/24/2017		(b) (6)
9	Catawba						N/A			5/15/2017	5/15/2017		

Sheet1

Ready

Fact Statement #66

Milam, Lisa

From: Buchanan, Chris (IHS/HQ)
Sent: Friday, July 7, 2017 2:17 PM
To: Ketcher, Martha A (IHS/NAS/AO)
Cc: Ruff, Tiara R (IHS/NAS/UHC); Claymore, Vickie (IHS/NAS/AO)
Subject: RE: Unity Youth Regional Treatment

More than enough...Thank you

cbb

RADM Chris Buchanan, REHS, MPH
Assistant Surgeon General, USPHS
Deputy Director
301-443-1083
chris.buchanan@ihs.gov

From: Ketcher, Martha A (IHS/NAS/AO)
Sent: Friday, July 07, 2017 3:02 PM
To: Buchanan, Chris (IHS/HQ) <Chris.Buchanan@ihs.gov>
Cc: Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>; Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Subject: FW: Unity Youth Regional Treatment
Importance: High

Martha Ketcher.

Martha A. Ketcher, hca-mba
IHS Area Director, Nashville Tn.
Office 615-467-1521

Our mission is.... "to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level."

From: Ruff, Tiara R (IHS/NAS/UHC)
Sent: Thursday, July 06, 2017 9:07 PM
To: Ketcher, Martha A (IHS/NAS/AO) <Martha.Ketcher@ihs.gov>; Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Subject: RE: Unity Youth Regional Treatment
Importance: High

Not sure where to start.

The OIG came on behalf of the Eastern Band on June 30th, 2017.

(b) (6), (b) (3) (A) of the OIG during the inquisition said we still need comply with The Eastern Band's (subpoenas) request for information.

Everything they asked for they OIG took. They are however, able to share the information removed from Unity.

We are waiting to hear from Lawyer (b) (6) who is in contact with (b) (6), (b) (7)(C)

He is preparing material for the Eastern Band. I am assuming it is the lawyer's place to do that.

(b) (6), (b) (3) (A) Nashville ERLR has a good majority of the information regarding the (b) (6), (b) (3) (A) case.

I will continue to update you as information flows.

RADM's inquiry [on the employee's detail from Cherokee to Mashpee] occurred back in the latter part of 2016

This TDY was part of an opportune-strategy to remove employee from the premise while the (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A) and investigate the incident involving him. (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

It was also to allow time for our investigation and consultation with HR.

The OIG was not involved during the latter part of 2016.

The employees proposed actions were complete prior to the OIG involvement for removal. We were ready to move on removal when the anonymous report came on allegations (b) (6), (b) (3) sexual abuse. From here IHS, OGC advised (b) (6), (b) (5)

(b) (6), (b) (5)

There is a record of the employee's TDY/Travel that (b) (6) could access. That information I do not have.

I can request those dates from (b) (6)

Thank you,

Ti

From: Buchanan, Chris (IHS/HQ)
Sent: Thursday, July 6, 2017 5:50:41 PM
To: Ketcher, Martha A (IHS/NAS/AO)
Cc: Meeks, Kevin (IHS/OKC/AO)
Subject: Unity Youth Regional Treatment

Today, the policy Team asked for the status of the OIG investigation – Do you have a short summary of where we are at with the investigation and status of the employee? Also, didn't the employee get detailed from Cherokee to Mashpee (if I recall correctly) as the investigation progressed?

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chris.buchanan@ihs.gov

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Assistant Surgeon General, USPHS
Deputy Director
301-443-1083
chris.buchanan@ihs.gov

Fact Statement #67

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Sent: Thursday, July 06, 2017 9:07 PM
To: Ketcher, Martha A (IHS/NAS/AO) <Martha.Ketcher@ihs.gov>; Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Subject: RE: Unity Youth Regional Treatment
Importance: High

Not sure where to start.

The OIG came on behalf of the Eastern Band on June 30th, 2017.

(b) (6), (b) (7)(C) of the OIG during the inquisition said we still need comply with The Eastern Band's (subpoenas) request for information.

