

STATE OF OHIO
OFFICE OF THE INSPECTOR GENERAL

RANDALL J. MEYER, INSPECTOR GENERAL

REPORT OF
INVESTIGATION



AGENCY: OHIO DEPARTMENT OF MENTAL HEALTH AND
ADDICTION SERVICES
FILE ID NO.: 2013-CA00093
DATE OF REPORT: DECEMBER 15, 2014

The Office of the Ohio Inspector General ... The State Watchdog

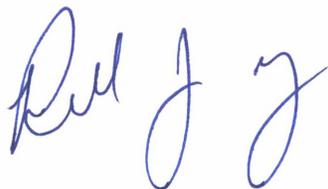
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Randall J. Meyer
Ohio Inspector General



STATE OF OHIO
OFFICE OF THE INSPECTOR GENERAL

RANDALL J. MEYER, INSPECTOR GENERAL

REPORT OF INVESTIGATION

FILE ID NUMBER: 2013-CA00093

SUBJECT NAME: Deavonte Williams

POSITION: Therapeutic Program Worker

AGENCY: Ohio Department of Mental Health and
Addiction Services

BASIS FOR INVESTIGATION: Agency Referral

ALLEGATIONS: Conflict of Interest

INITIATED: December 4, 2013

DATE OF REPORT: December 15, 2014

INITIAL ALLEGATION AND COMPLAINT SUMMARY

On October 29, 2013, the chief legal counsel of the Ohio Department of Mental Health and Addiction Services (MHAS) reported in a memo to the Ohio Governor's Office and the Office of the Ohio Inspector General potential misconduct or illegal activity by an MHAS employee. The memo identified the employee as Therapeutic Program Worker Deavonte Williams who works at the Northwest Ohio Psychiatric Hospital (NOPH) in Toledo, Ohio. Williams also owns Assurance Plus Residential Living Facility, a state-licensed adult care facility (group home) in Toledo, and received a referral from NOPH staff members for a patient at the hospital to be allowed day visits and overnight visits at the home. For these numerous visits, Williams was paid a total of \$1,550 by checks authorized and signed by hospital administrators through disbursements from the patient's individual money account. The author of the memo believed, at minimum, there was an appearance of impropriety or potential violation of Ohio Ethics Laws.

The Office of the Ohio Inspector General opened an investigation on December 4, 2013.

BACKGROUND

Ohio Department of Mental Health and Addiction Services

The Ohio Department of Mental Health and Addiction Services (MHAS) was created July 1, 2013, by consolidating the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services. The mission of the MHAS is to provide statewide leadership of a high-quality mental health and addiction prevention, treatment, and recovery system that is effective and valued by all Ohioans.

MHAS oversees a statewide mental health and alcohol, drug, and gambling addiction service system that consists of community behavioral health agencies (approximately 300 addiction treatment providers, 160 prevention providers, and 400 mental health agencies) and 53 county-based boards (47 alcohol, drug addiction, and mental health services boards; three community mental health services boards; and three alcohol and drug addiction services boards). The department employs nearly 2,400 individuals, the bulk of whom work in the state's six regional psychiatric hospitals including the Northwest Ohio Psychiatric Hospital (NOPH) in Toledo,

Ohio. Patients who are served by these psychiatric hospitals fall into one of two primary categories:

Forensic patients – Persons who are committed to MHAS by a court of common pleas after being found incompetent to stand trial or found not guilty by reason of insanity. These patients may be committed to MHAS either pre-trial or post-trial, depending on the circumstances. A forensic patient remains under the jurisdiction of the court for the duration of treatment or until the court orders otherwise.

Civil patients – Persons who are placed at a state psychiatric hospital after a referral from a county mental health board or local mental health center. Through this referral process, patients can admit themselves voluntarily, if they meet commitment criteria, or can be ordered involuntarily committed by the probate court with jurisdiction. Civil patients are not directly admitted (walk-in/self-admission) to state psychiatric hospitals.

