



Disability Law Center

Massachusetts Protection and Advocacy

Public Report: Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served



Exterior barbed wire fence and exterior sign of Bridgewater State Hospital.

A report to the President of the Senate, Speaker of the House of Representatives, Chairs of the Joint Committee on Mental Health Substance Use and Recovery, Joint Committee on the Judiciary, Senate Ways and Means Committee, and House Ways and Means Committee, submitted pursuant to the FY 2023 Budget (Line Item #8900-0001).

January 2023

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Introduction and Overview

This report covers the Disability Law Center's (DLC) monitoring of Bridgewater State Hospital (BSH), including the Bridgewater Units at Old Colony Correctional Center (OCCC Units), known as the Intensive Stabilization and Observation Unit (ISOU) and the Residential Unit (RU), pursuant to authority granted by Line Item #8900-0001,¹ for the period from June 2022 through December 2022. DLC is the federally designated Protection and Advocacy agency for persons with disabilities in Massachusetts. DLC's intensive ongoing monitoring of BSH would not be possible without the support and expanded authority granted by Line Item #8900-0001.

During this reporting period, DLC conducted monitoring of Wellpath LLC's (Wellpath) delivery of services at BSH, incorporating assessment of continuity of care for Person Served (PS) upon discharge, through a variety of activities, including:

- Weekly onsite BSH visits;
- Onsite visits to the Intensive Stabilization and Observation Unit and the Residential Unit at Old Colony Correctional Center to meet with facility staff and current and discharged PS;
- BSH PS video, phone, and in person meetings;
- BSH staff in-person meetings;
- BSH PS Governance Meetings;
- Participation in BSH Governing Body meetings and Department of Mental Health quarterly meetings;
- Attendance at BSH New Employee Orientation Mandt training and BSH Mandt Recertification Training;
- Requests for data and documentation to Wellpath and DOC;
- Review of Wellpath 24 Hour Nursing Reports;
- Review of DOC video footage of PS restraint and seclusion;
- Review of DOC Incident Reports;
- Review and analysis of BSH restraint and seclusion data;
- Review of limited BSH restraint and seclusion orders and documentation;
- Review of multiple PS medical records;

¹ FY23 Budget Line Item #8900-0001: "[P]rovided further, that not less than \$125,000 shall be expended for the Disability Law Center, Inc. to monitor the efficacy of service delivery reforms at Bridgewater state hospital, including units at the Old Colony correctional center and the treatment center; provided further, that the Disability Law Center, Inc. may investigate the physical environment of those facilities, including infrastructure issues, and may use methods including, but not limited to, testing and sampling the physical and environmental conditions, whether or not they are utilized by patients or inmates; provided further, that the Disability Law Center, Inc. may monitor the continuity of care for Bridgewater state hospital persons served who are discharged to county correctional facilities or department of mental health facilities, including assessment of the efficacy of admission, discharge and transfer planning procedures and coordination between the department of correction, Wellpath LLC, the department of mental health and county correctional facilities; provided further, that not less than once every 6 months, the Disability Law Center, Inc. shall report on the impact of these reforms on those served at Bridgewater state hospital to the joint committee on mental health, substance use and recovery, the joint committee on the judiciary, the house and senate committees on ways and means, the senate president and the speaker of the house of representatives."

- Review and analysis of PS discharge data;
- Onsite visits to Lemuel Shattuck Hospital, Solomon Carter Fuller Mental Health Center, Worcester Recovery Center and Hospital, Taunton State Hospital, and Vibra Hospital to meet with facility staff and discharged PS;
- Onsite visit to Middlesex County Jail & House of Corrections to tour facility, meet facility staff, and meet with discharged PS;
- Virtual meeting with Suffolk County Sheriff's Department administration;
- Phone interviews with discharged PS in DMH hospitals, county correctional facilities, and the community;
- Regular meetings with fellow mental health advocates about BSH; and
- Meetings and correspondence with BSH friends and family group.

In addition to the monitoring activities listed above, DLC has initiated four (4) new investigations pursuant to our federal Protection and Advocacy authority after making a probable cause finding that PS had been or were being subjected to abuse and/or neglect at BSH. Three (3) are investigations into complaints of violent attacks on PS – two (2) within BSH and one (1) on an individual awaiting evaluation in the ISOU. The fourth is an investigation into BSH policies and practices concerning the application of restraint, seclusion, and involuntary medication initiated for reasons described below.

The poor conditions and quality of care at BSH are not improving. At the same time, DOC and its contractor Wellpath refuse to acknowledge that BSH policies and practices concerning the administration of involuntary medication on PS plainly violate Massachusetts law. After well over eight (8) years of continuous oversight at BSH, DLC again urgently calls on the Commonwealth to protect the people with complex mental health needs who are forced to submit to evaluation and treatment at BSH by transferring oversight of this population to the Department of Mental Health and building a new hospital.

In the discussion below, DLC focuses on six (6) broad areas of concern during the period from January 2022 to June 2022:

1. Key Updates Since DLC's Law Report: Responses, Changes in DLC Access, and Oversight Hearings
2. Continuing Physical Plant Health and Safety Risks;
3. Illegal and Unreported Restraint and Seclusion;
4. De-Escalation Practices, Training, and Culture
5. Insufficient Language Access for Persons Served;
6. Persons Served Access to Treatment for Co-Occurring Substance Use Disorder;
7. Use of Atypical Medication on Persons Served;
8. Limitations on Persons Served Access to Medical Care;
9. Persons Served Continuity of Care; and
10. Other Important Issues DLC Is Following.

Each section includes DLC's recommendations to improve the safety and treatment of PS. The complete recommendations are compiled at the Conclusion of the report.

1. Key Updates Since DLC's Last Report: Responses, Changes in DLC Access, and Oversight Hearings

DLC's July 2022 report made several key findings concerning BSH, including that: the aging physical plant continues to pose unacceptable health and safety risks to PS and staff; DOC and Wellpath are imposing emergency medication, restraint, and seclusion in violation of the rights of PS and with insufficient oversight; DOC and Wellpath fail to adequately document and provide oversight of staff uses of force on PS; PS experience limitations on and barriers to accessing medical care; and BSH fails to accommodate language access needs of PS with limited English proficiency (LEP).²

On August 11, 2022, DLC and DOC held a virtual meeting for DLC's new Executive Director to meet DOC Commissioner Carol Mici and other DOC administrators. DOC indicated that a response to DLC's report would be forthcoming and that DOC wished to foster a productive and transparent relationship with DLC, with Commissioner Mici expressing a commitment to providing additional information and documentation as needed to aid in DLC's continuing efforts BSH and OCCC units.

DOC then provided a formal written response to DLC's report on August 31, 2022, **attached hereto as Appendix B.**³ In the letter, DOC reported that it was remedying physical plant issues by adopting new cleaning protocols and contracting with companies to remove asbestos, conduct air quality and surface testing for fungal growth, replace steam and condensation lines, and industrially clean the entire facility. As for patient treatment, DOC reiterated its disagreement with DLC's position that BSH Emergency Treatment Orders (ETO) are administered as unlawful chemical restraint, but reported that, with Wellpath, DOC was increasing its oversight of ETOs and uses of seclusion and restraint, subjecting all episodes to similar frequency of review and data requirements, and increasing reporting requirements for assessment and de-escalation completed before initiating restraint or seclusion. DOC also conceded that DLC's video reviews had described ETO administration under impermissible circumstances. As a result, DOC pledged to review the videos and direct Wellpath to take appropriate corrective action and to include auditing of video footage in its oversight practices. While disputing that adequate language access was under its control, DOC agreed that more multilingual staff should be hired, and that it would investigate DLC's reports of lack of multilingual signage and the need for staff training and education. Finally, DOC indicated that it would work to improve continuity of care at BSH from county correctional facilities, and was committed to working collaboratively with DLC to address all areas of concern in a timely manner to ensure that BSH patients receive quality care.

DLC hoped that these positive developments signaled a productive start to DOC addressing the serious problems with the physical plant and patient care at BSH. Unfortunately, as discussed below, DLC has instead found that DOC's efforts to date have not led to meaningful improvements and, far from collaborating with DLC, DOC

² DLC, *Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served* (July 2022), <https://www.dlc-ma.org/wp-content/uploads/2022/07/DLC-BSH-Report-July-2022-Final.pdf> (hereinafter "DLC July 2022 Report").

³ DOC *Response to July 2022 DLC BSH Report* (August 31, 2022) (hereinafter "App. B").

has sought to impose new restrictions on DLC's access to documents and information critical to our monitoring.

On September 2, 2022, DLC emailed DOC a correspondence containing requests for documents and information, including requests for further details regarding DOC's disclosures in its August 31 letter, recurring production of restraint and seclusion orders without the need for monthly requests, and another production of PS race/ethnicity, primary language, and LEP information.⁴ For the first time, DLC received only redacted information concerning uses of restraint and seclusion; DOC denied DLC access to identifying information for the PS and the formal restraint and seclusion forms going forward. DOC also removed identifiers from the table containing PS race/ethnicity and primary language information it produced. In addition, DOC narrowly construed DLC's requests to provide only limited information concerning the handling of emergencies during power outages, its reviews of video footage, American Correctional Association evaluations, and Joint Commission accreditation. DLC was forced to follow up in writing to restate its requests and seek a supplementary production.⁵ While DOC did provide a further information with respect to some requests, it remained resolute in its decision to abruptly deny DLC access to complete restraint and seclusion forms and necessary identifying information relating to PS race/ethnicity, PS languages spoken, and restraint and seclusion orders, citing constraints on DLC's access under its federal monitoring authority.⁶ It is, of course, no mystery that the restraint and seclusion forms and interviews with PS identified through information now being denied have featured heavily in DLC's recent reports and would impede our monitoring efforts.

Additionally, DOC and/or Wellpath cancelled and rescheduled the BSH Governing Body quarterly meeting in September 2022 without notifying DLC. As a result, DLC did not attend a BSH Governing Body meeting for the first time in over eight (8) years. DLC did attend the December 2022 meeting during this reporting period.

In response to such alarming obstruction to DLC's monitoring efforts, DLC expanded our oversight through finding probable cause to open a Protection and Advocacy investigation into past and continuing systemic abuse and neglect of BSH PS arising out of BSH policies and practices concerning the application of restraint, seclusion, and involuntary medication. DLC has also had to increase our staff involved in monitoring and investigations of BSH to 2017 pre-DOC/vendor transition staffing levels.

In correspondence dated November 17, 2022, the Chairs of the Joint Committee on the Judiciary notified Executive Office of Public Safety and Security (EOPSS) Secretary Terrance Reidy that the Committee would be holding formal oversight hearings of the Department of Correction. The correspondence included requests for information covering five broad topics; BSH was one of those topics, with the Committee making explicit mention of DLC's BSH work. On December 21, 2022, DLC was honored to provide testimony summarizing our major concerns about BSH at the request of the

⁴ *DLC Request for Information to DOC* (September 2, 2022).

⁵ *DLC Request for Supplemental Production to DOC* (November 18, 2022).

⁶ *DOC Response Re: DLC Request for Supplemental Production* (December 15, 2022).

Committee. Notably absent, however, throughout the oversight hearings were representatives from EOPSS, DOC, and Wellpath.

During this reporting period, DLC also received a letter from an anonymous group of long-time BSH direct care employees expressing their overwhelming concerns about the operation of the facility but too afraid of retaliation by the administration to publicly come forward. In their letter BSH staff raised the lack of safety for both PS and staff; the need for more support, supervision, and education from supervisors; lack of appropriate consideration for COVID-19 mitigation measures, including by members of the administration; and an overall disrespect and unresponsiveness to their concerns from Wellpath and DOC. The issues outlined in this anonymous letter echoed issues BSH staff raised directly with DLC during onsite monitoring visits.

2. Continuing Physical Plant Health and Safety Risks

Since May 2018, DLC has been highlighting physical plant and infrastructure issues at BSH that warrant closure of the facility.⁷ One year ago, in DLC's January 2022 report, we detailed that economic inefficiency and continuing risks to health and safety remain constants in the operation of BSH based on an expert assessment, lab testing, and results analysis conducted by Gordon Mycology.⁸

A. Mold and Asbestos

During this reporting period, DOC has provided detailed information about mold remediation and asbestos abatement efforts at BSH in response to DLC's January 2022 confirming the presence of mold throughout BSH, including HVAC system components, as well as need for potential asbestos abatement. An overview of the information DLC has received concerning those efforts is as follows:⁹

- DOC hired Arcadis U.S., Inc. to inspect the mechanical rooms that DLC identified and retained Select Demo Services, LLC to perform asbestos abatement and mold remediation.
 - *Mechanical Room Asbestos Abatement.* Select Demo Services (Cost: \$78,650.00) performed asbestos abatement in mechanical rooms with Arcadis (Cost: \$9,450.00) monitoring the removal.

⁷ All DLC's past public reports concerning investigation and monitoring activities at BSH are available at: <https://www.dlc-ma.org/monitoring-investigations-reports/>.

⁸ *Public Report: Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served* (January 2022), <https://www.dlc-ma.org/wp-content/uploads/2022/02/DLC-BSH-January-2022-Public-Report-2.9.2022.pdf> (hereinafter "DLC January 2022 Report").

⁹ This information comes from the following documents: App. B; *EOPSS Response to Joint Committee on the Judiciary Chairs* (December 12, 2022) (hereinafter "EOPPS Response to Judiciary"); Arcadis U.S., Inc., *Asbestos & Mold Remediation Oversight Report: Bridgewater State Hospital* (April 21, 2022); Select Demo Services LLC., *Bridgewater State Hospital – Quarterly Cleaning Proposal* (July 11, 2022).

- Administration Building: removed approximately twenty (20) asbestos-containing pipe fittings and repaired approximately fifteen (15) asbestos-containing pipe fittings.
- Medical Building (Lighthouse): removed approximately thirty (30) asbestos-containing pipe fittings and repaired approximately fifteen (15) asbestos-containing pipe fittings.
- *Mechanical Room Mold Remediation.* Select Demo Services conducted mold remediation services in select mechanical rooms, based on a scope of work developed jointly with DOC and Arcadis U.S., “to clean and disinfect mechanical areas with water staining, mold growth, biomatter accumulation, and efflorescence.”
 - Administration Building: repaired fiberglass pipe insulation; HEPA-vacuumed all surfaces of existing debris; wet wipe all surfaces (floor, ceiling, and mechanical systems) with simple green cleaning agent; mop floors with simple green cleaning agent and spray all areas with an approved biocide using an electrostatic spray.
 - Medical Building (Lighthouse): repair fiberglass pipe insulation; remove approximately 20 LF of fiberglass pipe insulation; HEPA-vacuum all surfaces of debris; remove all loose and flaking paint from HVAC system duct; dispose of wood cabinet; wet wipe ceiling deck with approved biocide to remove existing mold staining; wet wipe all surfaces with simple green cleaning agent.
 - Housing Units A, B, and C: remove approximately 30LF of fiberglass pipe insulation in each unit mechanical room; HEPA-vacuum all of debris; wet wipe ceiling deck with approved biocide to remove existing mold staining; wet wipe all surfaces with simple green cleaning agent.
- DOC contracted with Lighthouse to conduct biological air and surface testing for fungal growth and air quality throughout the facility using a recordable Flair unit. Based on the results, DOC adopted new cleaning methods and products, including “proper daily surface contamination cleaning methods and HVAC preventative maintenance protocols.”
- DOC contracted with Select Demo Services to perform a quarterly facility cleaning program (Cost for one (1) year: \$134,600.00).
 - The scope of work for all buildings generally includes: inspecting and remediating visible mold in each PS and staff common area, including bathroom and shower areas; inspecting and remediating visible mold in plumbing chases; cleaning ceiling and overhead vents that are *not secured*/tamper resistant; clearing and remediating visible mold in basement mechanical rooms, requiring shutdown of the mechanical systems during the work.
 - However, for both the Administration Building and the Medical Building (Lighthouse), this cleaning work is limited to the basements. This distinction is cause for concern, given that staff, PS, and visitors frequent

other areas of the Administration Building and staff work and PS live and receive medical services in Lighthouse.

- DOC purchased approximately 44 Beyond Guardian Air Purifiers with UVS light and HEPA filtration units for patient housing common areas, staff critical areas, mechanical rooms, and other areas of the facility.
- In addition, work is underway to replace the complex underground and steam condensate lines at BSH, as part of a Division of Capital Assessment Management and Maintenance contract. (Cost: \$2,496,000.00). This replacement will reduce the amount of steam or condensate leakage occurring in the BSH mechanical rooms.