Everything they asked for they OIG took. They are however, able to share the information removed from Unity.

We are waiting to hear from Lawyer (b) (6) who is in contact with (b) (6), (b) (7)(C)

He is preparing material for the Eastern Band. I am assuming it is the lawyer's place to do that.

(b) (6) Nashville ERLR has a good majority of the information regarding the (b) (6) case.

I will continue to update you as information flows.

RADM's inquiry [on the employee's detail from Cherokee to Mashpee] occurred back in the latter part of 2016

(b) (6), (b) (3) (A)

It was also to allow time for our investigation and consultation with HR.

The OIG was not involved during the latter part of 2016.

The employees proposed actions were complete prior to the OIG involvement (b) (6). We were ready to move on (b) (6) when the anonymous report came on allegations (b) (6), (b) (3) sexual abuse. From here IHS, OGC (b) (6), (b) (5) (b) (6), (b) (5)

There is a record of the employee's TDY/Travel that (b) (6) could access. That information I do not have. I can request those dates from (b) (6)

Thank you,

Ti

From: Buchanan, Chris (IHS/HQ)
Sent: Thursday, July 6, 2017 5:50:41 PM
To: Ketcher, Martha A (IHS/NAS/AO)
Cc: Meeks, Kevin (IHS/OKC/AO)
Subject: Unity Youth Regional Treatment

Today, the policy Team asked for the status of the OIG investigation – Do you have a short summary of where we are at with the investigation and status of the employee? Also, didn't the employee get detailed from Cherokee to Mashpee (if I recall correctly) as the investigation progressed?

Thanks

RADM Chris Buchanan, REHS, MPH
Assistant Surgeon General, USPHS
Deputy Director
301-443-1083
chris.buchanan@ihs.gov

Milam, Lisa

From: Buchanan, Chris (IHS/HQ)
Sent: Friday, July 7, 2017 2:17 PM
To: Ketcher, Martha A (IHS/NAS/AO)
Cc: Ruff, Tiara R (IHS/NAS/UHC); Claymore, Vickie (IHS/NAS/AO)
Subject: RE: Unity Youth Regional Treatment

More than enough...Thank you

cbb

RADM Chris Buchanan, REHS, MPH
Assistant Surgeon General, USPHS
Deputy Director
301-443-1083
chris.buchanan@ihs.gov

From: Ketcher, Martha A (IHS/NAS/AO)
Sent: Friday, July 07, 2017 3:02 PM
To: Buchanan, Chris (IHS/HQ) <Chris.Buchanan@ihs.gov>
Cc: Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>; Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Subject: FW: Unity Youth Regional Treatment
Importance: High

Martha Ketcher.

Martha A. Ketcher, hca-mba
IHS Area Director, Nashville Tn.
Office 615-467-1521

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Importance: High

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Everything they asked for they OIG took. They are however, able to share the information removed from Unity.

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He is preparing material for the Eastern Band. I am assuming it is the lawyer's place to do that.

(b) (6) Nashville ERLR has a good majority of the information regarding the (b) (6) case.

I will continue to update you as information flows.

RADM's inquiry [on the employee's detail from Cherokee to Mashpee] occurred back in the latter part of 2016

This TDY was part of an opportune-strategy to remove employee from the premise while the (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A) and investigate the incident involving him. (b) (6), (b) (3) (A)

(b) (6), (b) (3) (A)

It was also to allow time for our investigation and consultation with HR.

The OIG was not involved during the latter part of 2016.

The employees proposed actions were complete prior to the OIG involvement (b) (6) We were ready to move on removal when the anonymous report came on allegations (b) (6), (b) (3) sexual abuse. From here IHS, OGC advised (b) (6), (b) (5)

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RADM Chris Buchanan, REHS, MPH
Assistant Surgeon General, USPHS
Deputy Director
301-443-1083
chris.buchanan@ihs.gov

Fact Statement #68

Milam, Lisa

From: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Sent: Friday, January 17, 2020 2:42 PM
To: Cotton, Beverly (IHS/NAS/AO)
Subject: FW: Documents-proposal letter and response