MHAS is also responsible for the licensure and certification of Adult Care Facilities (ACF).¹ These facilities, often referred to as adult group homes or group homes, are residential care homes licensed by MHAS for the purpose of providing accommodations, supervision, and personal care services to unrelated adults. Facilities receive a two-year license to operate after complying with the statutory requirements prescribed in the Ohio Revised Code and the rules set forth in the Ohio Administrative Code. Operators must undergo a comprehensive onsite inspection of the home to verify the safe and sanitary condition of the facility, the capability of the operator and staff to meet their responsibilities in providing supervision and personal care services, and the appropriateness of the placement of each resident in the adult care setting. ACFs that serve residents with serious mental illness have an additional obligation by rule to have staff and managers oriented to the care and supervision needs of these residents, and to require specific training on an annual basis relevant to persons with a diagnosis of mental illness residing in the facility.²

¹ To more accurately report what was said during interviews, Adult Care Facility (ACF) and “group home” are used interchangeably for this report. ACF is the more formal name, while “group home” is more commonly used in conversation.

² Source: MHAS website at: <http://mha.ohio.gov/>

Patients from the state psychiatric hospitals are permitted to go, with the recommendation and approval of the patient's treatment team, to the ACF facilities for day visits, overnight visits, or in some cases, can be permanently discharged to reside in the facility. With regard to day and overnight visits, the owners of the group homes are typically compensated to offset the costs incurred for the visits. Compensation is received through disbursements from the patient's individual money account which is overseen by the hospital administration.

The decision to allow a patient to visit an ACF is based on the recommendation of the patient's treatment team and community mental health boards. When a patient is discharged to reside in an ACF, the selection of the facility involves the input of the community and the treatment team. In the case of forensic patients, these visits or potential discharges must be approved and ordered by the committing court.

INVESTIGATIVE SUMMARY

In furtherance of the investigation, the Office of the Ohio Inspector General obtained from MHAS, employment records, copies of policies and procedures, and records showing payments made to Williams.

MHAS Policies and Procedures

The Office of the Ohio Inspector General reviewed the MHAS policies that provided the guidelines for MHAS employees who engage in outside employment. (Note: Both policies are holdover policies from the Ohio Department of Mental Health (ODMH) prior to the agency merging with the Ohio Department of Alcohol and Drug Addiction Services):

ODMH Policy AH-32 – Outside Employment – Effective Date 4/3/2012 ([Exhibit 1](#))

This policy expands on the previous 2006 Outside Employment policy by adding definitions and additional restrictions that mirror the ODMH Ethics Policy as it applies to outside employment and replaces previous wording that prohibited employees from engaging in outside employment that posed a conflict of interest with their department employment. The current policy simply states that outside employment shall not conflict with the department's Ethics Policy. The

Outside Employment policy also requires employees to submit any questions regarding the Ethics Policy, as they relate to outside employment, to the department's chief legal counsel.

Note: During the course of this investigation, the Office of the Ohio Inspector General was advised by MHAS that this policy was undergoing a complete revision. Investigators were informed the revised policy would incorporate a more thorough vetting process for employees wishing to engage in outside employment.

ODMH Policy L-04 – Ethics Policy – Effective Date 8/9/2011 ([Exhibit 2](#))

This policy deals with general standards and ethical conduct of MHAS employees. The two sections below specifically address conflict of interest issues:

Section C (4)(b) states: “No official or employee shall use his or her public position to solicit or accept employment from anyone doing business with ODMH or accept employment that may result in a conflict of interest with his or her public position.”

Section E of the policy defines a conflict of interest and the requirement of employees to disclose potential conflicts of interest. Section E states:

A potential conflict exists if the private interests of the employee might interfere with the public interests the employee is required to serve in the exercise of the employee's authority and duties in the employee's office or position of employment. It is the duty of every ODMH employee to report a potential conflict of interest to their supervisor and seek advice from the Office of Legal Services.

During an initial meeting with MHAS on December 23, 2013, the Office of the Ohio Inspector General was made aware of the possibility that NOPH also may have violated an order from the Erie County Court of Common Pleas on 19 occasions from February 7, 2012, through February 14, 2013, by allowing the patient to visit a group home, and in this case, the one owned by Williams. After February 14, 2013, a new court order was issued allowing the patient to begin visiting group homes.

Also during this meeting, the investigator learned of a NOPH civil patient who had been permanently discharged to Williams' group home after a recommendation by the patient's treatment team at the hospital and with the consultation and concurrence of the local mental health board. This civil patient was later readmitted to NOPH.