Hoping to confirm that DOC's costly efforts over the course of 2022 successfully improved conditions that have been placing PS and staff health at risk for years, DLC returned to BSH with Gordon Mycology on December 5, 2022 to conduct a visual inspection and gather surface swab samples for the third time. As in the past, this inspection was possible due to DLC's expanded authority granted in Line Item #8900-0001. Gordon Mycology's detailed January 11, 2023 Mold Inspection Report and accompanying laboratory results are **attached hereto as Appendix C**.

As detailed in the two previous visits, firsthand observations by Gordon Mycology and laboratory results from the swabs taken confirmed the presence of mold growth throughout the areas inspected at BSH.¹⁰ After three yearly inspections in four years – there was no 2020 inspection due to COVID-19 – Gordon Mycology's conclusions were as follows:

Many of the sources of mold growth identified during the 2019 and 2021 inspections of the Bridgewater State Hospital buildings and HVAC systems were confirmed to still be present (visually and with laboratory data) during the current 2022 inspection. This indicates that the necessary mold remediation, cleaning, and maintenance actions have not been performed (or kept up with as regularly as they need to be). HVAC systems observed during the inspection continued to be in deplorable condition, some with air handlers in wet and flooded basements with rampant mold growth. The black dust/debris inside HVAC system air handlers and supply diffusers remained, seemingly untouched, along with unacceptable levels of mold growth; the air coming through these systems is what persons served and building staff members must breathe on a daily basis. Even one section of an HVAC system that had been professionally cleaned was confirmed to be filthy and riddled with active mold growth.

Significant and long-term basement water problems have been and were still occurring at the time of this inspection. The leaks have gone, for the most part, unnoticed and/or were ignored based on the amount of rust,

¹⁰ App. C at 2-8, 9-10, 14.

water damage, corroded pipes, and widespread mold growth[]. HVAC system air handlers in wet basements and systems with major problems (absence of filters, unfiltered and unconditioned outdoor air coming directly into the systems, absence of regular maintenance and specialized cleaning, etc.) have resulted in significant mold growth within the systems that provide air to people living and working in the buildings. There has been neglect of critical building systems. Mold remediation performed by an unqualified company who did not follow industry standards and procedures was proven to be inadequate, unsuccessful, deficient. Arcadis [U.S.] wrongly cleared remediated basements that still have pervasive and obvious visible mold growth on remediated surfaces. There also are remaining questions regarding the completeness of the asbestos abatement performed by Select [Demo Services] prior their mold remediation work; there appeared to be potentially asbestos-containing materials in the basements that should be investigated by an independent (not Arcadis [U.S.]) asbestos inspector.

Overall, this inspection suggests that inappropriate and harmful actions pertaining to the control and remediation of mold growth in the buildings of Bridgewater State Hospital continue and many of the 2019 and 2021 recommendations were largely ignored. These inactions have caused the mold problems to become worse in certain areas observed and potentially more harmful to those who work and live in the facility.¹¹

The laboratory results identified a variety of mold types, including *Alternaria*, *Aspergillus flavus*, *Aspergillus niger*, *Aspergillus ochraceus*, *Aspergillus sydowii*, *Aspergillus versicolor*, *Chaetomium*, *Cladosporium*, *Curvularia*, *Epicoccum*, *Memnoniella*, *Penicillium*, *Phoma*, and *Trichoderma*.¹² *Aspergillus*, confirmed to be present on most of the tested surfaces in the buildings inclusive of HVAC systems, “can cause chronic lung and sinus infections, produces mycotoxins, and is a common allergenic mold.”¹³ Chronic exposure to *Aspergillus* molds and others present at BSH “can cause a myriad of health problems, many of which may not initially be attributed to mold” like “colds that take longer to clear, chronic sinus infections, persistent coughing, itchy and runny eyes, sore throats, exhaustion, lethargy, mental foggiess, etc.”¹⁴ People with underlying medical conditions, particularly those who are immunocompromised or have respiratory conditions, are at an elevated risk of developing breathing issues and other complications from chronic mold exposure.¹⁵

In discussing the mold remediation completed by DOC’s contractor, Gordon Mycology noted that, according to the report prepared by Arcadis U.S., it failed to cite “the most accepted and widely used document in the mold remediation industry, the IICRC/ANSI

¹¹ *Id.* at 14-15.

¹² *Id.* at 9.

¹³ *Id.* at 10.

¹⁴ *Id.* at 9.

¹⁵ See *Id.* at 9; Centers for Disease Control and Prevention, *Basic Facts About Mold and Dampness*, <https://www.cdc.gov/mold/faqs.htm>.

Document S520: Standard and Reference Guide for Professional Mold Remediation (2015)” as informing development of its remediation protocol.¹⁶ Moreover, the remediation protocol “lack[ed] important steps for fully removing the mold contamination sources,” and inappropriately cleared the remediation project “with only a visual inspection and airborne mold samples.”¹⁷ Gordon Mycology also explained why DOC’s reliance on airborne samples was misguided:

Collecting only airborne mold samples is not an effective or correct method for clearing a space that has been remediated for mold; airborne mold samples have a high risk for false negatives as well as the inability to provide information about remediated surfaces. Air sampling cannot detect whether remediated surfaces still contain mold growth or high levels of settled mold spores, visible or not, and is therefore only one aspect of a clearance mold inspection.¹⁸

For the first time, Gordon Mycology also sent a sample of the black dust swabbed from a housing unit HVAC system supply air diffuser to Aerobiology Laboratory Associates, Inc. to conduct a particulate analysis of the black dust.¹⁹ “The black dust was already confirmed to contain abnormally elevated levels of mold spores but the dust was full of larger particles/fibers.”²⁰ The laboratory results revealed that the sample contained 2% fiberglass and 98% unspecified non-fibrous minerals; fortunately, the sample contained no percentage of asbestos.²¹ Based upon these results, Gordon Mycology recommends further analysis to identify the full composition of the particulates that PS and staff could be inhaling.²²

Faced again with evidence that PS and staff at BSH are being put at risk of illness from exposure to environmental toxins, despite DOC’s costly efforts, DLC implores the Commonwealth to take action to protect them. DLC calls upon the Commonwealth to shutter the aged prison facility and construct a hospital that meets both the health and mental health needs of the individuals forced to stay there.

B. Facility Sanitation

PS and staff have reported rodent infestations on the housing units, including a PS who reported a mouse in his cell. In November 2022, Recovery Place was so infested with rodents that it was completely shut down. A vendor began extermination of the rodents and decontamination of the building, which included removal of carpet in all three group rooms, sealing of wood flooring located in groups rooms, cleaning of ceiling, replacement of insulation, and replacement of the spiral ducts associated with the

¹⁶ App. C at 2.

¹⁷ *Id.* at 2.

¹⁸ *Id.* at 2. For the December 2022 inspection, Gordon Mycology explained that airborne mold samples were not warranted. “There was visible mold growth in many of the inspected areas, water/dampness in the basements, and a mold odor in the basements, all of which are confirmation of mold growth sources and, therefore, airborne mold spores and mVOC’s (microbial volatile organic compounds).” *Id.* at 1.

¹⁹ *Id.* at 2.

²⁰ *Id.* at 10.

²¹ *Id.* at 10.

²² *Id.* at 10.

bathroom exhaust fans.²³ The total project cost \$157,300.²⁴ The temporary closure of Recovery Place caused an interruption in programming, with some of it being made available to PS in the Attucks building.

PS have complained of fly, ant, and other insect problems in the housing units, often stemming from staff delays in removing trash that is attracting pests.

Despite the regular rotation of cleaning staff, DLC has observed common rooms littered with trash, food, and dirt, with carpet squares pulled off the floor exposing concrete flooring underneath. DLC observed one PS cell (with the PS inside) with a hastily rolled-up blanket under the outside of the door stained with what appeared to be feces. On another occasion, a pile of soiled clothing was bunched up on the floor next to the shower room (which contains a unit laundry bin), left by a PS who was unable to gain access to the room. According to this PS it had been there for hours, ignored by staff, creating both a tripping hazard and a sanitation issue. Another PS complained of a seclusion room mattress that had been left soiled for days after he had been held in 4-point restraints; while on the unit, DLC viewed the mattress, which appeared to be covered in dried feces. Wellpath reported in December 2022 that they offered a position to an infection prevention registered nurse. DLC supports the staffing of this position and urges Wellpath to immediately address sanitation issues to help prevent exposure to further infections.

C. Power Outages

Between August 11, 2022 and September 8, 2022, BSH had six (6) power outages lasting five (5) to six and one-half (6.5) hours. Each were due to what DOC described as a scheduled replacement of a transformer on campus.

According to staff interviewed by DLC, the first outage on August 11 from 4:53pm to 10:07pm was especially poorly managed, with little guidance for staff. PS were locked in their cells for half the day with no programming or movement whatsoever, as staff tried to devise ways to let them out safely. The frantic response and lack of preparation was not limited to direct care unit staff – one BSH administrator described rushing out to a local hardware store to purchase as many headlamps as possible for staff. If the outage was planned as DOC indicated, it appears that either communication concerning the event, or at least the length of the outage, between DOC and Wellpath may have been suboptimal or Wellpath was not able to execute an appropriate plan in a timely manner.

Over the next three weeks, the power went out during repairs to the transformer five additional times. Each time the lights went out across the BSH campus, the electronic medical record system went from digital to paper, and security cameras went dark. Thus, power outages also mean that there is no video footage available of incidents that take place during those periods.

The BSH Loss of Utilities Plan Policy contains detailed directions for staff on safety procedures and responsibilities at various levels of the chain of command, but there is

²³ BSH Governing Body Meeting Superintendent's Dashboard (December 2022).

²⁴ EOPPS Response to Judiciary Chairs at 13.

notably no mention of programming or movement for PS – only that PS should be secluded and remain secluded in their cells:

5.1.4 In the event the emergency is a loss of power the Shift Supervisor shall: ... Commence controlled Person Served movement back to the units in preparation for a major count...

5.2.2 In the event power has not been restored the Shift Supervisor shall[:] Ensure all Persons Served remain in their rooms until issue is resolved or at the direction of the Hospital Administrator....²⁵

The policy's failure to account for therapeutic aspects of facility operations during a loss of power is a reflection of Wellpath's challenges with effectively and simultaneously maintaining safe operation of BSH and respect for PS rights.

D. Heat Mitigation

During multiple heatwaves last summer, BSH PS experienced extremely hot temperatures with no air conditioning.²⁶ The “conditioned air” provided by BSH is forced through vents on the unit, lowered temperature or air flow barely perceptible when a hand is placed in front them. While “conditioned air” seemed to be more effective on the single-story Hadley and Lenox units, the three two-story units (Adams, Bradford and Carter) dealt with conditions described by staff as “brutal.” In an interview with DLC, one PS on these units said that being in his cell was “like an oven,” his sheets so wet with sweat that he could not sleep.

As dictated by Wellpath's BSH Heat Mitigation Plan, response measures included provision of popsicles (“available at various times per day to all individuals”), extra fluids with ice (“a Gatorade like drink”), and fans on each unit.²⁷ However, several PS whom DLC interviewed reported not receiving popsicles consistently, with one PS having been offered a popsicle to help cool down only once during a particularly hot week. Rather than “fans,” DLC observed a single large fan placed in each unit's dayroom or hallway, with three (3) to (4) PS huddled around the fan at the same time, leaving the others to sweat elsewhere on the unit or in their cramped cells barely cooled by “conditioned air.”

The impact of BSH's failed heat mitigation efforts are not simply discomfort among PS. Because psychotropic medications may impair the body's ability to regulate its own temperature, extreme heat of PS taking antipsychotics are at heightened risk of hyperthermia, which can be fatal. PS who are older and/or have co-occurring medical conditions, such as heart disease, are also at risk. Moreover, “[e]xtreme heat has been

²⁵ Bridgewater State Hospital Policy and Procedure Manual – Loss of Utilities Plan, 5.1.4, 5.2.2 (April 21, 2023).

²⁶ According to historical weather data available on AccuWeather.com, Bridgewater, Massachusetts experienced: in June 2022, temperatures ranged from 80 to 90 degrees on 11 days and 1 day the high reached 92 degrees; in July 2022, temperatures ranged from 80 to 90 degrees on 22 days and were above 90 degrees on 8 days; in August 2022, temperatures ranged from 80 to 90 degrees on 15 days and were above 90 degrees on 9 days.

²⁷ BSH, *Heat Mitigation Plan* (undated).

associated with a range of mental health impacts in research over many years, including increases in irritability and symptoms of depression and with an increase in suicide” and “[s]leep difficulties associated with extreme heat can contribute to and further exacerbate mental health symptoms.”²⁸

Recommendations:

Without further delay, DOC must completely remediate mold and complete asbestos abatement throughout BSH in accordance with expert recommendations and industry standards.

Until DOC provides information evidencing that the health and safety risks have been resolved, DOC and Wellpath BSH must provide regular health screenings for symptoms of mold and environmental toxin exposure to all PS and staff, provided by a contracted health professional with expertise in the area.

DLC recommends that DOC and Wellpath improve sanitation practices in all areas of BSH to prevent rodent and insect infestations.

DOC must devise more effective heat mitigation protocols to ensure that PS are more comfortable and do not suffer serious health complications or death in high temperatures.

DLC recommends that the Commonwealth protect the health of individuals confined to, working in, and visiting BSH by committing to shutter BSH and construct a modern facility designed to provide all individuals in need of “strict security” psychiatric evaluation and/or treatment in a safe, therapeutic environment.

The Commonwealth must immediately place BSH operations as well as the planning, construction, and oversight of the new facility under the authority of DMH to ensure current and future PS access to trauma-informed, person-centered mental health treatment.

²⁸ American Psychiatric Association, *Extreme Heat Contributes to Worsening Mental Health, Especially Among Vulnerable Populations* (June 30, 2021), <https://www.psychiatry.org/newsroom/news-releases/extreme-heat-contributes-to-worsening-mental-health-especially-among-vulnerable-populations>.

3. Illegal and Unreported Restraint and Seclusion

Throughout this reporting period, DOC and Wellpath again employed policies and practices that subject PS to all forms of restraint and seclusion in unsanctioned circumstances and sans required documentation. During this reporting period, DLC continued to gather information through review of daily nursing reports, the limited restraint and seclusion orders DOC provided (June 16, 2022 through August 25, 2022),²⁹ clinical records, and video footage of approximately fifteen (15) incidents as well as firsthand observations, countless discussions with PS, and conversations with staff. Despite DOC's decision to restrict DLC's access to that documentation and PS names, the information DLC did access makes plain that systemic failures to comply with Massachusetts law persist, creating a nightmare for PS.

Well-settled law strictly limits the use of restraint and seclusion. Massachusetts General Laws Chapter 123, §21 dictates that restraint and seclusion of a person with mental illness in DMH facilities and BSH "may only be used in cases of emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide," with explicit requirements regarding examinations and who may provide written authorizations for the restraint. All uses of restraint and seclusion must be tracked in individual medical records and recorded in restraint forms that are submitted to the DOC Commissioner to review and sign within thirty (30) days.³⁰ A legitimate order for chemical restraint further requires a finding by the ordering provider "that such chemical restraint is the least restrictive, most appropriate alternative available."³¹

Indeed, in recognition of the extraordinarily intrusiveness of forced medication³² and the fact that "doctors who are attempting to treat as well as maintain order in the hospital have interests in conflict with those of their patients who may wish to avoid medication,"³³ state law limits the administration of involuntary antipsychotic medication to three circumstances:

- (1) After a court has made a substituted judgement decision that the individual would accept the medication if competent and approved a treatment plan, establishing what is known as a *Rogers* guardianship;³⁴
- (2) Under the state's police power to prevent an *imminent threat of harm* to oneself or others when there is a clinical determination that there is *no less intrusive*

²⁹ As noted above, DLC was forced to invoke our federal authority to initiate yet another new P&A investigation of BSH into the use of restraint, seclusion, and ETOs due to DOC's refusal to provide the restraint and seclusion orders DLC had been receiving for years; DLC is awaiting a response to our records request as part of that investigation.

³⁰ M.G.L. c. 123, § 23.

³¹ *Id.*; see *Matter of Guardianship of Roe*, 383 Mass. 415, 435-438 (1981).

³² See *Matter of Guardianship of Roe*, 383 Mass. 415, 435-438 (1981) ("[F]ew legitimate medical procedures [] are more intrusive than the forcible injection of antipsychotic medication.").

³³ *Rogers v. Comm'r of the Dep't of Mental Health*, 390 Mass. 489, 503 (1983).

³⁴ *Id.* at 512-513.