From: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Sent: Monday, December 11, 2017 2:49 PM
To: (b) (6)
Cc: (b) (6); Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>; Ketcher, Martha A (IHS/NAS/AO) <Martha.Ketcher@ihs.gov>
Subject: RE: Documents-proposal letter and response

Good Afternoon, Has there been any updates? (b) (6), (b) (5)

(b) (6), (b) (5)

Thank you

Vickie Claymore, Ph.D.
Director, Field Operations, Nashville IHS
(615) 467-1623

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From: (b) (6)
Sent: Friday, September 01, 2017 2:46 PM
To: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Cc: (b) (6); Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>; Ketcher, Martha A (IHS/NAS/AO) <Martha.Ketcher@ihs.gov>
Subject: RE: Documents-proposal letter and response

(b) (6), (b) (5)

Thank you.

(b) (6)

From: Claymore, Vickie (IHS/NAS/AO) [<mailto:Vickie.Claymore@ihs.gov>]
Sent: Friday, September 01, 2017 2:55 PM
To: (b) (6)
Cc: (b) (6); Gyorda, Lisa (IHS/HQ); Ketcher, Martha A (IHS/NAS/AO)
Subject: RE: Documents-proposal letter and response

Good Afternoon,

I am checking into to see if there are any new updates or guidance.

Thank you

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Subject: RE: Documents-proposal letter and response

Dr. Claymore,

Please forgive me for not getting back to you sooner. (b) (6), (b) (5)

(b) (6), (b) (5)

Thank you for your patience in this matter.

Respectfully,

(b) (6)

From: Claymore, Vickie (IHS/NAS/AO) [<mailto:Vickie.Claymore@ihs.gov>]
Sent: Tuesday, July 11, 2017 4:01 PM
To: (b) (6)
Cc: (b) (6); Gyorda, Lisa (IHS/HQ); Ketcher, Martha A (IHS/NAS/AO)
Subject: Re: Documents-proposal letter and response

Good Afternoon. Do you have any update for me. (b) (6), (b) (5)
(b) (6), (b) (5)

Is there anything else that we need to do at this time? Is it still recommended (b) (6), (b) (5)
(b) (6), (b) (5)

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Fact Statement #69

Milam, Lisa

From: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Sent: Friday, January 17, 2020 2:42 PM
To: Cotton, Beverly (IHS/NAS/AO)
Subject: FW: Documents-proposal letter and response

From: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Sent: Monday, December 11, 2017 2:49 PM
To: (b) (6)
Cc: (b) (6); Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>; Ketcher, Martha A (IHS/NAS/AO) <Martha.Ketcher@ihs.gov>
Subject: RE: Documents-proposal letter and response

Good Afternoon, Has there been any updates? (b) (6), (b) (5)

(b) (6), (b) (5)

Thank you

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Director, Field Operations, Nashville IHS
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Sent: Friday, September 01, 2017 2:46 PM
To: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Cc: (b) (6); Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>; Ketcher, Martha A (IHS/NAS/AO) <Martha.Ketcher@ihs.gov>
Subject: RE: Documents-proposal letter and response

(b) (6), (b) (5)

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(b) (6)

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Sent: Friday, September 01, 2017 2:55 PM
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Subject: RE: Documents-proposal letter and response

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Subject: RE: Documents-proposal letter and response

Dr. Claymore,

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Is there anything else that we need to do at this time? Is it still recommended (b) (6), (b) (5)

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Fact Statement #70

Milam, Lisa

From: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Sent: Friday, January 17, 2020 2:42 PM
To: Cotton, Beverly (IHS/NAS/AO)
Subject: FW: Documents-proposal letter and response

From: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Sent: Monday, December 11, 2017 2:49 PM
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Subject: RE: Documents-proposal letter and response

Good Afternoon, Has there been any updates? (b) (6), (b) (5)

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Thank you

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Fact Statement #71

Milam, Lisa

From: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Sent: Friday, January 17, 2020 2:42 PM
To: Cotton, Beverly (IHS/NAS/AO)
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Director, Field Operations, Nashville IHS
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Fact Statement #72