Allegation of Conflict of Interest/Ethics Violation

The initial allegation which prompted this investigation centered on one forensic patient who was referred to an ACF, Assurance Plus Residential Living Facility (Assurance Plus), owned and operated by Williams. This was first discovered by NOPH administration when Chief Operating Officer Jim Skolmowski was processing payments from the patient's money account.

The Office of the Ohio Inspector General's review of MHAS payment records found that from May 2, 2013, to October 15, 2013, a total of 27 payments were made directly to Deavonte Williams and one payment was made to Assurance Plus, for a total of \$1,550. All 28 of these payments were drawn from the forensic patient's individual money account. ([Exhibit 3](#))

During a February 10, 2014, interview conducted by the Office of the Ohio Inspector General, Skolmowski stated that the hospital oversees patients' individual money accounts and writes checks to others on behalf of a patient when requested and approved.³ Skolmowski said it is common for checks to be written to hospital employees when they are tasked with accompanying patients on outings outside of the hospital. The reasons Skolmowski gave for writing the checks to the employee vary, and included situations when a patient is incapable of cashing a check or handling their own money. Upon their return to the hospital, the employees are required to reconcile the patient's account with receipts of purchases and any change left over from the initial check.

Skolmowski said that while processing the October 15, 2013, disbursement, he noticed the payment was being made directly to Williams, who he recognized as an employee, even though the purpose of the patient's outing was to visit Assurance Plus group home. Skolmowski questioned why the hospital wasn't asked to write a check directly to Assurance Plus rather than

³ Ohio Administrative Code §5122-2-03.

to an employee. Ultimately, Skolmowski authorized the check to be written to Assurance Plus and later learned the facility was owned by Williams. Upon learning the ownership of Assurance Plus, Skolmowski immediately reported his concerns and the potential ethics violation to his superiors.

On February 10, 2014, the Office of the Ohio Inspector General interviewed Candace Schmitt who currently works as the licensed social worker on Unit 500 at the hospital and had been a member of the above forensic patient's treatment team since November 2012. Unit 500 is primarily a forensic unit and a majority of the patients housed on the unit are forensic patients. Williams also works on Unit 500 at NOPH.

Schmitt, who began her duties on this unit in November 2012, replaced the unit's previous social worker, Carol Hill, who had been promoted. Schmitt, who is also a member of the unit's treatment teams, received binders from Hill containing patient information, including one concerning the forensic patient related to this investigation. Schmitt said that the patient's previous and future visits to Williams' group home had already been arranged at the time she assumed Hill's position. Schmitt noted that she questioned the decision for the patient to visit a group home owned by an employee, but did not address her concerns with anyone else. Schmitt said she felt that since a senior social worker had been involved in the process, the visits by the patient to Williams' group home must have been approved.

During a February 10, 2014, interview with Anne Engle, a nurse at the hospital, the Office of the Ohio Inspector General learned that Williams, who was hired by MHAS in August 2011, began making inquiries of co-workers about the requirements of opening a group home sometime in the summer of 2012. Engle, who had just completed serving eight months as a group home surveyor for MHAS said she had spoken with Williams about these requirements. Engle said that in her capacity as a surveyor, she was responsible for inspecting the facilities that applicants intended to use as potential group homes. Engle would also ensure the applicant and other employees had completed all of the required training to operate a group home. Engle acknowledged signing off on some of the training completed by Williams that was necessary for him to operate a group home. Engle said in her conversations with Williams about his interest in opening a group home,

Williams had asked where he could get referrals if he were to open one. Engle said she responded by telling Williams she wasn't sure where he could get referrals, but that he should talk to social workers in the county and they might be of help.

The investigator learned from Engle that she believed Williams also spoke to Rose Lester, the MHAS employee who replaced Engle as the surveyor for group homes in northwest Ohio. When asked during a February 11, 2014, interview with the Office of the Ohio Inspector General, Williams stated that he considered Lester to be the expert on group homes. Williams said Lester told him there was no issue with him receiving patient or client referrals from NOPH to his group home. When Williams was asked if he had checked with any other employees or supervisors at the hospital to determine if this was permissible, Williams said he did discuss his group home with others and that he did have concerns about receiving a referral to his group home from the hospital. However, Williams said he considered Lester the expert on what was permissible and what was not as far as patient referrals from the hospital.