*alternative to forced antipsychotic drugs available*³⁵ and “*the statutory and regulatory conditions for the use of chemical restraints must be followed*”³⁶; and

- (3) Exercising the state’s *parens patriae* power to administer medication involuntarily “in rare circumstances” to prevent “immediate, substantial, and irreversible deterioration of a serious mental illness...in cases in which ‘even the smallest of avoidable delays would be intolerable.’”³⁷

The Supreme Judicial Court has held that “[n]either doctors nor courts have the power to expand the circumstances in which a patient may be restrained.”³⁸ Nevertheless, with DOC’s approval, Wellpath frequently subjects PS to physical restraint, seclusion, and chemical restraint absent the requisite emergency circumstances. And BSH’s policy governing application of involuntary medication explicitly sanctions chemical restraint in the form of an “Emergency Treatment Order” when a PS presents with behaviors that pose only a “*potential* harm to self or others” as determined by “a risk assessment by the psychiatrist or other provider that contextualizes the current behavioral presentation with the PS’ historical and current risk factors for serious violence leading to significant personal injury or self-harm, or harm to others.”³⁹ In addition, ETO provisions in the BSH Use of Involuntary Psychotropic Medical policy do not require any determination that the forced antipsychotic medication is the least restrictive option or documentation of the forced medication as a restraint.⁴⁰ Since DLC’s January 2022 report, EOPSS and DOC have brazenly argued that ETOs are involuntary medication “for treatment,” rather than chemical restraint, in an apparent attempt to create a fourth permissible circumstance for subjecting PS at BSH and the OCCC Units to involuntary medication.⁴¹

A. Recurrent Deficiencies in Documentation of Restraint and Seclusion

BSH’s problematic restraint, seclusion and involuntary medication practices are reflected in, and obfuscated by, their problematic documentation practices. Too often there is missing documentation, forms filled out incorrectly, or records lacking appropriate detail, impairing the ability of Wellpath and DOC to effectively manage use of these extreme interventions at BSH, and making it similarly challenging for DLC to provide oversight.

³⁵ *Id.* at 490-491, 509-511; M.G.L. c. 123, § 21 (emphasis added). “No other State interest is sufficiently compelling to warrant the extremely intrusive measures necessary for forcible medication with the antipsychotic drugs. Any other result also would negate the Legislature’s decision to regulate strictly the use of mind altering drugs as restraints.” *Id.* at 511.

³⁶ *Id.* at 509.

³⁷ *Id.* at 511-512. If doctors determine that the involuntary medication should continue in order to prevent irreversible deterioration, “the doctors must seek an adjudication of incompetence.” *Id.* at 512.

³⁸ *O’Sullivan v. Sec’y of Hum. Servs.*, 402 Mass. 190, 194 (1988), citing *Rogers v. Comm’r of the Dep’t of Mental Health*, 390 Mass. 489, 510 (1983).

³⁹ Bridgewater State Hospital Policy and Procedure Manual – Use of Involuntary Psychotropic Medication, 5.2.1, 5.2.4 (July 12, 2022) (emphasis added) (hereinafter “BSH Use of Involuntary Psychotropic Medication Policy”). “Behaviors that may necessitate an ETO include, but are not limited to, , [sic] unremitting self-harm that is causing physical injury to the PS; serious physical harm to a team member or other PS; *escalating aggression that cannot be verbally de-escalated*; and *mental health emergencies such as catatonia or delirium*.” *Id.* (emphasis added).

⁴⁰ *Id.* at 5.2.8, 5.2.9.

⁴¹ App. B at 4.

Below are reproductions of critical excerpts from PS BSH restraint and seclusion order forms completed between June 16, 2022 and August 25, 2022, received before DOC decided to restrict DLC's access. These are the forms the DOC Commissioner reviews and customarily approves, per M.G.L. c. 123, § 21. Considering the intrusiveness and traumatic potential of these interventions, the lack of detail contained within and the nonadherence to Wellpath's internal standards are striking. Below each excerpt is a brief analysis highlighting some of the critical concerns it raises, keeping in mind the legal requirements discussed above. Please note: all PS references to PS names throughout this report utilize pseudonyms for PS protection.

"Edgar" – June 2022

Manual Hold Reason: *Threat of Harm to Others, Threat of Harm to Self*

ETO Administered: Yes

Describe the observed changes in the observed behavior(s) and/or elements of the Person Served's presentation and mental/status and explain how they signify, for this individual, that he currently presents a behavioral emergency such as THE OCCURRENCE or SERIOUS THREAT OF EXTREME VIOLENCE, PERSONAL INJURY, or ATTEMPTED SUICIDE: *PS was restless with multiple behavior issues prior to this episode. Manual hold needed for safe administration of IM medication due to increased agitation.*

- The form fails to indicate the nature of the observed behavior or how "restless" and "increased agitation" meet the statutory standard to justify a manual hold (physical restraint) or an ETO (chemical restraint).
- The lack of detail provided fails to fulfill the requirements of the form itself ("explain how they signify... a behavioral emergency").

"Jonathan" – July 2022

Manual Hold Reason: *Threat of harm to others*

ETO Administered: Yes

Describe the observed changes in the observed behavior(s) and/or elements of the Person Served's presentation and mental/status and explain how they signify, for this individual, that he currently presents a behavioral emergency such as THE OCCURRENCE or SERIOUS THREAT OF EXTREME VIOLENCE, PERSONAL INJURY, or ATTEMPTED SUICIDE: *PS refused to cooperate for safe administration of IM ETO medication. Manual hold applied due to risk of harming self or others.*

- This description of Jonathan refusing to "cooperate" provides no information about the PS behaviors that gave rise to the ETO used to justify the manual hold (physical restraint). In addition, had DOC and Wellpath appropriately recognized an ETO as a restraint, more information would have been required.

- It is possible, due to Wellpath’s piecemeal documentation practices, that prior orders detailing the events preceding this ETO order may contain more information about the rationale. Based on DLC’s supplemental review of daily nursing reports, there appears to be either a missing seclusion order or Jonathan was locked in in his cell finishing his dinner prior to the ETO being ordered and administered. The shift logs attribute the reason for the ETO to Jonathan “creating climate issues within the housing unit,” apparently from the confines of his cell, where any “risk of harming...others” is negated by the solid cell door.

“Francis” – June 2022

Manual Hold Reason: *Escort to another location*

ETO Administered: *No*

Describe the observed changes in the observed behavior(s) and/or elements of the Person Served’s presentation and mental/status and explain how they signify, for this individual, that he currently presents a behavioral emergency such as THE OCCURRENCE or SERIOUS THREAT OF EXTREME VIOLENCE, PERSONAL INJURY, or ATTEMPTED SUICIDE: *PS out for his rec time. PS went to a secluded area of the yard near the fence and sat. Multiple attempt [sic] made by staff to redirect PS went unsuccessful. PS presents an imminent risk to his own safety at this time. PS placed in a manual hold to escort him back to his unit.*

- Based upon the sparse details, the “imminent risk” to Francis’ safety posed by sitting near the innermost tall prison fence that surrounds BSH is not clear.
- A subsequent mechanical restraint (handcuffs) order from this sequence states, “While PS was manually held to transfer him to Bradford, PS started to violently struggle with staff. Handcuffs applied for the safety of PS and staff.” He was brought to his unit and placed in seclusion under the reason “threat of harm to others,” concluding what reads as a disturbing and unjustified escalation by staff.

“George” – August 2022

Mechanical Restraint Reason: *Actual harm to self*

ETO Administered: *Yes*

Describe the observed changes in the observed behavior(s) and/or elements of the Person Served’s presentation and mental/status and explain how they signify, for this individual, that he currently presents a behavioral emergency such as THE OCCURRENCE or SERIOUS THREAT OF EXTREME VIOLENCE, PERSONAL INJURY, or ATTEMPTED SUICIDE: *Patient was agitated and banging on the door for minutes after he was examined by internal medicine and found not in need for transfer to a medical hospital, he was suspected to be opioid seeking, he started to get agitated, and was banging on the door for minutes, not responding to redirection*

- “[B]anging on a door” and getting “agitated” do not describe emergency circumstances justifying restraint – physical or chemical. Based upon this scant

description, George may have been subjected to mechanical restraint, an ETO (chemical restraint), and the manual hold (physical restraint) involved in securing the mechanical restraints and administering the ETO simply because he was upset and being loud.

- The method of mechanical restraint (e.g., handcuffs or four-point restraints) is not specified anywhere on the form. Only by consulting daily nursing reports did DLC determine that four-point restraints were utilized while George received the ETO, and that staff also used a manual hold on him for ten (10) minutes prior to the four-point restraints. However, a form for this manual hold was not provided to DLC among the DOC Commissioner-approved restraint forms we received.

“Harold” – July 2022

Manual Hold Reason: *Escort to another location*

ETO Administered: *Yes*

Describe the observed changes in the observed behavior(s) and/or elements of the Person Served’s presentation and mental/status and explain how they signify, for this individual, that he currently presents a behavioral emergency such as THE OCCURRENCE or SERIOUS THREAT OF EXTREME VIOLENCE, PERSONAL INJURY, or ATTEMPTED SUICIDE: *PS escorted on a manual hold due to history of refusing to interact with staff. PS refused to leave the cell, safety 2 were called to escorted him to the unit.*

- This form provides no indication that there were any present observed behaviors warranting an emergency intervention – only Harold’s refusal to leave a cell. A “history of refusing to interact with staff” is a troubling justification for a restraint, reflecting that the order was not only based on seemingly non-threatening behaviors, but upon non-emergency past behavior.
- Only by consulting internal shift logs was DLC able to see that, at this time, BSH staff was attempting to process Harold through booking so he could be discharged. While this might explain their decision to regard the situation with urgency, it does not justify restraint in any form.

In addition to Wellpath’s failures to comply with the law and maintain complete records, DOC’s rubber stamping of restraint orders constitutes a failure to meaningfully provide the oversight required by M.G.L. c. 123, § 21. And, in spite of their glaring deficiencies, DOC and Wellpath appear to hide behind them in an effort to legitimize their policies and practices. Both Wellpath’s oversight of its staff and DOC’s oversight of Wellpath have allowed irresponsible and dangerous practices to go unchecked.

B. Unreasonable Force in Restraint, Seclusion, and Involuntary Medication Administration

Staff use of force on PS at BSH and in the OCCC Units often seems rote, committed with little consideration of the PS’ psychiatric diagnosis and current symptoms, their disability status, and the lasting impact that it may have on PS and staff alike.

As mentioned above, DOC has opened three (3) investigations into complaints of violent attacks on PS – two (2) inside BSH and one (1) on an individual awaiting evaluation in the ISOU. The primary aggressor in the two BSH investigations was one TST who continued working after the first incident and was allowed to keep victimizing PS despite the availability of video footage recording his misconduct. This failure of Wellpath oversight continued even after Wellpath opened an internal investigation into the TST’s conduct when the TST was inappropriately assigned to staff the housing unit of one of the PS he attacked. This was only remedied when PS filed a grievance and the PS Advocate took corrective action.⁴² DLC’s investigation into the assault of a PS in the ISOU involves the conduct of correctional officers. The PS’ injuries were significant, yet correctional officer reports provided little explanation about how he sustained them. DLC hopes to conclude these investigations during the next reporting period.

Sadly, DLC does not have the staff capacity to open an investigation or acquire about every video of BSH staff using inappropriate force, whether done gratuitously or in order to execute provider orders for physical restraint, seclusion, and ETOs. However, we were able to acquire from DOC and view approximately fifteen (15) videos involving ETOs accomplished through violent restraint. In each video, intramuscular (IM) ETOs were forcibly injected by nurses with a team of TSTs equipped in riot gear – including black helmets with visors obscuring their faces and one TST holding a large plexiglass shield – holding down the PS. Owing to BSH’s Use of Involuntary Psychotropic Medication Policy, Wellpath did not report any of these ETOs as chemical restraints or record any finding that the involuntary medication was the least restrictive, most appropriate alternative available.⁴³

Below are several examples of PS experiences that DLC viewed on video:

Example No. 1 – “Alan”

9:45am - 10:00am

The video starts with PS Alan, a slight older man, is lying on his back in bed with his shirt off, seemingly sleeping. At 9:53am, the lights turn on and he immediately jumps up and peers out the window on his door into the unit hallway. His cell is notably dilapidated: scratched-off paint on the walls, scrawled graffiti, scuffed concrete floors; and sheets that hardly fit the thin mattress. Ready to protect himself from the coming invasion of staff, Alan reaches for a paper cup on top of his sink (presumably filled with soap) and pours its contents below the length of the door. He then moves back into his cramped cell, his back against the side wall. He alternately peers through the window into the hallway and stands back in an active stance looking anxiously at the door. He repeatedly motions to the staff outside to come in.

When the door opens at 9:55am, four (4) TSTs enter wearing khaki jumpsuits covering the bulky riot gear, the first holding a large blue shield. Alan runs toward the first TST, who extends the shield and violently knocks him onto the bed and then briefly covers him with the shield. As the others attempt to grab Alan, he tries to shake free and three

⁴² BSH Governing Body Meeting Minutes (September 2022).

⁴³ Compare M.G.L. c. 123, § 21; 104 CMR. 27.12(5)(d), (i).

(3) TSTs, all of whom are significantly larger than him, bear down on him and begin to struggle in the corner. Alan completely disappears from the view of the camera beneath them. Meanwhile, another TST gathers his bedding and throws it in the middle of the unit hallway alongside other items removed from his cell.

The TSTs get hold of Alan's hands, contort them behind his back, and forcefully hold him down on the bed, face down. Alan appears to be breathing hard. The TSTs hold each point of his body, pressing him into the bare mattress. The nurse quickly pulls down his pants and injects him with two large syringes in his buttocks, one after the other. Then, at 9:57am, the TSTs hurry out one by one, either by backing out or running quickly. Alan gets up and attempts to run after them as they close the door in his face. His back is covered in red marks from the struggle.

This video highlights major concerns about the conditions of PS cells, the brutality employed in administering involuntary medication, particularly on a man of Alan's age and stature, and the unavoidably traumatic impact on Alan, to name a few. More broadly, the video described above demonstrates Wellpath policies and practices that run afoul of Massachusetts law in action. The footage shows no safety threats until staff created them in order to forcefully execute an ETO that was unwarranted by Alan's behavior at the time the TSTs stormed into his cell.

Equally concerning, review of Alan's records suggests that the ETO was not even warranted at the time the provider made the order. Records indicate that, about an hour and half prior to the ETO, Alan had become upset with staff and after "postur(ing)" and making "verbal threats" towards them, was put in a manual hold, escorted to his cell, and locked inside. The restraint order for this first manual hold describes Alan as "calm, no longer threatening" once he is in his cell; yet other notes in his record indicate that "he continued banging and kicking on (the) door, making threats" from inside his cell. Twenty (20) minutes after he was placed in his cell, another note reads: "[Alan] is expected to receive emergency medications. Treatment team aware." As the video footage shows – *yet no records describe* – it is over an hour after that determination, when Alan is lying on his bed, relaxing, unmedicated, that TSTs assemble to forcefully administer the ETO.

Even Wellpath records concerning the ETO administration vary widely, demonstrating the unreliability of staff documentation of these types of incidents. In different documents within Alan's medical records, the incident that DLC reviewed on video is described as follows:

- "P/S attempted to jump over the shield to assault TST'S, but was unsuccessful, and placed into manual holds from 0954-0957. P/S continued to struggle with staff during administration of medication."
- "Manual Hold was required for safe administration of IM medication from 9:54-57. No injury to PSS or staff."
- "PS required Manual Hold for safe administration of IM medication as PS would not comply with safety directives."

A small poster in the administration building lobby reminds staff entering the facility that “If you don’t document it, it didn’t happen.” Indeed, in the case of this incident, Wellpath’s documentation erases what actually happened. Had DLC not requested that this video be preserved, it would have likely been automatically erased after three (3) months in keeping with DOC’s practice and never viewed, leaving no record of the specifics of this brutal encounter and what led up to it. For most other incidents, only the recorded descriptions that read like the terse sentences listed above exist – with no video evidence to reveal the true circumstances.

As DLC discussed in our July 2022 report, if Wellpath applied DOC’s Use of Force regulations to all instances of physical restraint, record keeping and oversight would be more robust. Likewise, properly documenting ETOs as chemical restraints, would make it more difficult for BSH to skirt accountability by avoiding documentation.

Example No. 2 – “Steven”
6:25pm - 7:35pm

The video footage begins at 6:25pm with PS Steven walking in the hallway of his unit when he comes up behind another PS and wraps his arms around him in a sort of bearhug. Two TSTs intervene, quickly separating Steven from the other PS without any apparent resistance. Steven continues to cooperate as the TSTs place his arms behind his back as if he were being arrested, escort him to his cell, and lock him in. For the next thirty (30) minutes, he talks to the 1:1 staff standing outside his cell door, eats his dinner, then lies down in bed. Finally, he gets out of bed and lies down on the floor of his cell.⁴⁴ At 7:11pm, four (4) TSTs abruptly enter his cell and drag him up from the floor by his arms, lift him onto his bed, and hold him down by his legs and shoulders. Steven still does not appear to resist. A nurse enters, pulls his pants down, and administers multiple injections. Steven presents as calm throughout his interactions with staff and remains in bed as staff quickly exit the cell and shut the door behind them.