Milam, Lisa

From: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Sent: Friday, January 17, 2020 2:42 PM
To: Cotton, Beverly (IHS/NAS/AO)
Subject: FW: Documents-proposal letter and response

From: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Sent: Monday, December 11, 2017 2:49 PM
To: (b) (6)
Cc: (b) (6); Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>; Ketcher, Martha A (IHS/NAS/AO) <Martha.Ketcher@ihs.gov>
Subject: RE: Documents-proposal letter and response

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(b) (6), (b) (5)

Thank you

Vickie Claymore, Ph.D.
Director, Field Operations, Nashville IHS
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Cc: (b) (6); Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>; Ketcher, Martha A (IHS/NAS/AO) <Martha.Ketcher@ihs.gov>
Subject: RE: Documents-proposal letter and response

(b) (6)

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(b) (6)

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From: (b) (6)
Sent: Friday, July 14, 2017 5:49 PM
To: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Cc: (b) (6); Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>; Ketcher, Martha A (IHS/NAS/AO) <Martha.Ketcher@ihs.gov>
Subject: RE: Documents-proposal letter and response

Dr. Claymore,

Please forgive me for not getting back to you sooner. (b) (6), (b) (5)

(b) (6), (b) (5)

Thank you for your patience in this matter.

Respectfully,

(b) (6)

From: Claymore, Vickie (IHS/NAS/AO) [mailto:Vickie.Claymore@ihs.gov]
Sent: Tuesday, July 11, 2017 4:01 PM
To: (b) (6)
Cc: (b) (6); Gyorda, Lisa (IHS/HQ); Ketcher, Martha A (IHS/NAS/AO)
Subject: Re: Documents-proposal letter and response

Good Afternoon. Do you have any update for me. (b) (6), (b) (5)

(b) (6), (b) (5)

Is there anything else that we need to do at this time? Is it still recommended (b) (6), (b) (5)

(b) (6), (b) (5)

Thank you.

Vickie Claymore, Ph.D.

Director, Field Operations, Nashville IHS
(615) 467-1623

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Fact Statement #73

Clipboard Font Alignment Number Styles Cells Editing

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Normal Bold Italic Underline

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	(b) (6)																	
4	(b) (6)		(b) (6)	(b) (6)(b) (6)									(b) (6)					
													(b) (6), (b) (5)					
	(b) (6)		(b) (6)										(b) (6), (b) (5)					
6	(b) (6)		(b) (6)	N/A				5/9/2017					(b) (6), (b) (5)					Proposal rescinded 4/5/18
7	(b) (6)		(b) (6)	N/A									(b) (6), (b) (5)					
8	(b) (6)			Y				5/12/2017	5/24/2017				(b) (6)					
9				N/A				5/15/2017	5/15/2017									

ER Tracking Nashville (0002018) - Read-Only - Excel

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Share Comments

05/11/17

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)		(b) (6)	(b) (6)					(b) (6)
5	Unity Healing Center	9/28/2017	(b) (6)			(b) (6)								(b) (6), (b) (5)
6	Unity Healing Center	3/12/2017	(b) (6)			(b) (6)	N/A			5/9/2017				(b) (6), (b) (5)
7	Unity Healing Center Nashville	3/13/2017	(b) (6)			(b) (6)	N/A							(b) (6), (b) (5)
8	Area	5/2/2017	(b) (6)				Y			5/12/2017	5/24/2017			(b) (6)
9	Catawba						N/A			5/15/2017	5/15/2017			

Sheet1

Ready

Fact Statement #74

Milam, Lisa

From: (b) (6)
Sent: Tuesday, March 20, 2018 12:34 PM
To: Gyorda, Lisa (IHS/HQ)
Cc: (b) (6)
Subject: RE: Unity-personnel issues

Good Afternoon,

Yes, I will be following-up with Dr. Claymore today. Thank you.

(b) (6)

Our mission is... " to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level."

From: Gyorda, Lisa (IHS/HQ)
Sent: Tuesday, March 20, 2018 12:14 PM
To: (b) (6)
Cc: (b) (6)
Subject: FW: Unity-personnel issues

(b) (6) – Are you following-up with Vickie on her questions below?