Williams was asked if he had received ethics training during his orientation when he was hired at NOPH and any additional yearly trainings during the course of his employment. When asked about the yearly online ethics training and subsequent test, Williams commented that he did not recall the training or taking the test but was sure he probably did. When Williams was asked if, during the online training, he remembered conflicts of interest being discussed, he said, "No, probably not. I don't really ... 'cause a lot of times I just go through and click. I don't really read a lot of them."

When interviewed by the Office of the Ohio Inspector General on March 18, 2014, Lester said she recalled having a conversation with Williams sometime in 2012 about his desire to open a group home. She also had a recollection of Williams asking if it was permissible for him to get patient referrals from the hospital. Lester stated that she responded to this inquiry from Williams in the same manner that she responded to all applicants. She added she believed she told him, "I don't see why not," or words to that effect. Lester said she assumed Williams would have checked with his supervisor or others before attempting to get a referral from the hospital.

The Office of the Ohio Inspector General learned from those interviewed that Williams made no attempt to hide the fact that he was opening a group home. At one point, he placed flyers around the hospital with the contact information of his group home, Assurance Plus Residential Living Facility. ([Exhibit 4](#))

Carol Hill was interviewed by the Office of the Ohio Inspector General during a telephone call on March 17, 2014. Hill no longer works for the state of Ohio and is now employed by a private mental health agency in northwest Ohio. When questioned, Hill recalled the circumstances surrounding the patient visiting Williams' group home, and said the reason the visit was given approval was mostly due to the close proximity of Williams' group home to the hospital. Hill also said that Williams' group home was on the approved list of homes she received from MHAS. Hill said that prior to the visits, she questioned Williams about receiving referrals from the hospital, but Williams told her he had received permission to accept those referrals. Hill acknowledged this created a potential conflict of interest, but felt the information that Williams owned the group home and the hospital was preparing to, and ultimately sent, a patient to the home was widely known to many of the employees, including members of hospital management.

Hill's belief is supported, to some extent, by an email sent by Williams to Robert Cooley on January 22, 2013. Cooley, a psychologist at NOPH, was and remains a member of the patient's treatment team. In the email, Williams wrote, "Hey, I was just informing you that my group home that [the patient] has been coming to visit has been licensed! and he can now start visiting for overnight stay." Cooley responded, "WOOHOO!!!" Cooley copied his response and the original email from Williams to several other staff members, including Social Work Supervisor Randy Clements, Legal Assurance Administrator (LAA) Kimberly Skinner, and Director of Clinical Services Christopher Harvey. ([Exhibit 5](#))

During a February 11, 2014, interview with the Office of the Ohio Inspector General, Social Work Supervisor Randy Clements acknowledged receiving the above-mentioned email string. Clements said he did have concerns about referring a hospital patient to an employee's group home, but did not discuss the matter with anyone. Clements said his focus, at the time, was supervising the social workers and attempting to resolve conflicts they were having with each

other. Clements recalled conversations with Hill and others about allowing the forensic patient to visit Williams' group home and it was his belief and understanding the reason Williams' home was selected was due to its close proximity to the hospital and the familiarity the patient had with Williams.

During a March 18, 2014, interview with the Office of the Ohio Inspector General, Cooley said that when it was first decided to send the patient to the Assured Plus group home, he did not see a potential conflict of interest. Cooley said that, at the time, he didn't know that the home was owned by Williams and thought it was owned by someone else. Cooley also said that Williams never approached him to get a referral from the hospital. However, after learning in October 2013 that Williams was the primary owner of the group home, Cooley said an apparent conflict of interest did exist and the hospital administration took action to prevent any further referrals from the hospital to Williams' group home.

Violation of Erie County Court Order

As indicated earlier, forensic patients are committed to the care of a state psychiatric hospital through an order from the court of common pleas, or in rare cases, from municipal courts which preside over the case. Movement levels are given to patients in the psychiatric hospitals. Movement levels 3 and above must be granted by the trial court and are based on evaluations and recommendations by the patient's treatment team, and forensic review teams. Hearings are held at a minimum of every two years and often more frequently as the patient progresses through his or her treatment.⁴

Movement level changes occur when a hospital's LAA or other staff member presents the facts and their recommendations to the court.⁵ The patient's attorney advocates for the patient at the hearing. The court will either accept or deny the request for the change, and restrictions or privileges may be granted at the court's discretion. At the conclusion of the hearing, a written order will be issued outlining the court's final decision. A copy of this order is sent to the LAA at the hospital and is then distributed to those involved with the patient's care.