After Steven’s initial physical contact with another PS, this video footage is replete with indicia of his calm demeanor, from his acquiescence during the manual hold and escort to his cell, to the thirty (30) minutes of uneventful behavior that followed, and his cooperation with TST’s rough conduct and the injections. In Steven’s medical records, the Seclusion Check List for his hour-long seclusion period indicate that he was alternately “standing in his room,” “talking to staff,” and “laying down in bed.” Throughout the video footage, Steven posed no observable risk of “imminent harm to others” – the recorded reason for his seclusion – or “potential harm to others” – the recorded reason for his ETO. Indeed, Steven’s records indicate that a central reason he received medication was not any present threat or “emergency,” but his history of “repetitive assaultive violence.” His Progress Notes also reveal that a nurse offered Steven his usual 8:00pm medication early following the incident in the hallway and he declined; the nurse told him that he would receive “IM medication if he refused,” although he did not have any court-ordered Rogers treatment plan in place. These

⁴⁴ Historical weather data available from AccuWeather.com for the date of this incident indicates that temperature climbed to 92 degrees.

medical records in combination with the video footage raise serious questions about whether, when making determinations of “emergency” and “threat,” Steven’s ETO was simply punishment for past behaviors or for not bending to the will of a nurse.

This incident also raises serious concerns about the consistency and accuracy of Wellpath’s documentation practices. Although video footage clearly showed Steven wrapping his arms around the other PS torso in a “bear hug,” three alternate accounts of this incident exist in his medical records, recounting that he:

- “[A]ttempted to place PS [redacted] into a bear hug”
- “[A]ttacked another PS from behind and wrapped his hands around the other PS’ neck”
- “[W]as observed to punch another inmates [sic] at the back of the victim’s neck”

Such discrepancies not only indicate poor quality control; records falsely portraying acts of violence may follow PS and impact their ability to be transferred to DMH facilities. And, once again, had DLC not requested this video before it was automatically destroyed, the ability to confirm what actually happened would have been lost.

Example 3 – “Rafael”

10:30am – 11:00am

At 10:30am, PS Rafael is in his cell talking to staff through his door. He begins pacing back and forth while gesticulating and talking to himself. After a few minutes, he begins to slow down and become less animated. He sits on his toilet where he appears calm for ten (10) minutes. Staff begins to assemble outside his cell, at which point he rises and speaks to them through the door for about two minutes. At 10:45am, four (4) TSTs in riot gear abruptly open the door and quickly enter the cell as Rafael turns his back to them and places his arms out in front of him, resembling a gesture of surrender. A TST then wraps his arms around Rafael from behind and forces him to his bed stomach-down atop the bunched-up sheets and blankets that lay there. The TST at Rafael’s waist pulls out one arm from under him and twists it around his back but leaves the other arm under his stomach. Two other TSTs hold down his legs and feet. A nurse comes in with her assistant, pulls down his pants, and injects three long syringes into his buttocks one by one. During this process, a TST supervisor watches and frequently checks their wristwatch, while another staff member videotapes the IM administration with a handheld camera at the foot of the bed. In the midst of eight (8) people working to restrain and medicate him, Rafael is notably cooperative. Finally, TSTs run out of the cell, some running backwards. When they close the door, Rafael gets up and talks to the staff through the door again, then continues to pace around the cell and talk to himself, just as he did before the aggressive encounter.

Again, Rafael’s experience reinforces the rampant practice at BSH of engaging in unnecessary and disproportionate use of physical restraint in order to effectuate ETOs justified by stale or entirely insufficient information to permit a use of chemical restraint.

The recurring sequence of events is: (1) PS are secluded in their cells after an incident on their unit; (2) by virtue of their seclusion PS no longer have the capacity to inflict harm on others; and (3) PS behavior is calm and unthreatening by the time staff arrive to deliver the ETO. Often, as in Examples 2 and 3, PS are even cooperative with staff the restraining them and administering the ETO. At every turn, the video footage exhibits violations of M.G.L. c. 123, § 21 and the realities of a dangerous environment ruled by fear and force, rather than trauma-informed principles of de-escalation.

Documentation around the event that caused staff to order the ETO presents further concerns. Rafael 's records, taken together, describe what led to that order: *While receiving his morning scheduled medication, PS exhibited "aggressive" behavior toward the nurse. In addition to being highly agitated and manic, PS used profane language and racial slurs toward the nurse and then threw his medications on the floor. In light of increased psychosis and continual aggression and inappropriate behavior towards peers and staff psychiatrists, MD ordered that ETO be administered.*

There is no indication of what time these events occurred (a problem in and of itself), so one can only assume that this happened around 8:00am when morning medications are usually delivered, and the ETO ordered shortly thereafter. At this time, Rafael would have been in his cell and, while he may have exhibited "aggression" and racist language this does not constitute imminent or even potential risk of harm to others. Rafael remained in his cell for approximately two (2) hours and forty-five (45) minutes, until the ETO was finally administered 10:45am. Even more disconcerting, staff had hours to reconsider whether forced IM medication was necessary, with every fifteen (15)-minute check indicating no outstanding behavioral notes except for being "agitated" at 8:00am and 8:15am.

There are additional discrepancies between the documentation and video footage. As the video clearly demonstrates, Rafael was compliant with staff's orders, various physical holds and the three (3) injections that comprised the ETO. Yet, the restraint order for the manual hold indicates that the reason was "threat of harm to others" and "actual harm to others." While notes in PS Rafael's records recount verbal threats made that morning, there is not a single reference to any "actual" physical harm in his records about these events. Again, such discrepancies present serious concerns around documentation and accountability, as well as PS' future, as they may adversely affect a PS' risk rating or success in later court proceedings. It is also concerning that, although Rafael remained in his cell the entire morning until 12:30pm, there is no seclusion order in his records.

C. Analysis of Available Data Concerning ETO Applications

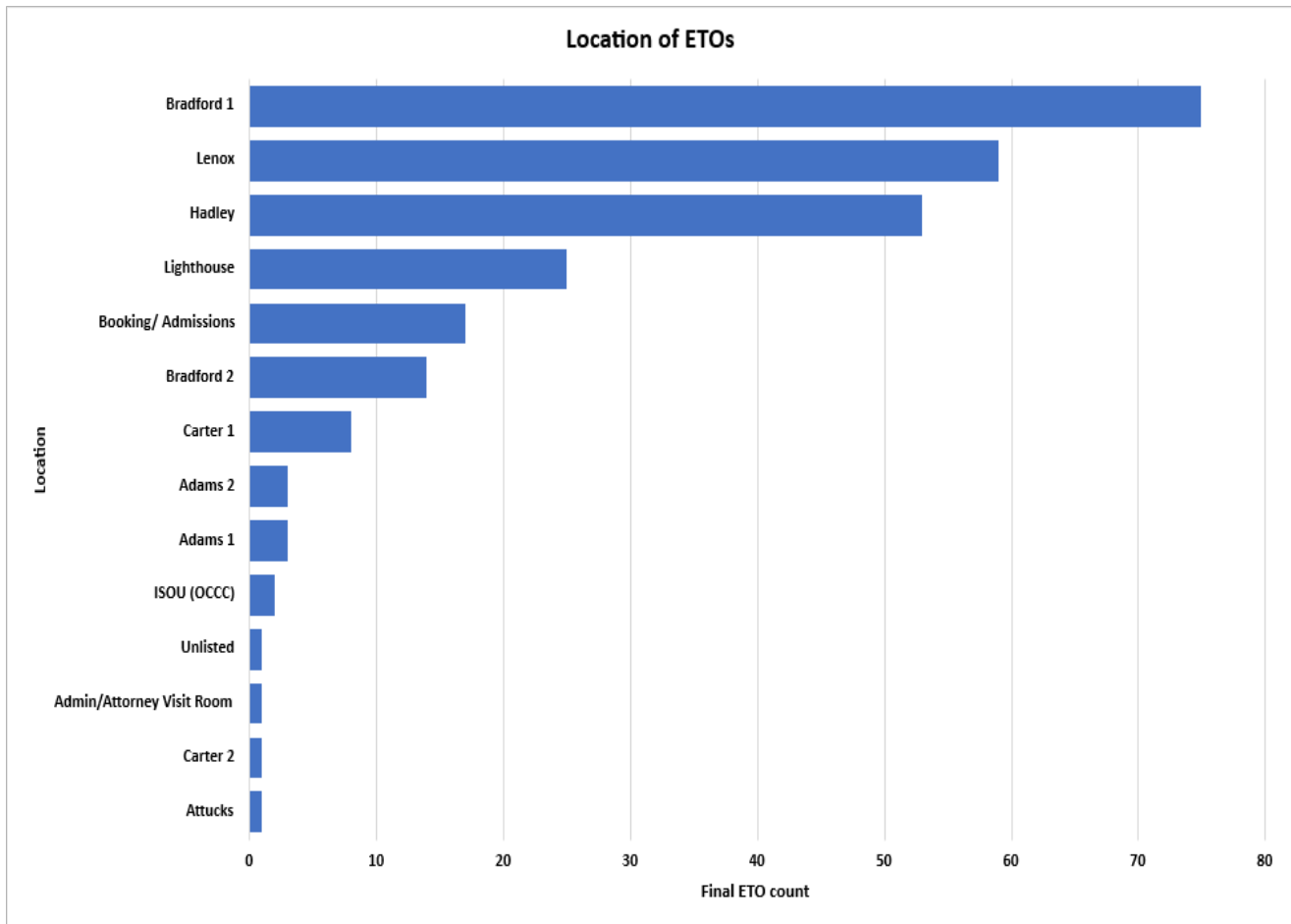
Without Access to complete restraint and seclusion records for this reporting period, DLC has had to rely on BSH daily nursing reports to identify the occurrence of ETOs. These reports are produced daily to provide incoming staff an update on the important happenings at BSH the previous day. The daily nursing reports, however, are not a part of PS medical records, do not form a part of formal records of restraint, seclusion, or involuntary medication, and do not always constitute a complete accounting of all uses of restraint, seclusion, and involuntary medication on a given day. With these limitations

in mind, DLC presents below data concerning ETO applications during this reporting period.

i. ETOs by Facility Location

ETOs can be ordered on PS in any area of BSH and in the OCCC Units. As indicated by the table below, the number of ETOs varies widely per BSH area. The disparities can largely be attributed to the purpose of the building and, with respect to housing units, the designated purposes and populations for each unit. Within BSH, for instance, Adams and Carter largely house PS who have been committed; Bradford 1 is the unit for PS newly admitted to BSH; Bradford 2 is for PS who are in their evaluation period and have transitioned from Bradford 1; Hadley and Lenox are BSH's maximum security units that generally house PS pre- and post-commitment who have more acute needs and/or behaviors; and Lighthouse is the building in which medical services are provided and PS with serious medical issues and/or co-occurring disabilities are often housed. At OCCC, the ISOU is for new PS admissions in need of stabilization and evaluation and the RU, which had no ETOs during this reporting period, is the unit for committed state prisoner PS. At the same time, the Wellpath staff of each unit and the providers making restraint and seclusion decisions also play a substantial role in the interventions staff choose to utilize and overreliance on sedative medication.

Table 1. ETOs by Facility Location	
Facility Location	Number of ETOs
Adams 1	3
Adams 2	3
Administration/Attorney Visit Room	1
Attucks	1
Booking/Admissions	17
Bradford 1	75
Bradford 2	14
Carter 1	8
Carter 2	1
Hadley	53
ISOU (OCCC)	2
Lenox	59
Lighthouse	25
Unidentified	1
Total Across BSH and OCCC Locations	263



A total of two hundred sixty-six (266) ETOs in this reporting period, based on the daily nursing reports alone, show BSH's disturbing overreliance on ETOs. Per Table 1, ETOs overwhelmingly occur in Bradford 1, Hadley, and Lenox. While this may be expected in some respects, it is important to remember that uses of seclusion and restraint in any form are well understood to be the most extreme psychiatric interventions and the use of chemical restraint by far the most intrusive. In addition, ninety-two (92) ETOs inflicted upon new PS – whether immediately upon entering BSH at Booking/Admissions or once housed in Bradford 1 – paints a troubling picture of how individuals already in mental distress and forced to adjust to new environment are introduced to the facility. Looking at these figures, the fear and aversion to engaging with BSH staff that PS have repeatedly expressed should come as no surprise.

ii. ETOs Per Day

Table 2 provides a look at the use of ETOs over the course of the reporting period and the frequency of ETOs, which profoundly impacts the BSH environment and PS experience. For context, in the last year, BSH generally held between two hundred (200) and two hundred forty (240) PS at any given time.

Table 2. ETOs Per Day			
Month	Number of Days	Number of ETOS	ETOs Per Day (avg)
June (15-30)	15	34	2.27
July (1-31)	31	39	1.26
August (1-31)	31	56	1.81
September (1-30)	30	47	1.57
October (1-31)	31	38	1.23
November (1-30)	30	40	1.33
December (1-15)	15	12	0.8
Total (June 15 - Dec15)	183	263	1.44

iii. Delays in ETO Administration Preceded by PS Seclusion or Four-Point Restraint

DLC has repeatedly reported on ETOs administered following delays during which PS become or remain calm, obviating both the need and legitimate legal justification for imposing involuntary medication on PS. Table 3 reflects the delay in minutes between PS placement in seclusion or four-point restraint and the administration of the ETO. Unfortunately, the common omissions and inconsistencies in terminology used in the summaries included in daily nursing reports do not allow for DLC to provide precise counts. However, the below data substantiates DLC's findings that significant delays between the emergency event warranting seclusion or four-point restraint and the ultimate execution of ETOs are common.

Table 3. Time Between Seclusion/Four-Point Restraint and ETO Administration	
Time Delay (minutes)	Number of ETOs
0-15	27
16-30	13
31-60	27
60-120	20
120+	3
Unable to Determine	20
Total Seclusion/Four-Point Restraint ETOs	110

iv. The Number of ETOs Administered on Unique PS

The legal and human rights violations at BSH inflicted through the use of ETOs is not limited to a handful of PS. Table 4 makes clear that well over a hundred individual PS during this reporting period suffered these forceful, traumatic interventions.

Table 4. Number of ETOs Per Unique PS	
ETOs Received in Reporting Period	Number of Unique PS
1	56
2 to 5	43
6 to 10	9
>10	2
Total Unique PS Receiving ETOs	110

D. Systemic Inequity in Application of ETOs/Chemical Restraint

In the reporting period covered by the July 2022 report, DLC began gathering and comparing the demographics of PS who received ETOs during the reporting period with those of the BSH population as a whole to determine whether Black and Latinx PS are disproportionately subjected to ETOs. DLC's plan, announced in our report, to pursue comprehensive data sets related to race/ethnicity and the PS population during the next reporting period, to allow a more complete discussion of this issue was frustrated by DOC's refusal to provide both race/ethnicity and restraint and seclusion documentation including PS names. DLC now hopes to access this information through our recently opened investigation.

Recommendations:

DOC and Wellpath must immediately cease imposition of chemical restraint, including ETOs, physical restraint, and seclusion in circumstances that do not meet the narrowly tailored dictates of M.G.L. c. 123, § 21.

The Commonwealth must demand that DOC and Wellpath accurately document and report all uses of chemical restraint, physical restraint, and seclusion in keeping with applicable law and engage DMH or another external party to conduct an in-depth investigation into BSH practices.

DOC must immediately resume providing DLC access to complete information and documentation of uses of restraint and seclusion and PS race/ethnicity to allow DLC serve its vital functions under Line Item #8900-001 and as the Commonwealth's Protection and Advocacy agency.

To fully address the restraint and seclusion practices to which PS are subjected, the care of all individuals found to need "strict security" for psychiatric evaluation and/or treatment must be placed under the DMH. Based on DLC's observations, maintaining DOC's control over BSH will foreseeably permit variation in both quality of care and compliance with legal requirements.

All policies and practices concerning the involuntary medication, restraint, and seclusion of PS should be amended to conform with DMH regulations and policies, including provisions regarding staff training requirements, tracking less restrictive alternatives, de-escalation efforts, debriefing with PS, and accurately reporting all restraint and seclusion to the Commissioner.