From: (b) (6)
Sent: Tuesday, March 20, 2018 12:00 PM
To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>; (b) (6)
Subject: RE: Unity-personnel issues

Yes, I have been in discussions with the attorneys regarding all of these cases along with (b) (6). He said, he was going to update Vickie. I will check on this tomorrow when I get back in the office. Let her know she needs to contact (b) (6) please.

Thanks!

(b) (6)

Sent with BlackBerry Work
(www.blackberry.com)

From: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Date: Tuesday, Mar 20, 2018, 8:50 AM

To: (b) (6) (b) (6)

Subject: FW: Unity-personnel issues

(b) (6) – Who can help review and provide guidance? I need help with this request. Thanks, Lisa

From: Claymore, Vickie (IHS/NAS/AO)
Sent: Tuesday, March 20, 2018 11:30 AM
To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: RE: Unity-personnel issues

Good Morning. Is there an update on this?

Vickie Claymore, Ph.D.
Director, Field Operations, Nashville IHS
(615) 467-1623

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From: Gyorda, Lisa (IHS/HQ)
Sent: Friday, March 09, 2018 6:37 AM
To: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: RE: Unity-personnel issues

I'm reviewing your questions and will follow-up very soon.

From: Claymore, Vickie (IHS/NAS/AO)
Sent: Tuesday, March 06, 2018 11:15 AM
To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: RE: Unity-personnel issues

Thank you Lisa. It would be good to discuss next steps. I also have a few questions.

1. In reviewing the OGC recommendations (b) (6), (b) (5) Is there anything else such as the OIG investigation or (b) (6), (b) (3) (A), (b) (5) (b) (6), (b) (3) (A), (b) (5)
2. (b) (6) mentioned that (b) (6) is also reviewing the proposal (b) (6) Is there a time frame when we can expect that one?
3. From the recommendation there are (b) (5) (b) (6), (b) (5) (b) (6), (b) (5)

Vickie Claymore, Ph.D.
Director, Field Operations, Nashville IHS
(615) 467-1623

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anyone other than the intended recipient is prohibited. If you have received this e-mail in error, please notify the sender by reply e-mail, phone, or fax, and destroy the original message and all copies.

From: Gyorda, Lisa (IHS/HQ)
Sent: Tuesday, March 06, 2018 7:10 AM
To: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: RE: Unity-personnel issues
Importance: High

Hi Vickie – I have attached the email I received from (b) (6). Please review and let me know if you need any assistance or would like to discuss next steps. Thanks, Lisa


From: Claymore, Vickie (IHS/NAS/AO)
Sent: Monday, March 05, 2018 4:29 PM
To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: Unity-personnel issues

Good Afternoon,

Dr. Finke and I were working with (b) (6) to try to get updates on several personnel issues that are in the works at Unity. (b) (6) stated that (b) (6) had provided you with his legal review and recommendations (b) (6), (b) (5) (b) (6), (b) (5)

(b) (6) recommended we check with you regarding the recommendations. Can you please share the information so that we can move forward with these issues?

Thank you

	Vickie Claymore, Ph.D
	Director, Field Operations Nashville Area Indian Health Service 711 Stewarts Ferry Pike Nashville, TN 37214 (615) 467-1623 FAX (615) 467-1644 vickie.claymore@ihs.gov

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Fact Statement #75

Milam, Lisa

From: (b) (6)
Sent: Monday, March 5, 2018 2:35 PM
To: Gyorda, Lisa (IHS/HQ)
Cc: (b) (6)
Subject: (b) (6)
Attachments: (b) (6), (b) (5)

Lisa,

We have finished our legal review of the proposed personnel action for (b) (6) dated March 28, 2017. I have attached a talking point analysis and our legal opinion regarding the proposal. After your office's review, if you have any questions or concerns, please reach out to (b) (6) or me. Also, at this point, we would (b) (6), (b) (5)
(b) (6), (b) (5)

Thank you for your continued support and assistance in this matter.