⁴ Ohio Revised Code §2945.38, §2945.39, §2945.40 and §2945.401 deal with issues of Not Guilty by Reason of Insanity and Incompetency to Stand Trial.

⁵ Ohio Mental Health and Addiction Services policy, Legal Assurance Administrator, page 152.

In the case of the forensic patient involved in this investigation, there is a long history of court orders dating back to his commitment date in 1992. Throughout the years, several court orders have been issued changing this patient's movement levels and privileges. In an order dated March 10, 2011, the patient was given permission by the court to travel unsupervised off the grounds of NOPH. ([Exhibit 6](#)) MHAS classifies this as Movement Level 5 which is the least restrictive of the five movement levels.⁶

The following year, on February 10, 2012, the court issued a new order which reaffirmed the previous court order for the patient and added an additional restriction, "... the defendant shall not be permitted to visit group homes and shall follow any conditions as previously set forth by Northwest Ohio Psychiatric Hospital until further Order of this Court." ([Exhibit 7](#))

As a member of the forensic patient's treatment team, Schmitt was asked during her February 10, 2014, interview if she was aware of the Erie County court order that prohibited the forensic patient from visiting group homes. Schmitt said that when she first began performing her duties on Unit 500 in November 2012, she was not aware of the February 2012 order prohibiting the patient from visiting group homes. However, she was aware of an order dated December 20, 2012, that stated, in part; "... the defendant shall not enter a group home at this time."

([Exhibit 8](#)) When asked if she or other members of the treatment team had any concerns about the meaning of the December 2012 order, she replied they did, but chose to interpret that order themselves rather than consult with NOPH's Legal Assurance Administrator Skinner. Schmitt said that normally, treatment team members would have consulted with Skinner if they had any questions about a court order, but did not do so in this instance.

It was during a treatment team meeting in October 2013 that Schmitt said she first became aware of the February 2012 order that prohibited the patient from even visiting group homes. Schmitt said she and the other members of the treatment team were told of this order by Skinner, and after it was revealed, the patient's visits to group homes was immediately stopped.

⁶ Ohio Mental Health and Addiction Services policy (ODMH) MF-04, Movement of Patients Committed Under a Forensic Status – page 75 of the 2012 Ohio Forensic Manual.

During the telephone interview on March 17, 2014, Carol Hill was also asked about her knowledge of the February 2012 court order. Hill said that at the time she was a member of the patient's treatment team, she was not aware of the existence of the order. Hill did become aware of the order in 2013, well after she turned over her duties on Unit 500 to Schmitt. Hill said she knew that when the existence of this order became known, the patient's visits to Williams' group home stopped.

Cooley was also asked about the court order during the March 18, 2014, interview at NOPH. Cooley said he too was unaware of the February 2012 court order at the time the decision was made to send the patient out to Williams' group home for visits. Cooley said if he had known of the order at that time, the patient would not have been allowed to visit the group home. According to Cooley, he was first made aware of this order in October 2013, during a treatment team meeting. At that time, he said the patient's visits to Williams' group home were immediately stopped. He acknowledged that violations of the court order would have occurred anytime the patient was sent to visit Williams' group home or any other group home.

On March 18, 2014, hospital Legal Assurance Administrator Skinner was interviewed by the Office of the Ohio Inspector General about the violation of the Erie County court order. Skinner said early in the interview that one of her responsibilities as the LAA was to distribute copies of court orders to the patient's treatment team members. Skinner told the investigator she had distributed a copy of the February 2012 Erie County court order to the treatment team members at that time, prohibiting the forensic patient at the center of this investigation from visiting group homes. Skinner provided a scanned copy of the email and the attached court order sent on February 14, 2012, by her assistant, Beth Downey, to Robert Cooley, Carol Hill, and Unit 500 psychiatrist Habeeb Arar. ([Exhibit 9](#))

Skinner said she first learned of the possible violations in an October 2013 treatment team meeting she attended concerning the forensic patient visiting Williams' group home. Skinner learned during this meeting that the patient had visited the group home on several occasions in the past and said she immediately advised the members of the treatment team that the patient was prohibited from visiting group homes. Skinner said the team members were initially confused as

to why the patient was not allowed to visit the home. Later, Skinner reported her concerns to Chief Clinical Officer Thomas Osinowo, hospital Chief Executive Officer Mychail Scheramic and the Erie County Court of Common Pleas. After this, the forensic patient's visits to Williams' or any other group home immediately stopped. The administration also implemented new safeguards requiring a staff member or the legal assurance administrator to be present in treatment team meetings to prevent any future potential court order violations.