4. De-escalation Practices, Training, and Culture

Building on the monitoring work presented in our July 2022 report, DLC continued to observe staff-PS interactions with a focus on the use of de-escalation and crisis prevention. In addition to interviews and in-person monitoring, DLC attended BSH's New Employee Orientation (NEO) Mandt training – the portion of NEO broadly focused on communication, relationships and de-escalation – and the Mandt Recertification training for current staff. DLC's observations during these trainings highlighted serious concerns around staff treatment of PS rooted in the everyday culture of BSH that often negatively impacts PS wellbeing and the safety of the BSH environment. Notably, DLC was disturbed to find out that de-escalation was only added to the onboarding Mandt training during this reporting period.⁴⁵ While de-escalation is a core component of the Mandt system, Wellpath training has focused on the hands-on restraint components of Mandt, rather than the preventative interventions.

A. Practices

i. DLC Direct Observations

During onsite visits this reporting period, DLC regularly witnessed all manner of conflict between PS and between PS and Wellpath staff. Often, staff recognized and responded appropriately to challenging situations, whether putting their body in between two PS with escalating behaviors or leveraging their relationship with a PS and using a particularly calm and encouraging tone of voice. DLC commends BSH staff who exhibit exemplary behavior in what are frequently stressful and difficult situations.

Sometimes, however, DLC has witnessed firsthand TSTs and other Wellpath staff straying from trauma-informed care and de-escalation and escalating conflict with PS. In one notable instance, DLC observed a PS standing in line for medication at the nurses' station calling out vague threats and insults to a TST who was walking away from him. Every time the PS addressed him, the TST turned around quickly and yelled angrily back at the PS the same phrase: "do what she said – take your meds!" This back and forth occurred three or four times, heightening in intensity. It appeared that the TST would have walked back towards the PS but for fellow staff encouraging the TST to disengage. While it was fortunate that the TST's coworkers intervened and that he did not retaliate physically, it was the TST's responsibility to *deescalate* the situation rather than trading barbs and engaging in a conspicuous power struggle with a PS. While such interactions can be re-traumatizing for both staff and PS, only PS are at risk of suffering repercussions such as violent forced medication and seclusion when staff fail to fulfill their responsibilities.

ii. PS Experiences

Numerous PS have reported staff intentionally escalating PS who are attempting to gain their attention while locked-in – a trend that appears to occur most often during the second shift. One PS reported that, while kicking his door repeatedly to get staff's

⁴⁵ BSH Governing Body Meeting Minutes (September 2022).

attention during an evening shift, multiple staff chose to egg him on rather than inquiring about what he needed. Echoing the concerns of other PS who spoke with DLC, he shared how discouraging it was to be disregarded by staff and how difficult it is for PS stuck in their cells behind metal cell doors to be heard over the sounds of staff talking, laughing, and watching the unit TV during their shifts. He issued a dire warning, declaring that one of these days staff is going to “push someone over the edge and they are gonna kill themselves.” This PS highlights the importance of respectful and responsive staff, particularly when PS must rely on staff to meet all their needs.

Conflicts between staff and PS do not always de-escalate in the end and, far too frequently, become physical due to staff escalation. Multiple PS have described either witnessing or experiencing escalatory violence by staff, including one who reported having been choked during escorts to his cell on more than one occasion. DLC has also reviewed video of incidents in which PS have been brutally assaulted by staff during incidents that had previously been only verbal, resulting in both physical injury and psychological trauma. Such incidents are alarming not only because of the violence inflicted upon PS as a result of staff’s failure to de-escalate, but also because of the active steps some staff take to *escalate* situations and assert dominance on vulnerable people with complex mental health needs. As noted above, DLC initiated three (3) Protection and Advocacy investigations into violent assaults on PS – two (2) BSH PS and one (1) ISOU PS.

iii. Staff Experiences:

PS are not the only ones who struggle with the disrespectful and escalatory behavior of staff. During DLC’s monitoring, Wellpath employees have expressed disapproval of their coworkers’ behaviors, particularly when it comes to communication that is detrimental to PS, their relationships with PS, and unit safety. For example, one Wellpath staff member told DLC about a longtime TST who had been in a verbal altercation with a PS when the PS threw a book toward him. Instead of maintaining the space between them, the TST walked back toward the PS, put him in a choke hold, and began punching him in the face.

Staff confiding in DLC reported being taxed by having to constantly manage and compensate for the inconsistency of their coworkers’ skillsets and behaviors. They described staff who failed to read body language, staff who provoked fights by escalating with PS, and staff who made PS feel threatened, leading to conflict. In one concerning example, a staff person described trying to convince a TST coworker to remove himself from the hallway because a PS who was angry with him needed to be moved to another cell that required crossing that hallway. The TST kept refusing, endangering everyone involved. Indeed, multiple staff expressed that they often have more difficulty dealing with their colleagues than the PS in their care.

DLC also listened to staff describe the unwillingness on the part of many of their coworkers to apologize to PS when they make errors. One explained that this refusal to apologize to PS directly causes issues on the unit, saying, “You need to apologize. There’s no reason you can’t say sorry to people who are sick.” Similarly, staff described

others' resistance to explaining to PS when and why they are unable to fulfill a PS' request, which leads to frustration about a lack of communication and transparency.

B. Training

Having witnessed a range of interactions between PS and staff – from the respectful and de-escalatory to the instigative and abusive – DLC observed two BSH Mandt trainings in the hopes of learning more about how staff learn these methods.

The Mandt System is a “holistic evidence-based training to reduce workplace violence”⁴⁶ used in a variety of settings, including DMH hospitals at present. According to Mandt's website, “Building healthy positive relationships is the ultimate goal of our training programs.” At BSH, Mandt trainings are offered on a rolling basis, providing a 2-day Mandt training within New Hire Orientation and a 1-day Mandt Recertification training version for current staff. Mandt trainings at BSH are facilitated by Wellpath staff who have been through a week-long Train-the-Trainer program: two staff trained as TSTs (one of whom left BSH during the reporting period) and a BSH Training Coordinator. All BSH staff are required to complete the Recertification training yearly, although some are compelled to attend more often due to job performance concerns.

The first day of the Orientation training consists of six (6) hours of slides and didactics, involving minimal participation from the class. The slides are divided into the following sections: “Relational” (covering crisis recognition, de-escalation, relationship building, interpersonal communication skills, and conflict management); “Conceptual” (covering trauma and trauma-informed care and “Positive Interventions and Behavior Support,” a functional approach to behavior modification); and “Technical” (covering restraint techniques, injury minimization, and threat recognition).

The second day of NEO Mandt training consists of about two (2) hours of “role plays,” in which new employees are assigned roles as both “PS” and “staff” and then tasked with acting out various scenarios and responding in character, such as staff attempting to deescalate a verbal altercation between two PS. Staff then receive feedback from the trainers as well as a clinician who assists with this portion. After taking a test on the covered material, trainees then spend the remainder of the afternoon in “technical” training, learning through trainer demonstration to perform different stances, physical holds, and releases (maneuvers that allow safe escape from having one's wrist held or hair pulled, for example). Unlike the two-day NEO Mandt training, the Mandt Recert training does not include role plays or technical training, but rather, the identical deck of slides as Day 1 of NEO.

Most of the Mandt training content is appropriate for the setting, offering methods for thinking about how to manage crises, assess situations for safety, and make difficult decisions, and guidance on using both spoken and body language to communicate with those in crisis. Unfortunately, the sheer quantity of slides, and the countless conceptual models and acronyms to be memorized, require the trainers to rush through the material, often without explaining or connecting it in a meaningful way.

⁴⁶ The Mandt System, *About Us*, www.mandtsystem.com/about-us/.

One troubling omission from BSH's Mandt training was the lack of acknowledgement of the traumatizing potential of imposing restraint, seclusion, and involuntary medication on PS. The Mandt training references research around ACEs (Adverse Childhood Experiences) as well as other kinds of trauma, including historical trauma; yet there was no mention of institutional or medical trauma. Instead, the presented rationale for avoiding restraint was more often preventing physical injury to those involved or avoiding disciplinary consequences for staff, rather than avoiding the psychological toll these extreme interventions take on PS. Without vital information concerning their capacity to do harm and the long terms effects, new BSH employees are unprepared to take on the important tasks of caring for individuals with some of the most complex mental health needs in our Commonwealth.

In interviews with DLC, multiple BSH staff shared critiques or misgivings about the Mandt training. Multiple staff members felt that there was not enough emphasis on practical de-escalation skills in the training. Others emphasized the limits of the Mandt System's technical skills. One TST explained that, at some point, he and his coworkers put Mandt aside and their "instincts kick in" when "going hands on." Given DLC's extensive observations of what those instincts can look like in the context of planned and spontaneous staff brutality, this staff input is alarming.

Overall, rather than a constructive training, Mandt at BSH ends up functioning as a reflection of DOC's prevailing cultural influence and Wellpath's ineffectiveness at mitigating it— a mechanism that serves the reproduction of the status quo, not disrupting it. One of the Mandt System's mantras is "in this place, and with these people, I feel safe™." ⁴⁷ At BSH, and with Wellpath, this still does not ring true, even with Mandt.

Recommendations:

DLC recommends that Wellpath revise the BSH Mandt trainings in the following respects: hire an experienced external Mandt training to train new and retrain existing BSH staff; incorporate Peer Support Specialists into the training program; introduce role play de-escalation exercises into the recertification program; and emphasize trauma-informed understanding of each staff member's role and of restraint, seclusion, and involuntary medication.

Wellpath must protect PS by adopting policies requiring: immediate termination, upon confirmation through video footage, of staff using unnecessary and/or disproportionate force on PS; and suspension and/or complete separation from the PS alleged victim throughout the course of all investigations into accusations against staff for using unnecessary or disproportionate force on PS.

DLC recommends that DOC and Wellpath provide more oversight and support for BSH staff by developing a system for staff to confidentially share their concerns about coworkers' performance to BSH administrators, and for those concerns to be addressed.

⁴⁷ The Mandt System, *About Us*, www.mandtsystem.com/about-us/.

DLC recommends that Wellpath prioritize the hiring of additional Peer Support Specialists and commit to their increased utilization in de-escalation, in 1-1 peer support assignments with Persons Served, and as dedicated Peer Support group facilitators.

5. Insufficient Language Access for Persons Served

PS at BSH who have limited English proficiency (LEP) report struggling to access treatment and programming due to limited – and sometimes no – options in their primary language and difficulty communicating with BSH staff. Miscommunication for some PS with LEP has led to frustrated interactions with staff and use of restraint and seclusion that may have been avoided if the PS had adequate language access. The information DLC gathered during this reporting period indicates that BSH fails to provide adequate language access and, in turn, accessible mental health services to many PS with LEP.

During this reporting period, DOC has restricted DLC’s monitoring of continued deficiencies in language access for BSH PS who have limited English proficiency. In July 2022, DLC reported on the limitations of language access accommodations for PS who limited English proficiency (LEP). From meetings with PS with LEP and clinical records review, DLC determined that Wellpath failed to reliably identify LEP, and that PS lacked sufficient access to written materials, groups and individual therapy in their primary language. BSH lacked sufficient numbers of bilingual clinical staff and access to trained interpreters for the numbers of PS who should be identified with LEP. These fundamental inadequacies limited the possibility of recovery and contributed to episodes of seclusion and restraint.

In order to review this problem even more comprehensively, DLC again requested the following demographic information for the BSH population: PS race/ethnicity, primary language, and LEP designation. In response, DOC produced only a table entitled “Wellpath PS Race Ethnicity and Primary Language” with columns for the “Race,” “Ethnicity,” “Primary Language,” and “Secondary Language” of each BSH PS. DOC removed all columns from the table that contained identifying information for PS from the document it produced to DLC. As discussed above, DOC also redacted all documentation relating to seclusion and restraint, which may also include information concerning PS language barriers. As a result of DOC’s refusal to provide the requested information, DLC was unable to systematically identify and meet with PS with LEP and review documentation of their assessment, treatment, and any seclusion and restraint episodes. DLC has, however, continued to observe and receive reports concerning individual PS with LEP being denied language access in both regular and clinical interactions with staff and being provided inaccessible written materials in English.

The apparent lack of tracking by DOC and Wellpath of PS with LEP alone confirms a continued failure to assess LEP within the BSH population – a necessary preliminary step to providing language access to PS. Of course, identifying a primary language

other than English is not synonymous with identifying LEP. Individuals who do not speak English as their primary language and who have a limited ability to read, speak, write, or understand English can be limited English proficient, or “LEP.” There are many multilingual people who do not have LEP. Unfortunately, consistent with in the July 2022 report, BSH staff are not trained in making assessments of LEP.

DOC and Wellpath have not taken simple steps to improve language access during the intake process or throughout the units in keeping with DLC recommendations. Although in its August 31, 2022 response to DLC’s July 2022 report, DOC stated it would “investigate DLC’s suggestions regarding the posting of multi-lingual signage” of PS rights to language access and to self-identify their language needs in the booking area and on the units, no such signage was posted during this reporting period. In June 2022, Wellpath also informed DLC that additional Voyce tablets were on order so as to be available on each unit. However, as of this reporting period, the Voyce tablets still have not arrived. Because units must still share Voyce tablets, they are not always available to accommodate PS in need of interpretation.

DOC further stated in its August 31, 2022 response that it would work with Wellpath to increase initiatives to recruit bilingual clinicians. However, monthly redacted lists of bilingual personnel provided from July through November 2022 show no increase in bilingual staff. Of the clinicians, only the recovery treatment assistants who speak Haitian-Creole are in sufficient numbers, assuming they are distributed across units and shifts; and depending again on their allocation, RTA’s who speak Spanish may also be sufficient. Three RN’s and two LPN’s speak Haitian-Creole, which may be sufficient for nursing depending upon the unit location of PS with LEP who speak Haitian-Creole. For the most common language need at BSH – Spanish -- there are no clinicians and one Spanish-speaking peer support specialist. Despite this pervasive deficiency, Wellpath job postings reviewed during this reporting period failed to advertise that bilingual skills were even desirable, let alone offer incentives for bilingual candidates to apply.

As of September 8, 2022, the Wellpath PS Race Ethnicity and Primary Language table identified 22 out of 254 individuals at BSH as speaking a language other than English as a primary language. The proportions of PS identified as speaking Haitian-Creole or Spanish as their primary language are far lower than would be expected based on Massachusetts demographic data and reports to DLC. Wellpath staff’s lack of guidance and training in language assessment, discussed in DLC’s July Report, coupled with the continued failure to encourage requests for language access services, likely results in inaccurate data.

For medical care as well as mental health treatment, the need for onsite, trained interpreters is especially great for individuals with psychiatric disabilities and LEP. DLC met with a PS who speaks only Spanish, Andres, whose experience at BSH demonstrates the lack of language access and its consequences:

Using a Voyce tablet, DLC met with PS Andres about two months after his admission to BSH, and subsequently reviewed Andres’ records. Andres was aware of only a few BSH staff who spoke Spanish and did not feel they supported him. Andres recalled only using Voyce tablets and Language Line for treatment; though his record showed an

occasion where a TST was used as a translator. Documentation of his meetings with clinicians showed the limitations of Language Line and Voyce tablets: several days following his admission to BSH, Andres' speech was too low in volume for a Language Line interpreter to support his discussion with a doctor concerning a rash he had had at least since his admission to BSH. As a result, Andres was not assessed for three more days, when a TST was used as an interpreter. That day, a mental health clinician also attempted a mental status exam using Language Line, but again Andres hung his head down and mumbled too softly to be audible over the phone. The mental health clinician terminated the session without assessing Andres.

BSH's failure to provide language access played a marked role in Andres' inability to engage with staff, isolation, and long-term decompensation, and likely contributed to the multiple episodes of restraint, seclusion, and ETO's – episodes that Andres told DLC left him even more fearful. DLC reviewed progress notes in his medical records and video footage of one incident which particularly exhibits how the lack of language access in the intimidating atmosphere of his unit appears to have escalated Andres' discomfort, fear, and agitation. The episode DLC viewed on video ultimately led to seclusion and administration of intramuscular medication. The video footage and notes present the following chain of events:

- Andres meets with the mental health staff supervisor on his unit. According to notes, the supervisor had been able to redirect Andres into the meeting room after he was in an escalated state on the unit. Three TST's and a nurse are also present in the room.
- The supervisor tries to set up a Voyce tablet, but it does not work. Andres becomes escalated again and yells at one of the TST's in the room.
- The supervisor gets an interpreter on the telephone. Andres grabs the phone and, according to the supervisor, yells that he is being kidnapped and asks the interpreter to call the police.
- Staff try to retrieve the phone from Andres. He hangs up and tries to dial 911. Staff place Andres in a manual hold, retrieve the phone, and bring him to a seclusion cell.
- An hour later, after he has calmed down and slept for a time, four TST's enter with a nurse to give him court-ordered medications via intramuscular injection to his buttocks, causing him to bleed.