Warm regards,

(b) (6)

(b) (6)
Attorney
Office of the General Counsel

(b) (6)

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(b) (6), (b) (5)

(b) (6), (b) (5)

(b) (6), (b) (5)

Fact Statement #76

Milam, Lisa

From: (b) (6)
Sent: Tuesday, March 20, 2018 12:34 PM
To: Gyorda, Lisa (IHS/HQ)
Cc: (b) (6)
Subject: RE: Unity-personnel issues

Good Afternoon,

Yes, I will be following-up with Dr. Claymore today. Thank you.

(b) (6)

Our mission is.... " to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level."

From: Gyorda, Lisa (IHS/HQ)
Sent: Tuesday, March 20, 2018 12:14 PM
To: (b) (6)
Cc: (b) (6)
Subject: FW: Unity-personnel issues

(b) (6) – Are you following-up with Vickie on her questions below?

From: (b) (6)
Sent: Tuesday, March 20, 2018 12:00 PM
To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>; (b) (6)
Subject: RE: Unity-personnel issues

Yes, I have been in discussions with the attorneys regarding all of these cases along with (b) (6). He said, he was going to update Vickie. I will check on this tomorrow when I get back in the office. Let her know she needs to contact (b) (6) please.

Thanks!

(b) (6)

Sent with BlackBerry Work
(www.blackberry.com)

From: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Date: Tuesday, Mar 20, 2018, 8:50 AM

To: (b) (6) (b) (6)
Subject: FW: Unity-personnel issues

(b) (6) – Who can help review and provide guidance? I need help with this request. Thanks, Lisa

From: Claymore, Vickie (IHS/NAS/AO)
Sent: Tuesday, March 20, 2018 11:30 AM
To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: RE: Unity-personnel issues

Good Morning. Is there an update on this?

Vickie Claymore, Ph.D.
Director, Field Operations, Nashville IHS
(615) 467-1623

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From: Gyorda, Lisa (IHS/HQ)
Sent: Friday, March 09, 2018 6:37 AM
To: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: RE: Unity-personnel issues

I'm reviewing your questions and will follow-up very soon.

From: Claymore, Vickie (IHS/NAS/AO)
Sent: Tuesday, March 06, 2018 11:15 AM
To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: RE: Unity-personnel issues

Thank you Lisa. It would be good to discuss next steps. I also have a few questions.

1. In reviewing the OGC recommendations (b) (6), (b) (5) Is there anything (b) (6), (b) (5)
2. (b) (6) mentioned that (b) (6) is also reviewing the (b) (6) Is there a time frame when we can expect that one?
3. From the recommendation there are (b) (5) (b) (6), (b) (5)

Vickie Claymore, Ph.D.
Director, Field Operations, Nashville IHS
(615) 467-1623

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From: Gyorda, Lisa (IHS/HQ)
Sent: Tuesday, March 06, 2018 7:10 AM
To: Claymore, Vickie (IHS/NAS/AO) <Vickie.Claymore@ihs.gov>
Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: RE: Unity-personnel issues
Importance: High

Hi Vickie – I have attached the email I received from (b) (6). Please review and let me know if you need any assistance or would like to discuss next steps. Thanks, Lisa


From: Claymore, Vickie (IHS/NAS/AO)
Sent: Monday, March 05, 2018 4:29 PM
To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: Unity-personnel issues

Good Afternoon,

Dr. Finke and I were working with (b) (6) to try to get updates on several personnel issues that are in the works at Unity. (b) (6) stated that (b) (6) had provided you with his legal review and recommendations (b) (6), (b) (5) (b) (6), (b) (5)

(b) (6) recommended we check with you regarding the recommendations. Can you please share the information so that we can move forward with these issues?