CONCLUSION

The original complaint identified a potential conflict of interest and ethics violation by Deavonte Williams. During the investigation, the Office of the Ohio Inspector General learned a conflict of interest was evident in Williams' actions and, also, in the actions of other hospital employees. Several NOPH employees had concerns regarding the apparent conflict of interest; however, these employees took no action and failed to report the potential violation to their superiors. Other employees simply failed to identify the situation as a potential conflict of interest. Emails copied to supervisors and senior members of NOPH's administration should have raised concerns about a potential conflict of interest violation but were overlooked by the recipients.

The decision by the hospital for the forensic patient to be allowed to visit Williams' group home as a referral was made by several staff members other than Williams. Had staff members recognized the potential conflict of interest, these visits would probably not have occurred.

For his part, Williams consulted with and took guidance from Rose Lester, who he believed to be the expert on group homes. Lester stated that she believed Williams would follow policy and check with his supervisor prior to taking any action; however, Williams did not.

Accordingly, the Office of the Ohio Inspector General finds reasonable cause to believe that wrongful acts or omissions occurred in this instance.

During this investigation, the Office of the Ohio Inspector General was made aware of a potential violation of an Erie County Court of Common Pleas order involving the same NOPH patient at the center of the conflict of interest allegation. LAA Kimberly Skinner alleged that the

patient was sent out to visit Williams' group home on 19 occasions in violation of a February 10, 2012, court order. The court order made it irrelevant which group home the patient visited since the order stated that the patient was not to visit group homes.

Investigators interviewed members of the treatment team who said that they were not aware of the order. LAA Skinner stated to investigators that a copy of the order was sent to the treatment team members and provided a scanned copy of the email and attached order that was sent to them. Investigators could not determine whether the treatment team received, opened, or read the copy of the order that was sent. The only member of the treatment team that remains from the time the email was sent is psychologist Robert Cooley and the email was not found in his state email mailbox; this was most likely due to the amount of time that has elapsed since the email was sent to the treatment team.

When the court order violation was identified, NOPH administration advised the court and instituted several safeguards to prevent occurrences from happening in the future. In particular, NOPH instituted the policies of requiring either a member from administration or the LAA to attend treatment team meetings, and having all Level 5 off-grounds visits by forensic patients reviewed and authorized by the LAA.

Although NOPH has taken action to prevent future violations of court orders, it remains that in this instance, the Erie County court order was violated on numerous occasions.

Accordingly, the Office of the Ohio Inspector General finds reasonable cause to believe that wrongful acts or omissions occurred in this instance.

RECOMMENDATION(S)

The Office of the Ohio Inspector General makes the following recommendations and asks the director of the Ohio Department of Mental Health and Addiction Services to respond within 60 days with a plan detailing how these recommendations will be implemented. The Ohio Department of Mental Health and Addiction Services should:

1. Implement the revised statewide policy on secondary employment. Requests for secondary employment should be vetted through MHAS administration and approved before the employee engages in the secondary employment.
2. Ensure that court orders are not violated by having a member of each hospital's respective administration sit in on treatment team meetings as an observer. This should also assist in preventing any future conflict of interest issues.
3. Provide additional ethics training to all employees, highlighting potential conflict of interest issues. All employees should be instructed that it is their responsibility to immediately report potential ethics issues to their supervisors.

REFERRAL(S)

The Office of the Ohio Inspector General has determined that no referrals are warranted for this report of investigation.

[\(Click here for Exhibits 1 – 9 combined\)](#)



STATE OF OHIO
OFFICE OF THE INSPECTOR GENERAL

RANDALL J. MEYER, INSPECTOR GENERAL

NAME OF REPORT: Ohio Department of Mental Health and Addiction Services

FILE ID #: 2013-CA00093

KEEPER OF RECORDS CERTIFICATION

This is a true and correct copy of the report which is required to be prepared by the Office of the Ohio Inspector General pursuant to Section 121.42 of the Ohio Revised Code.

Jill Jones
KEEPER OF RECORDS

CERTIFIED
December 15, 2014

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