Andres' difficulty communicating with staff is noted throughout his records; he often appears not to respond to staff. By speaking supportively with Andres in Spanish, the peer support specialist learns that Andres feels threatened and unsafe. The bilingual peer support specialist came to Andres' cell to meet with him for the first time (approximately six weeks after his admission to BSH), observed that he was not responding to staff, and offered to assist Andres with support. The peer support specialist spoke with Andres in Spanish, and Andres told the peer support specialist that he was feeling unsafe and scared. The peer support specialist reassured Andres, who

then took medication offered by staff, became more responsive, and tells the peer support specialist that he feels calmer. Despite the evident help from the peer support specialist, Andres' treatment plan mentions nothing about utilizing bilingual services and supports to help him achieve recovery.

Meaningful treatment and de-escalation in crisis situations, which are all too common at BSH, must be provided by culturally competent clinical staff in an individual's language. The consequence of the low numbers of bilingual staff and onsite professional interpretation cannot be overstated in the unstable environment of BSH's maximum security units.

Without language-accessible services, the Commonwealth subjects BSH PS with LEP to involuntary commitment absent any legitimate promise of meaningful evaluation and treatment in a nontherapeutic environment that may be foreseeably harmful to their physical and mental wellbeing. It is essential that DLC be permitted access to records of PS demographics to fully evaluate language access at BSH, in light of DOC's failure to ensure implementation of DLC's recommendations (restated below) and compliance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d *et seq.* and clear federal and state guidance.

Recommendations:

DOC must resume providing DLC access to information concerning PS race/ethnicity, primary language, and identification as LEP to allow DLC to effectively monitor compliance with DOC's legal requirements to provide language access to PS.

DLC recommends that the Commonwealth immediately place BSH operations under the authority of DMH to ensure that current and future PS with LEP have access to trauma-informed, person-centered mental health treatment. Until this is accomplished, DOC must ensure that Wellpath takes the following steps to ensure universal access:

- **Appoint a Language Access Monitor, who shall oversee and track language access needs;**
- **Train BSH clinical staff to assess English language proficiency;**
- **Post notices in multiple languages of rights to language interpreter and translation services, in the BSH booking/intake area as well as on the units;**
- **Post language cards for PS to identify their language of choice in booking/intake area;**
- **Recruit bilingual clinical staff and train staff in interpretation for mental health services, offering salary enhancements as needed;**
- **Train all BSH staff in cultural competency;**
- **Track the number of PS with LEP and report those numbers to DOC;**
- **Report the number of bilingual staff and languages spoken;**
- **Expand group programming offerings in Spanish, Haitian-Creole, and other languages as needed to suit the needs of the BSH population;**

- Ensure that PS are aware of available programming offerings in various languages;
- Enhance access to Voyce services and video interpretation technologies, including by improving internet access;
- Ensure that all vital documents and therapeutic tools are translated into PS' preferred language, using quality translation services tailored to mental health services;
- Create a grievance process for language access complaints, to be reviewed by the LAM, and a feedback process for PS with LEP to provide comments to the LAM on their access to LEP services.

6. Persons Served Access to Treatment for Co-occurring Substance Use Disorder

It is well-established that mental health issues and substance use disorder (SUD) are often co-occurring. The reality is no different within the walls of BSH. Indeed, dual diagnosis is especially pronounced for individuals deemed to meet the Centers for Medicare & Medicaid Services definition of “serious mental illness” (SMI) – namely, adults, who, at any time during a given year, had a diagnoseable mental, behavioral, or emotional disorder that resulted in functional impairment which substantially interferes with or limits one or more major life activities⁴⁸ – a definition that applies to most, if not all, PS at the time of their admission. In the Northeast region, 44% of those who meet criteria for SMI also have a co-occurring SUD, on par with the national average of 45%.⁴⁹ Given these staggering numbers, the impact of SUD among PS at BSH would be predictably significant, and the need for treatment equally so.

Nevertheless, until December 2022, it is DLC's understanding that BSH had only one (1) Addiction Specialist on staff for several years, although the DOC's contract with Wellpath anticipates having two (2). Given the demand for services, such limited staffing to conduct SUD-related groups, assessments, individual meetings, and Medication Assisted Treatment (MAT) for opioid use disorders appears grossly insufficient to meet the needs of the BSH population.

Unlike many other correctional facilities in Massachusetts, BSH is approved to prescribe and administer MAT, including methadone and suboxone, without any requirement to

⁴⁸ See 42 CFR § 483.102. DLC does not endorse identifying people with lived mental health experience as SMI due to the negative connotation the term carries and the impact such labeling may have, but references it herein as a term of art with legal significance under federal and Massachusetts law.

⁴⁹ See Substance Abuse and Mental Health Services Administration, *Results from the 2021 National Survey on Drug Use and Health: Detailed Tables* (October 2022), at Table 6.6A, Table 6.12A, <https://www.samhsa.gov/data/report/2021-nsduh-detailed-tables>. According to this collection of tables presenting national estimates from the 2021 National Survey on Drug Use and Health, out of 2,079,000 adults who meet SMI criteria in the Northeast, 908,000 have co-occurring SUD and SMI; nationally, 6,376,000 adults have co-occurring SUD and SMI out of 14,087,000 meeting SMI criteria.

partner with MAT clinics in the community for medication delivery. Wellpath reports that an internist is available at all times who assists with management of PS experiencing withdrawal onsite or who need admission to an emergency room. While this gives BSH an advantage in its ability to promptly treat PS transferred from the courts or county correctional facilities who are experiencing opioid withdrawal, PS and staff report challenges with SUD treatment at BSH, including delays and interruptions in MAT administration. Interviews with staff suggest that delays may be due to difficulties obtaining releases of information from the sending institution to confirm PS' prescription history, impacted by the burden placed on existing BSH addiction treatment staff.

During this reporting period, DLC has identified potentially serious issues when it comes to BSH opioid agonist prescribing practices through review of records, shift logs, and interviews with PS. DLC's review suggests that BSH providers may be inappropriately and/or unnecessarily tapering and terminating access to MAT for PS.

DLC is aware of numerous examples of PS requesting that their suboxone be reinstated due to withdrawal symptoms such as anxiety, nausea, and dizziness, as well as PS complaining of withdrawal symptoms in conjunction with self-harming. For instance, according to available records, one PS repeatedly requested suboxone and engaged in serious self-injurious behavior over the course of his first week at BSH after being re-admitted from a community hospital; his requests appeared to be denied on the basis that he received his "last dose" while out at the hospital. During this period, the PS was subjected to physical restraint and an ETO and placed on 1:1 supervision. DLC also interviewed a PS who, despite being in pain on the lower dose of methadone he was prescribed at BSH, was fearful of talking to staff about it because they "always get mad" when he would ask them about medications.

In one particularly alarming saga, a PS described his BSH provider abruptly terminating his prescriptions for consecutive opioid agonists based on his behavior. With each suspension of MAT, his provider reportedly told him that a taper was unnecessary because he would not suffer withdrawal symptoms – in direct contradiction with clear, publicly available information about each medication. Not surprisingly, however, each lengthy interruption in MAT subjected the PS to symptoms of withdrawal. During one period the PS explained feeling so sick and in so much pain from the withdrawal that he began to engage in life-threatening self-harm, and experienced vomiting, shakes, and seizures; he was hospitalized multiple times. The PS also experienced increased restraint, including four-point restraint and ETOs stemming from his withdrawal's effects on his physical and mental state. Finally, at the brink, he was prescribed another medication for his addiction, but he continues to feel deeply outraged and upset by the torturous ordeal.

Complaints DLC has received to date suggest that BSH may be improperly interfering with maintenance of opioid agonist medication for PS who have opioid use disorder and were engaging in MAT prior to their admission in contravention of Title II of the Americans with Disabilities Act.⁵⁰ Such practices may also fail to comport with the MAT

⁵⁰ See, e.g., *Pesce v. Coppinger*, 355 F. Supp. 3d 35, 45-47 (D. Mass. 2018).

program components that DOC committed to providing during the course of an investigation by the U.S. Attorney's Office for the District of Massachusetts.⁵¹ Accordingly, DLC plans to look more closely into the availability and appropriateness of treatment for PS with SUD in the next reporting period. In the meantime, DLC implores DOC and Wellpath to review established BSH practices and the conduct of its individual providers in prescribing and discontinuing MAT.

Recommendations:

DOC must ensure that MAT access and treatment for BSH PS complies with medical standard of care, state and federal antidiscrimination law, and DOC's program for accommodating people with opioid use disorder, as memorialized in the November 4, 2021 letter from the U.S. Attorney's Office.

DOC should immediately conduct an audit of medical records for each PS prescribed MAT at BSH or denied access to MAT upon admission to BSH despite receiving it prior to their arrival. The audit should review the appropriateness of all Wellpath providers' treatment decisions requiring discontinuation or suspension of PS' MAT.

7. Use of Atypical Medication on Persons Served

During this reporting period, Wellpath began touting its utilization of "inhaled Loxitane (ADASUVE) on PS as [pro re nata (PRN)] medication following successful completion of the Risk Evaluation and Mitigation Strategy (REMS)."⁵² ADASUVE is an "atypical antipsychotic indicated for the acute treatment of agitation."⁵³ According to BSH, use of ADASUVE as PRN medication for PS would be recorded in individual patient records alone. As DLC does not have complete access to nor the capacity to review every PS progress note, we have not been able to discern how commonly this medication has been used. DLC is nevertheless deeply concerned.

Although the Food and Drug Administration (FDA) approved ADASUVE in 2012, to DLC's knowledge, its use is not very common in Massachusetts facilities. Per Wellpath,

⁵¹ See U.S. Department of Justice, U.S. Attorney Rollins Announces Correctional Facilities Statewide to Maintain All Medications for Opioid Use Disorder (April 1, 2022), <https://www.justice.gov/usao-ma/pr/us-attorney-rollins-announces-correctional-facilities-statewide-maintain-all-medications> (linking to a letter of resolution with DOC outlining a program that: does not change or discontinue a medication to treat opioid use disorder "except upon an individualized determination made by a qualified specialist that the treatment is no longer appropriate based on the person's condition"; does not use incentives, rewards, or punishments to encourage or discourage a person to receive any particular medication to treat opioid use disorder; and does not deny health or drug rehabilitation services based on an individual's current illegal use of drugs if the person is otherwise entitled to such services.).

⁵² BSH Governing Body Meeting Department Report: Seclusion and Restraint (December 2022).

⁵³ ADASUVE, *Instructions for Using ADASUVE*. (January 2022), <https://www.adasuve.com/administration.aspx>.

BSH “is pleased to be one of the few hospitals in the Commonwealth that offers this treatment and underscores our commitment to staying at the forefront of patient care.”⁵⁴ The rare utilization of ADASUVE is likely, at least in part, due to the significant health risks associated with its use in certain populations. Specifically, use of ADASUVE is associated with an increased risk of pulmonary toxicity, primarily bronchospasm, that can lead to respiratory distress or arrest and increased mortality in elderly patients with dementia-related psychosis.⁵⁵ As a result, it is contraindicated for individuals with a diagnosis or history of asthma, chronic obstructive pulmonary disease, or other lung diseases, patients experiencing acute respiratory symptoms (e.g., wheezing), and aging individuals with dementia.⁵⁶

In recognition of the risks, the FDA determined that a REMS is necessary to ensure that the benefits of treatment with ADASUVE outweigh the risks of bronchospasm.⁵⁷ The REMS requires that health care settings seeking to dispense ADASUVE are specially certified to meet these requirements: (1) “must have immediate access on-site to equipment and personnel trained to provide advanced airway management, including intubation and mechanical ventilation;” (2) “be equipped to provide immediate access on-site to a metered-dose inhaler and nebulizer for a short-acting beta agonist bronchodilator (e.g. albuterol); (3) must “screen patients, prior to treatment with ADASUVE, for a current diagnosis or history of asthma, COPD, other lung disease, acute respiratory signs/symptoms, and examine patients for respiratory abnormalities; (4) must train relevant staff on the safe use of ADASUVE.”⁵⁸ Certified healthcare settings must have a short-acting bronchodilator (e.g. albuterol) available for the immediate treatment of bronchospasm; this short-acting bronchodilator can be delivered by inhaler (with spacer) or nebulizer. If BSH has indeed demonstrated compliance with the REM requirements, it is unclear how. BSH is not a licensed hospital and, to DLC’s knowledge, does not have the capacity provide immediate access to intubation and mechanical ventilation onsite.

DLC believes that use of medication on PS at BSH is not the medical standard in the Commonwealth and exploits the vulnerable population of PS who are already contending with complex mental health needs in a prison facility that does not offer a therapeutic milieu or a choice of providers. Given the mold and other environmental hazards at BSH that may impact PS respiratory health and the often-cursory medical screening that occurs upon PS admission to BSH, DLC recommends the immediate removal of ADASUVE from the formulary of medications that may be prescribed to PS.

⁵⁴ BSH Governing Body Meeting Psychiatry, Medicine and Dental Report (December 2022).

⁵⁵ ADASUVE, *Important Safety Information*, <https://www.adasuve.com/default.aspx>.

⁵⁶ *Id.*

⁵⁷ Center For Drug Evaluation and Research, *Application Number: 022549Orig1s000 – Risk Assessment and Risk Mitigation Reviews*, https://www.accessdata.fda.gov/drugsatfda_docs/nda/2012/022549Orig1s000RiskR.pdf.

⁵⁸ Center For Drug Evaluation and Research, *Application Number: 022549Orig1s000 – REMS*, https://www.accessdata.fda.gov/drugsatfda_docs/nda/2012/022549Orig1s000REMS.pdf (12/24/2022).

Recommendations:

DLC recommends that DOC require Wellpath to cease use of ADASUVE on PS due to the increased risks of bronchospasm and contraindications for people with underlying respiratory conditions and aging individuals with dementia.

Whether or not use of ADASUVE is terminated, DLC recommends that Wellpath provide each PS regular health screenings to determine whether they are experiencing symptoms of mold and environmental toxin exposure.

8. Limitations on Persons Served Access to Medical Care

DLC's and PS' concerns about PS difficulties accessing medical care are ongoing. From requesting care and getting an appointment with onsite medical staff, to receiving test results and follow-up after a procedure or specialist consultation, PS report lack of communication and delayed care. At the same time, the persistent presence of environmental toxins throughout BSH makes reliable access to medical care all the more important.

DOC and Wellpath have not implemented DLC's recommendations from our 2022 reports to enhance access to care by providing an additional accessible avenue for PS to request medical evaluation and treatment, such as the written sick call slips used in other DOC facilities and county correctional facilities. However, since April 2022, Wellpath did increase PS access to the BSH PS Advocate by allowing PS to make complaints by phone, rather than only via written complaints. Calls to PS Advocate have increased steadily each month. This suggests that PS needs are not being met by seeking care through the current process that requires reliance on nursing staff, mental health staff, TSTs, and other Wellpath personnel who they interact with on their units to convey their concerns to the medical clinic in Lighthouse. The high demand for the lone PS Advocate's assistance also indicates that Wellpath should increase staffing and the authority of the PS Advocate office.

Recommendations:

DOC and Wellpath must provide more avenues for PS to access medical services to ensure that the process is accessible to all PS, including PS with LEP and PS with disabilities that impact their communication abilities.

DLC recommends that DOC and Wellpath adopt a process that allows PS to submit a written request for evaluation and treatment of medical issues directly to a designated member of medical staff.

DLC recommends increasing staffing and the authority of the PS Advocate office to allow the PS Advocate to efficiently address concerns and advocate for PS at BSH.

9. Persons Served Continuity of Care

With the expanded role granted by Line Item #8900-001, DLC continued to review discharges from BSH and the transfer of individuals to DOC facilities, county correctional facilities, and DMH facilities, through site visits and discussions with current and former PS, BSH staff and administrators, Sheriff's Department staff and administrators, and family and friends of PS. During this reporting period, in addition to site visits to BSH and the OCCC Units, DLC conducted site visits at Middlesex Jail & House of Correction, and four (4) DMH Hospitals – Worcester Recovery Center and Hospital, Lemuel Shattuck Hospital, the Solomon Carter Fuller Mental Health Center and Vibra Hospital.

Consistent with interviews during previous reporting periods, most former PS report to DLC that they were told several days prior to their discharge that they would be leaving BSH regardless of whether they were headed to a DMH hospital or a county correctional facility. A few had more lead time, but many others were told the day of their transfer. PS leaving OCCC BSH Units reported generally being notified of their transfer on the day it occurs. The vast majority of former PS still report that they were not invited to any meetings to discuss discharge, ask questions, or learn about what to expect. Many felt this would have helped facilitate a successful transition. DLC concurs.

As discussed below, many impediments to continuity of care for former PS remain unchanged since DLC's last report. DOC, Wellpath, and DMH should work collaboratively to try to address them and mitigate the negative impact on former PS.