Thank you

	Vickie Claymore, Ph.D
	Director, Field Operations Nashville Area Indian Health Service 711 Stewarts Ferry Pike Nashville, TN 37214 (615) 467-1623 FAX (615) 467-1644 vickie.claymore@ihs.gov

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Fact Statement #77

Milam, Lisa

From: (b) (6)
Sent: Monday, March 5, 2018 2:35 PM
To: Gyorda, Lisa (IHS/HQ)
Cc: (b) (6)
Subject: (b) (6)
Attachments: (b) (6), (b) (5)

Lisa,

We have finished our legal review of the proposed personnel action for (b) (6) dated March 28, 2017. I have attached a talking point analysis and our legal opinion regarding the proposal. After your office's review, if you have any questions or concerns, please reach out to (b) (6) or me. Also, at this point, we would (b) (6), (b) (5)
(b) (6), (b) (5)

Thank you for your continued support and assistance in this matter.

Warm regards,

(b) (6)

(b) (6)
Attorney
Office of the General Counsel

(b) (6)

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(b) (6), (b) (5)

(b) (6), (b) (5)

(b) (6), (b) (5)

Milam, Lisa

From: (b) (6)
Sent: Tuesday, March 20, 2018 12:34 PM
To: Gyorda, Lisa (IHS/HQ)
Cc: (b) (6)
Subject: RE: Unity-personnel issues

Good Afternoon,

Yes, I will be following-up with Dr. Claymore today. Thank you.

(b) (6)

Our mission is.... " to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level."

From: Gyorda, Lisa (IHS/HQ)
Sent: Tuesday, March 20, 2018 12:14 PM
To: (b) (6)
Cc: (b) (6)
Subject: FW: Unity-personnel issues

(b) (6) - Are you following-up with Vickie on her questions below?

From: (b) (6)
Sent: Tuesday, March 20, 2018 12:00 PM
To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>; (b) (6)
Subject: RE: Unity-personnel issues

Yes, I have been in discussions with the attorneys regarding all of these cases along with (b) (6). He said, he was going to update Vickie. I will check on this tomorrow when I get back in the office. Let her know she needs to contact (b) (6) please.

Thanks!

(b) (6)

Sent with BlackBerry Work
(www.blackberry.com)

From: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Date: Tuesday, Mar 20, 2018, 8:50 AM

To: (b) (6)

Subject: FW: Unity-personnel issues

(b) (6) – Who can help review and provide guidance? I need help with this request. Thanks, Lisa

From: Claymore, Vickie (IHS/NAS/AO)

Sent: Tuesday, March 20, 2018 11:30 AM

To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>

Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>

Subject: RE: Unity-personnel issues

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Vickie Claymore, Ph.D.

Director, Field Operations, Nashville IHS

(615) 467-1623

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Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>

Subject: RE: Unity-personnel issues

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From: Claymore, Vickie (IHS/NAS/AO)

Sent: Tuesday, March 06, 2018 11:15 AM

To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>

Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>

Subject: RE: Unity-personnel issues

Thank you Lisa. It would be good to discuss next steps. I also have a few questions.

1. In reviewing the OGC recommendations (b) (6), (b) (5) Is there anything (b) (6), (b) (5)
2. (b) (6) mentioned that (b) (6) is also reviewing the (b) (6) Is there a time frame when we can expect that one?
3. From the recommendation there are (b) (5) (b) (6), (b) (5) (b) (6), (b) (5)

Vickie Claymore, Ph.D.

Director, Field Operations, Nashville IHS

(615) 467-1623

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Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: RE: Unity-personnel issues
Importance: High

Hi Vickie – I have attached the email I received from (b) (6). Please review and let me know if you need any assistance or would like to discuss next steps. Thanks, Lisa


From: Claymore, Vickie (IHS/NAS/AO)
Sent: Monday, March 05, 2018 4:29 PM
To: Gyorda, Lisa (IHS/HQ) <Lisa.Gyorda@ihs.gov>
Cc: Finke, Bruce MD (IHS/NAS/AO) <Bruce.Finke@ihs.gov>
Subject: Unity-personnel issues

Good Afternoon,

Dr. Finke and I were working with (b) (6) to try to get updates on several personnel issues that are in the works at Unity. (b) (6) stated that (b) (6) had provided you with his legal review and recommendations (b) (6), (b) (5) (b) (6), (b) (5)

(b) (6) recommended we check with you regarding the recommendations. Can you please share the information so that we can move forward with these issues?

Thank you

	Vickie Claymore, Ph.D
	Director, Field Operations Nashville Area Indian Health Service 711 Stewarts Ferry Pike Nashville, TN 37214 (615) 467-1623 FAX (615) 467-1644 vickie.claymore@ihs.gov

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Milam Consulting

Fact Statement #78

Milam, Lisa

From: (b) (6)
Sent: Thursday, March 29, 2018 7:01 AM
To: Ruff, Tiara R (IHS/NAS/UHC)
Subject: (b) (6)

Forgot to put cc'c on the letter. Cc to Dr. Finke, (b) (6) and Dr. Claymore.

From: Ruff, Tiara R (IHS/NAS/UHC)
Sent: Wednesday, March 28, 2018 3:39 PM
To: (b) (6)
Subject: (b) (6)

Ok. Yes I will.
Thank you

From: (b) (6)
Sent: Wednesday, March 28, 2018 4:39 PM
To: Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>
Subject: (b) (6)

If the tribe asks questions, refer them to Dr. Finke.

From: Ruff, Tiara R (IHS/NAS/UHC)
Sent: Wednesday, March 28, 2018 2:15 PM
To: (b) (6)
Subject: (b) (6)

Ok so (b) (6) What do I say to staff who ask questions?

From: (b) (6)
Sent: Wednesday, March 28, 2018 1:10 PM
To: Ruff, Tiara R (IHS/NAS/UHC) <Tiara.Ruff@ihs.gov>
Subject: (b) (6)

Ti, what position does (b) (6) occupy? I spoke with (b) (6) yesterday and we think that we should proceed to give a letter to (b) (6) I thought I could draft a letter for you and return him next Monday.

Fact Statement #79



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Nashville Area Indian Health Service
Unity healing Center,
Cherokee, NC 28719

March 28, 2018

(b) (6)

Dear **(b) (6)**

This is notice that the **(b) (6)**
(b) (6)

You are to report to **(b) (6)** Administrative Officer, **(b) (6)**
(b) (6)

Please let me know if you have any questions concerning this notice.

CAPT Tiara Ruff
Chief Executive Officer

Cc: Dr. B. Finke

(b) (6)

Dr. Claymore

Fact Statement #80

Clipboard Font Alignment Number Styles Cells Editing

Normal Bold Italic Underline Text Color Background Color

Insert Delete Format

Fill Clear Find & Select

	(b) (6)																	
	(b) (6)	(b) (6)	(b) (6)	(b) (6)									(b) (6)					
													(b) (6), (b) (5)					
	(b) (6)	(b) (6)											(b) (6), (b) (5)					
	(b) (6)	(b) (6)	N/A					5/9/2017					(b) (6), (b) (5)					Proposal rescinded 4/5/18
	(b) (6)	(b) (6)	N/A										(b) (6), (b) (5)					
	(b) (6)		Y					5/12/2017	5/24/2017				(b) (6)					
	(b) (6)		N/A					5/15/2017	5/15/2017									

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Clipboard: Paste, Copy, Format Painter

Font: (b) (6)

Alignment: (b) (6)

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Styles: Normal, Bad, Good, Neutral, Note

Cells: Insert, Delete, Format

Editing: Find & Select, Clear

		(b) (6)				(b) (6)		(b) (6)						05/11/17
4	Micmac Service Unit	01/09/2017	(b) (6)	(b) (6)		(b) (6)		(b) (6)	(b) (6)					(b) (6)
						N								(b) (6), (b) (5)
5	Unity Healing Center	9/28/2017		(b) (6)		N								(b) (6), (b) (5)
6	Unity Healing Center	3/12/2017		(b) (6)		N/A				5/9/2017				(b) (6), (b) (5)
7	Unity Healing Center	3/13/2017		(b) (6)		N/A								(b) (6), (b) (5)
8	Nashville Area	5/2/2017		(b) (6)		Y				5/12/2017	5/24/2017			(b) (6)
9	Catawba					N/A				5/15/2017	5/15/2017			