A. Continuity of Care: DMH Hospitals

i. Challenges with Facilitating BSH Transfers

"Second Shift Arrivals"

DMH hospital administrators continue to emphasize the challenges of "second shift arrivals" – BSH PS who are transferred to DMH facilities in the late afternoon or evening. This ongoing systemic issue originated with the adoption of virtual court during the COVID-19 pandemic, and the resulting later signing of commitment papers. When PS arrive at DMH facilities after their designated treatment team has already ended their shift – and there is less psychiatric or clinical support available – there are a number of downstream effects. Accommodating second shift arrivals places undue stress on on-call doctors, staff morale, and the PS, who have to go through the intake process twice – upon entry intake again the next day with the staff they will be working with during their admission. In the midst of chronic understaffing at many DMH hospitals, this is particularly burdensome.

Clinical Coordination and Documentation

Difficulty obtaining PS records from BSH continues to pose an obstacle for DMH hospitals seeking to ensure a successful transition for transferred PS. While hospitals typically receive lengthy forensic reports ahead of PS arrival, it is difficult to find the necessary information in them. On top of this, court-ordered *Rogers* treatment plans

and Discharge Summaries often do not arrive prior to PS arrival – both of which DMH hospital administrators cite as being extremely helpful to the transition process when included and potentially harmful when omitted. Receiving facility access to crucial information about PS prior to their arrival must be a priority.

Patient Funds

DMH Hospital administrators and many BSH PS who have stepped down to DMH hospitals all complain of continued difficulty with the transfer of patient funds. PS transferred to DMH facilities have expressed deep frustration with money that never followed them from BSH - money that they could use to buy needed or desired items and save to assist in their transition back to the community upon discharge.

Benefits

As discussed in our last report, DMH hospital administrators with whom DLC spoke during this reporting period continue to report difficulties in helping transferred BSH PS obtain MassHealth benefits. PS arrive at DMH facilities with their status having not been updated to reflect that they are no longer incarcerated, and thus eligible for full MassHealth benefits. Depending on the PS, this may indicate failings in MassHealth's timely processing of status change, a District Court issue, an issue with how BSH is handling discharge, or some combination thereof. In any event, it may result in delays in continued medical and dental care for PS upon arrival at DMH hospitals and delayed discharge due to lack of health coverage.

ii. Experiences in DMH Hospitals for Transferred BSH PS

Individuals transferred from BSH to DMH hospitals find their DMH experiences to be an improvement from BSH in most ways. Former PS whom DLC interviewed described cleaner environments with better food, better living quarters, improved medical care, and more privileges, such as electronics and the ability to order outside food. Others felt they were learning skills for the real world to prepare them for discharge, which is not a component of BSH care.

Despite these positive comparisons to BSH, some former PS also complained of feeling bored, depressed, and dissatisfied with the lack of access to fresh air and off-unit activities, such as the large gym and library offered at BSH. Former PS described DMH facilities as being restrictive – one patient said only 5 people on his unit of 25 patients were approved to go to the gym. One former PS also expressed that he felt that as a result of the stigma carried by former BSH PS, staff were notably nervous around him and the only person who would speak to him was his psychiatrist.

Limited access to fresh air and opportunities for community integration since the COVID-19 pandemic continue to be areas of concern in DLC's Continuity of Care

monitoring, as they are integral to former PS building independence and receiving services in the most integrated setting appropriate.⁵⁹

Former PS report that access to outdoor time varies, with time(s) of day and duration based on staff availability. Contained outdoor spaces may be closed if there is insufficient staffing. Up to 30 minutes twice a day of outdoor time continues to be the norm across facilities, which former PS find insufficient. There is, however, significant variation even within some facilities. For instance, PS at Lemuel Shattuck Hospital describe getting out for supervised walks in Franklin Park three (3) times per day, while others did not get walks in Franklin Park at all— and didn't know they were entitled to outdoor access. One former PS who wanted more outdoor time said they had been at their DMH facility for two (2) months and still had not been approved to use the gym or go to the outdoor "healing garden." In addition, multiple PS have described their fresh air privileges being taken away as punishment – one described not being allowed to go outdoors for days after he punched objects in his room out of frustration.

The opportunities available for community integration that were available pre-COVID yet to return. Many PS reported being at their current DMH facilities for months and receiving no access to the world outside of the facility. PS reminisced about 30- and 60-minute day pass privileges that used to exist. One DMH hospital administrator explained that they have instituted regular "supervised community walks" with groups of PS as well as supervised individual trips to the bank, the Department of Motor Vehicles, and to do other discharge-related activities. However, individual unsupervised passes are still being limited due to COVID concerns. While this incremental approach to "opening up" makes some sense, it has moved too slowly. Since the Commonwealth's declarations about the end of the public health emergency and the availability of COVID-19 screening processes, DMH's use of COVID-19 as a justification for suspending community activities and individual passes. The "new normal" for individuals in psychiatric facilities should not be to strictly limit their access to community activities that promote successful discharge.

B. Continuity of Care: County Correctional Facilities

i. Middlesex Emergency Stabilization Unit

During this past reporting period, DLC visited the Middlesex County House of Correction (MHOC) to take a tour, focusing on its Emergency Stabilization Unit (MESU), the Regional Mental Health Stabilization Unit operated by the Middlesex Sheriff's office. This facility serves an intended catchment area of the eastern counties of Barnstable, Bristol, Dukes County, Essex, Nantucket, Middlesex, Norfolk, Plymouth, and Suffolk.⁶⁰ DLC received a tour of the facility, met with former BSH PS, and spoke extensively with administrators to learn about the various challenges faced by transferred PS and the quality of care at the facility.

⁵⁹ While reasonable access to the outdoors is a fundamental right of patients in DMH facilities, there is no defined amount of time that constitutes minimum reasonable access M.G.L. c. 123, §23.

⁶⁰ Massachusetts FY 2022 Budget, Line Item #8910-1101, *Middlesex Sheriff's Mental Health Stabilization Unit*.

The MESU operates within, and shares space with, MHOC's Health Services Unit, which has a total of twenty-two (22) beds. Prisoners on the MESU live in either in one of eight (8) single cells or one of two (2) dorm cells that house about six (6) people each. According to staff, patients on the MESU will often move to the dorms to acclimate to group living prior to being transferred back to general population. The MESU has nursing coverage twenty-four (24) hours per day, daily clinician rounds, and access to clinicians via sick call slips or in response to crises. Multidisciplinary meetings are held daily to discuss the needs of the MESU, participation in treatment and programming, and programming to foster transition to the general population. Cell checks are conducted roughly every ten (10) minutes, and utilize "Guard 1," an automated wand system that allows staff to automatically time stamp each cell check using a sensor on the door. Inmates on the MESU receive regular outdoor recreation time.

Transfers to MESU come from within MHOC and other facilities in the catchment area for a variety of reasons such as suicide watch, mental health crises, and issues with medication compliance or changes. According to MESU staff, prisoners transferred from within MHOC often only stay a few days; those from other facilities stay is no less than two (2) weeks. While the MESU is meant in part to alleviate flow of patients to BSH, staff explained that individuals experiencing a 'psychotic break' who might require involuntary medication to start or stabilize on a new regimen will likely be sent to BSH. MESU is also used for patients returning to MHOC from BSH, where mental health staff can support them in readjusting to a penal environment. Because it houses the MESU, MHOC is responsible for a higher percentage of transfers to BSH than any other county.

When individuals return to MHOC from BSH, administrators report receiving a few days' notice and having no issue obtaining records due to Inter-Facility Case Conferences. However, as with other county correctional facilities, when individuals are sent by the court back to MHOC after a competency evaluation at BSH, obtaining records is significantly more burdensome and can hamper the ability to provide informed care. MHOC also receives very little notice in these cases, making the transition difficult for new inmates and staff alike.

Beyond the MESU, MHOC appears to be proactive in its provision of mental health programming and attention to inmate health compared to other county facilities. Administrators reported that roughly 50% of the population at MHOC has an open mental health case, in part, due to MHOC mental health staff input into the classification process facility-wide, ensuring that a range of risk factors that might lead to victimization are taken into account when determining a prisoner's status. MHOC also has a 50-bed dorm unit designated for individuals with mental health diagnoses. Administrators reported their efforts to pilot an innovative Expressive Digital Imagery program as a therapeutic intervention in that unit.

MHOC also uses a digital sick call system to increase ease and speed of access to medical services. Inmates may use their unit kiosks to submit digital sick call slips directly to nursing. According to MHOC staff, these submissions are then reviewed daily from 3p-11p by nurses at the facility with a 24-hour turnaround time for follow up. While MHOC still utilizes paper sick call slips as well, this sort of alternative allows for a broader range of inmates to access care and have their needs met.

Former BSH PS at MHOC reported that the mental health services at MHOC are better quality, more frequent, and more prompt than at BSH. One said there was more library time, more outdoor time, and more interaction in general at MHOC. In addition, they commended their access to staff at MHOC, particularly to administrators, whereas at BSH, said one person, “whoever was higher up, you never see that person.”

ii. Varying Access to Behavioral Health Treatment Across County Correctional Facilities

Both former and current BSH PS describe an overall lack of meaningful mental health treatment as well as limited contact with clinicians and doctors in county correctional facilities. While some describe mental health services as superior to those provided at BSH, the level of care is not sufficient to treat many of the high acuity individuals who may end up at BSH. In even the best-equipped environments in county correctional facilities, like the Emergency Stabilization Unit at Middlesex Jail & House of Correction, mental health contacts and interventions appear designed to focus on observation, de-escalation, and maintaining physical safety (including suicide prevention), rather than therapy. And, in the worst environments, this containment of behaviors is achieved by subjecting individuals to harsh conditions of confinement on Mental Health Watch. This practice, as noted in DLC’s last report has a chilling effect on prisoners reporting mental health distress and talking about their feelings— without the fear of being forced into “treatment” that feels distinctly like punishment.

During this reporting period, one PS described his traumatic experience on Mental Health Watch at the Plymouth County Correctional Center.⁶¹ He was placed in a Mental Health Watch cell – a cell with rubberized walls and floor that is bare but for a drain in the middle of the floor – for thirteen (13) days in the fall of 2022. During that time, he reported having access only to an anti-suicide smock for clothing and the drain in the floor as his toilet while his mental health declined further due to the conditions and dehydration resulting from his limited food and water intake. As of the date of the interview, which took place at a DMH hospital, the PS was still having flashbacks to his traumatic Mental Health Watch experience.

The Commonwealth must ensure that all individuals with psychiatric diagnoses in the custody of county correctional facilities have access to meaningful behavioral health care and are not subjected to inhumane conditions while on Mental Health Watch. DMH, in conjunction with Sheriff’s Departments, should devise uniform minimum standards concerning access to mental health treatment for individuals in general population and on Mental Health Watch at county correctional facilities, and minimum standards for conditions of confinement in Mental Health Watch cells.⁶²

⁶¹ DLC visited the Plymouth County Correctional Center as part of continuity of care monitoring during the last reporting period and observed cells fitting this description while vacant.

⁶² With respect to Restrictive Housing (RH), DMH already bears responsibility for: consulting with DOC to promulgate clinical standards concerning contraindications for placement in RH; providing some “supervision” of the provision of clinically indicated medical and psychiatric treatment and periodic mental and physical examinations to persons in RH. See M.G.L. c. 127, § 39. Notably, Chapter 127, § 39 also

C. Continuity of Care: OCCC Units

During this reporting period, DLC's monitoring of continuity of care for PS in the OCCC units revealed little progress by DOC and Wellpath in addressing the issues we identified within these units in previous reports.

To recap, the OCCC Units – the ISOU, where PS are held during the evaluation period, and the RU for PS who have been committed to BSH – were designed to serve as an annex to BSH for PS who are sentenced state prisoners living in DOC facilities designated for men. Both units are controlled by DOC correctional officers, rather than Wellpath security; in the ISOU, PS reports that these officers interfere with Wellpath staff performing their duties and escalate conflict in the unit. The ISOU also provides very limited contact with mental health clinicians and limited access to programming. Taken together, ISOU conditions generally fail to promote positive outcomes for PS, most of whom are not committed to the RU after the completion of their observation periods and clinical evaluations.

There was, however, recent external progress that may greatly improve continuity of care for PS leaving the ISOU. On December 20, 2022, the U.S. Department of Justice (DOJ) publicly announced its Settlement Agreement with DOC concerning conditions of confinement for prisoners in mental health crisis.⁶³ In November 2020, DOJ issued findings that DOC's failure to provide adequate mental health care and supervision to prisoners in mental health crisis constitutes an Eighth Amendment violation.⁶⁴ The Agreement includes key provisions to protect prisoners on Mental Health Watch – a common status for DOC prisoners who engage in self-harm and suicide attempts and end up temporarily in the ISOU for evaluation and observation – including:

- **Creation of an Intensive Stabilization Unit (ISU) within eighteen (18) months.** The purpose of the ISU is “to provide intensive stabilization for prisoners unable to effectively progress with placement on Mental Health Watch or general population due to serious mental illness or marked behavior dysregulation.” ISU treatment is intended for prisoners who do not meet the statutory criteria for inpatient commitment to the RU, “but who have been on Mental Health Watch and are clinically appropriate for a higher level of care.” The focus of treatment in the ISU will be “to address immediate clinical needs in an intensive environment restoring safety and stabilizing symptoms while working with the prisoner to identify treatment needs to maintain in a non-ISU

established standards for RH conditions, including access to meals, showers, visitation and communication, and compliance with applicable Department of Public Health regulations. *Id.*; 105 CMR 451 (“Minimum Health and Sanitation Standards and Inspection Procedures for Correctional Facilities”).

⁶³ DOJ, *Justice Department Secures Agreement with Massachusetts Department of Correction Investigation Involving Individuals in Mental Health Crisis* (December 20, 2022), <https://www.justice.gov/opa/pr/justice-department-secures-agreement-massachusetts-department-correction-investigation>.

⁶⁴ 4 U.S. Department of Justice, *Investigation of the Massachusetts Department of Correction* (November 17, 2020), <https://www.justice.gov/opa/press-release/file/1338071/download>. Per DOJ's findings, looking only “between July 1, 2018 and August 31, 2019, there were 217 instances of cutting, 85 instances of prisoners inserting objects into their bodies, 77 attempted hanging incidents, 34 instances of ingestion of foreign bodies, and 17 attempted asphyxiations, all on mental health watch.” *Id.* at 5-6.

environment.” Prisoners in the ISU will have individualized treatment plans, an assigned stabilization clinician from the ISU treatment team, daily documented clinician evaluations, access to Support Persons between clinical interactions, opportunities for group programming, access to a therapeutic de-escalation area, and recreation, among other things;⁶⁵

- **Development and Approval of annual staffing plans.** The plans are intended “to ensure that there are a sufficient number of security staff and mental health staff to provide meaningful supervision and/or therapeutic interventions to prisoners in mental health crisis.” Plans must account for the supervising clinician for the ISU; an increase in mental health staffing as needed; sufficient security staff to facilitate access to programming covered by the Agreement and to permit rotation every two (2) hours for those assigned to Constant Observation Watch – the highest Mental Health Watch status;⁶⁶
- **Enhanced access to and documentation of mental health care on Mental Health Watch.** Requirements, to be implemented within one (1) year, include three (3) daily out-of-cell mental health contacts; access to “meaningful therapeutic interventions, including regular, consistent out-of-cell therapy and counseling, in group and/or individual settings, as clinically appropriate”;⁶⁷
- **Prohibition of use of Mental Health Watch as a punishment, for the convenience of staff, or when less restrictive means may be clinically appropriate;**⁶⁸
- **Development and implementation of a cell checklist for security to ensure that the cell is free from potential hazards prior to placing a prisoner in the cell;**⁶⁹
- **Documentation of individualized crisis treatment plans upon initiation of Mental Health Watch;**⁷⁰
- **Minimum standards and documentation requirements concerning conditions of Mental Health Watch.** Conditions include access to clothing, showers, property, and exercise;⁷¹ and
- **Enhanced data tracking as part of a quality assurance program.** DOC’s contracted healthcare vendor must engage in a quality assurance program to

⁶⁵ See Agreement Between the United States and the Massachusetts Department of Correction (December 20, 2022), at paras. 113-135, <https://www.justice.gov/opa/press-release/file/1558976/download>.

⁶⁶ *Id.* at paras. 32-37.

⁶⁷ See *id.* at paras. 66-76.

⁶⁸ See *id.* at para. 51.

⁶⁹ See *id.* at para. 55.

⁷⁰ See *id.* at para. 52.

⁷¹ See *id.* at paras. 56-65.

identify and correct “deficiencies with the provision of supervision and mental health care to prisoners in mental health crisis.”⁷²

DLC looks forward to seeing how implementation of the terms of this Agreement, under the watchful monitoring of accomplished Designated Qualified Expert Dr. Reena Kapoor positively impacts the lives of PS and other individuals with behavioral health conditions in DOC custody.

Recommendations:

DLC recommends that DOC, Wellpath, and DMH work together and with the court system to facilitate first shift arrivals for BSH PS discharged to DMH hospitals, as well as the timely transfer of important PS documents for continuity of care, such as court-ordered treatment plans and discharge summaries.

DLC strongly urges DMH to take the necessary steps to ensure daily access to the outdoors of at least two (2) hours per day, weather permitting, and provide increased opportunities for community integration for individuals receiving services in DMH hospitals.

DLC recommends that DOC and Wellpath take the necessary steps to ensure that, upon discharge, MassHealth is promptly notified of any change in incarceration status and PS funds are transferred in a timely manner to receiving facilities.

DMH resources should be committed to further DMH engagement with all county correctional facilities to enhance access to mental health care for all county prisoners, including recently discharged BSH PS. Such engagement should include enforcing minimum standards, promoting best practices, and creating working groups to ensure a collaborative approach to care and responsiveness to the needs of this population.

DOC and Wellpath must improve access to mental health clinicians and therapeutic programming in the ISOU to break the cycle of self-harm, ISOU evaluation, discharge and repeat for prisoners with serious behavioral health conditions deemed to not meet the commitment standard.

DLC recommends that the care of all individuals found to need “strict security” for psychiatric evaluation and/or treatment be placed under the DMH. Based on DLC’s observations, maintaining DOC’s control over BSH will foreseeably permit variation in both quality of care and compliance with legal requirements.

⁷² *Id.* at paras. 137-139.

10. Other Important Issues DLC Is Following

- Treatment of Transgender PS and Compliance with the Requirements of M.G.L. c. 127, s. 32A
- Applicability of and BSH Providers' Compliance with Requirements Related to Safety Review Via Institutional Review Board of Human Research Studies Using PS as Subjects
- PS Access to Disability-Based Accommodations and Deficiencies with the BSH Reasonable Accommodation Policy
- PS Access to Chaplain and Religious Programming

Conclusion

Based upon the discussion above, DLC calls upon DOC, Wellpath, DMH, and the Commonwealth to follow the recommendations discussed above and restated below to protect the health, safety, and rights of current and former PS.

DISABILITY LAW CENTER RECOMMENDATIONS

Continuing Physical Plant Health and Safety Risks

Without further delay, DOC must completely remediate mold and complete asbestos abatement throughout BSH in accordance with expert recommendations and industry standards.

Until DOC provides information evidencing that the health and safety risks have been resolved, DOC and Wellpath BSH must provide regular health screenings for symptoms of mold and environmental toxin exposure to all PS and staff, provided by a contracted health professional with expertise in the area.

DLC recommends that DOC and Wellpath improve sanitation practices in all areas of BSH to prevent rodent and insect infestations.

DOC must devise more effective heat mitigation protocols to ensure that PS are more comfortable and do not suffer serious health complications or death in high temperatures.

DLC recommends that the Commonwealth protect the health of individuals confined to, working in, and visiting BSH by committing to shutter BSH and construct a modern facility designed to provide all individuals in need of "strict security" psychiatric evaluation and/or treatment in a safe, therapeutic environment.

The Commonwealth must immediately place BSH operations as well as the planning, construction, and oversight of the new facility under the authority of DMH to ensure

current and future PS access to trauma-informed, person-centered mental health treatment.

Illegal and Unreported Restraint and Seclusion

DOC must immediately resume providing DLC access to complete information and documentation of uses of restraint and seclusion and PS race/ethnicity to allow DLC serve its vital functions under Line Item #8900-001 and as the Commonwealth's Protection and Advocacy agency.

DOC and Wellpath must immediately cease imposition of chemical restraint, including ETOs, physical restraint, and seclusion in circumstances that do not meet the narrowly tailored dictates of M.G.L. c. 123, § 21.

The Commonwealth must demand that DOC and Wellpath accurately document and report all uses of chemical restraint, physical restraint, and seclusion in keeping with applicable law and engage DMH or another external party to conduct an in-depth investigation into BSH practices.

DLC recommends that, to fully address the restraint and seclusion practices to which PS are subjected, the care of all individuals found to need "strict security" for psychiatric evaluation and/or treatment must be placed under the DMH. Based on DLC's observations, maintaining DOC's control over BSH will foreseeably permit variation in both quality of care and compliance with legal requirements.

All policies and practices concerning the involuntary medication, restraint, and seclusion of PS should be amended to conform with DMH regulations and policies, including provisions regarding staff training requirements, tracking less restrictive alternatives, de-escalation efforts, debriefing with PS, and accurately reporting all restraint and seclusion to the Commissioner.

De-escalation Practices, Training, and Culture

DLC recommends that Wellpath revise the BSH Mandt trainings in the following respects: hire an experienced external Mandt training to train new and retrain existing BSH staff; incorporate Peer Support Specialists into the training program; introduce role play de-escalation exercises into the recertification program; and emphasize trauma-informed understanding of each staff member's role and of restraint, seclusion, and involuntary medication.

Wellpath must protect PS by adopting policies requiring: immediate termination, upon confirmation through video footage, of staff using unnecessary and/or disproportionate force on PS; and suspension and/or complete separation from the PS alleged victim throughout the course of all investigations into accusations against staff for using unnecessary or disproportionate force on PS.

DLC recommends that DOC and Wellpath provide more oversight and support for BSH staff by developing a system for staff to confidentially share their concerns about

coworkers' performance to BSH administrators, and for those concerns to be addressed.

DLC recommends that Wellpath prioritize the hiring of additional Peer Support Specialists and commit to their increased utilization in de-escalation, in 1-1 peer support assignments with Persons Served, and as dedicated Peer Support group facilitators.

Insufficient Language Access for Persons Served

DOC must resume providing DLC access to information concerning PS race/ethnicity, primary language, and identification as LEP to allow DLC to effectively monitor compliance with DOC's legal requirements to provide language access to PS.

DLC recommends that the Commonwealth immediately place BSH operations under the authority of DMH to ensure that current and future PS with LEP have access to trauma-informed, person-centered mental health treatment. Until this is accomplished, DOC must ensure that Wellpath takes the following steps to ensure universal access:

- Appoint a Language Access Monitor, who shall oversee and track language access needs;
- Train BSH clinical staff to assess English language proficiency;
- Post notices in multiple languages of rights to language interpreter and translation services, in the BSH booking/intake area as well as on the units;
- Post language cards for PS to identify their language of choice in booking/intake area;
- Recruit bilingual clinical staff and train staff in interpretation for mental health services, offering salary enhancements as needed;
- Train all BSH staff in cultural competency;
- Track the number of PS with LEP and report those numbers to DOC;
- Report the number of bilingual staff and languages spoken;
- Expand group programming offerings in Spanish, Haitian-Creole, and other languages as needed to suit the needs of the BSH population;
- Ensure that PS are aware of available programming offerings in various languages;
- Enhance access to Voyce services and video interpretation technologies, including by improving internet access;
- Ensure that all vital documents and therapeutic tools are translated into PS' preferred language, using quality translation services tailored to mental health services;
- Create a grievance process for language access complaints, to be reviewed by the LAM, and a feedback process for PS with LEP to provide comments to the LAM on their access to LEP services.

Persons Served Access to Treatment for Co-occurring Substance Use Disorder

DOC must ensure that MAT access and treatment for BSH PS complies with medical standard of care, state and federal antidiscrimination law, and DOC's program for

accommodating people with opioid use disorder, as memorialized in the November 4, 2021 letter from the U.S. Attorney's Office.

DOC should immediately conduct an audit of medical records for each PS prescribed MAT at BSH or denied access to MAT upon admission to BSH despite receiving it prior to their arrival. The audit should review the appropriateness of all Wellpath providers' treatment decisions requiring discontinuation or suspension of PS' MAT.

Use of Atypical Medication on Persons Served

DLC recommends that DOC require Wellpath to cease use of ADASUVE on PS due to the increased risks of bronchospasm and contraindications for people with underlying respiratory conditions and aging individuals with dementia.

Whether or not use of ADASUVE is terminated, DLC recommends that Wellpath provide each PS regular health screenings to determine whether they are experiencing symptoms of mold and environmental toxin exposure.

Limitations on Persons Served Access to Medical Care

DOC and Wellpath must provide more avenues for PS to access medical services to ensure that the process is accessible to all PS, including PS with LEP and PS with disabilities that impact their communication abilities.

DLC recommends that DOC and Wellpath adopt a process that allows PS to submit a written request for evaluation and treatment of medical issues directly to a designated member of medical staff.

DLC recommends increasing staffing and the authority of the PS Advocate office to allow the PS Advocate to efficiently address concerns and advocate for PS at BSH.

Persons Served Continuity of Care

DLC recommends that DOC, Wellpath, and DMH work together and with the court system to facilitate first shift arrivals for BSH PS discharged to DMH hospitals, as well as the timely transfer of important PS documents for continuity of care, such as court-ordered treatment plans and discharge summaries.

DLC strongly urges DMH to take the necessary steps to ensure daily access to the outdoors of at least two (2) hours per day, weather permitting, and provide increased opportunities for community integration for individuals receiving services in DMH hospitals.

DLC recommends that DOC and Wellpath take the necessary steps to ensure that, upon discharge, MassHealth is promptly notified of any change in incarceration status and PS funds are transferred in a timely manner to receiving facilities.

DMH resources should be committed to further DMH engagement with all county correctional facilities to enhance access to mental health care for all county prisoners,

including recently discharged BSH PS. Such engagement should include enforcing minimum standards, promoting best practices, and creating working groups to ensure a collaborative approach to care and responsiveness to the needs of this population.

DOC and Wellpath must improve access to mental health clinicians and therapeutic programming in the ISOU to break the cycle of self-harm, ISOU evaluation, discharge and repeat for prisoners with serious behavioral health conditions deemed to not meet the commitment standard.

DLC recommends that the care of all individuals found to need “strict security” for psychiatric evaluation and/or treatment be placed under the DMH. Based on DLC’s observations, maintaining DOC’s control over BSH will foreseeably permit variation in both quality of care and compliance with legal requirements

Appendix A: Glossary of Acronyms Used in the Report

BSH	Bridgewater State Hospital
DLC	Disability Law Center
DMH	Department of Mental Health
DOC	Department of Correction
DOJ	U.S. Department of Justice
ETO	Emergency Treatment Order
IM	Intramuscular
ISOU	Intensive Stabilization and Observation Unit in the Bridgewater Annex located at Old Colony Correctional Center
ISU	Intensive Stabilization Unit
LEP	Limited English Proficiency
MAT	Medication Assisted Treatment
MESU	Middlesex Emergency Stabilization Unit
MHOC	Middlesex County House of Correction
NEO	New Employee Orientation
OCCC	Old Colony Correctional Center
PS	Person(s) Served
RH	Restrictive Housing
RU	Residential Unit in the Bridgewater Annex located at Old Colony Correctional Center
SMI	Serious Mental Illness
SUD	Substance Use Disorder
TST	Therapeutic Safety Technician

Appendix B: Department of Correction Response to July 2022
Disability Law Center Report on Bridgewater State Hospital
(August 31, 2022)



The Commonwealth of Massachusetts
Executive Office of Public Safety & Security

Department of Correction
50 Maple Street, Suite 3
Milford, MA 01757
Tel: (508) 422-3300
www.mass.gov/doc

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

TERRENCE M. REIDY
Secretary



CAROL A. MICI
Commissioner

SHAWN P. JENKINS
Chief of Staff

KELLEY J. CORREIRA
PATRICK T. DEPALO, JR.
ROBERT P. HIGGINS
MITZI S. PETERSON
THOMAS J. PRESTON
Deputy Commissioners

August 31, 2022

Barbara L'Italien
Executive Director
Disability Law Center
11 Beacon Street, Suite 925
Boston, MA 02108

Re: Disability Law Center July 2022 Report on Bridgewater State Hospital

Dear Director L'Italien:

I write in response to the Disability Law Center's (DLC) July 2022 report on Bridgewater State Hospital (BSH), the Commonwealth's mental health facility for providing care to male patients who require strict security hospitalization. The Department of Correction (DOC) remains in disagreement with DLC's arguments that the DOC has been unsuccessful in its response to environmental hazards in the facility and has been providing Persons Served at BSH with unlawful and substandard medical and mental health care.

Bridgewater State Hospital's Physical Plant

In its July report, DLC renews its call for the construction of a new hospital facility and criticizes DOC's ongoing work to ensure that the existing BSH facility provides a safe environment for Persons Served and BSH staff. In my March 23, 2022 letter responding to DLC's earlier statement of concerns regarding the BSH physical plant, I identified DOC's program of remediation work then underway to address concerns with mold in the facility and other, continuing investments in the BSH physical plant. Since that time, DOC, the Commonwealth's Division of Capital Assets Management and Maintenance (DCAMM), and the DOC Ombudsman's Office have continued to work to address these concerns. The DLC July report objects that DOC's program does not directly track the recommendations and findings of Gordon Mycology, the vendor that DLC worked with in highlighting its concerns. This is not a substantive finding of fault: DOC's decision to use experts other than those chosen by DLC does not in any way evidence a failure to maintain a safe and healthful environment at BSH or a failure to effectively remediate any environmental hazards that may develop. As noted below, DOC continues its extensive work in partnership with several highly qualified outside experts to ensure that BSH remains a safe environment for Persons Served.

Since I last summarized DOC's ongoing work on the BSH physical plant, DOC and its expert consultants have taken additional steps to ensure the safety and health of Persons Served and BSH staff. Those steps include:

- DOC hired Arcadis, a company with decades of experience performing environmental remediation work, to inspect the mechanical rooms identified in DLC's last report. Arcadis identified asbestos in small areas and replaced fittings accordingly and performed industrial quality cleaning of the mechanical rooms. Arcadis ensured that the remediation team performed the work consistent with all applicable federal, state, and local regulations.
- Following Arcadis's remediation work, DOC contracted with a different vendor, Lighthouse, which the DOC Ombudsman recommended, to conduct biological air and surface testing for fungal growth and air quality throughout the facility. Lighthouse used a recordable Flair unit which measures particulate matter as small as 0.1 microns, temperature, CO2 and humidity. Based upon the results, new cleaning methods and products are now being deployed. With guidance from Dr. Curtis Donskey, an Infectious Disease Specialist working with Lighthouse, DOC adopted proper daily surface contamination cleaning methods and HVAC preventative maintenance protocols. Lighthouse will continue to monitor compliance with the process.
- DOC purchased approximately 44 Beyond Guardian Air Purifiers, which have UVS lights and HEPA filtration units. All patient housing common areas and staff critical areas now have units, as do the mechanical rooms and other areas at the facility.
- DCAMM has entered into a \$1.5 million contract with Select Demo to replace steam and condensate lines throughout the BSH facility. This will substantially reduce the amount of steam or condensate leakage occurring in BSH mechanical rooms. Under a second contract, Select Demo will also be performing a complete industrial cleaning and inspection of the facility on a quarterly basis, which will include any necessary mold remediation and duct diffuser cleaning.

Restraint, Seclusion, Emergency Treatment Orders, and Medical Care

The July DLC report renews DLC's earlier allegations that Wellpath is administering Emergency Treatment Orders (ETOs) as a form of unlawful chemical restraint. DOC responded to this allegation at length in my March 23, 2022 letter, and DOC stands by that response. Simply stated, DOC continues to disagree with DLC's claim that there is no distinction, from a clinical perspective, between providing medication – albeit involuntarily through an ETO – as a form of treatment, and the involuntary administration of medication for the purpose of restraint.¹

Since my March 23, 2022 letter, DOC has been working with Wellpath to review, and, to the extent necessary, clarify its policies on the involuntary administration of medication to ensure that this distinction is properly understood and observed. As detailed below, DOC and Wellpath have also increased oversight of and reporting on the use of ETOs, and seclusion and restraint.

- Wellpath is working with its internal Information Technology Team to ensure consistent transparent and accurate reporting of ETOs, seclusion, and restraint, and, where necessary, to implement changes in its

¹ DMH's regulations likewise distinguish between medication restraints and medications given "for other treatment purposes." 104 CMR 27.12 (exempting medication given for treatment from the requirements of restraint and seclusion). The Supreme Judicial Court also recognized this distinction in *Rogers v. Comm'r of Dept. of Mental Health*, 390 Mass. 489 (1983) (Where there is an "immediate, substantial, and irreversible deterioration of a serious mental illness," use of chemicals for treatment is permissible.).

reporting practices. For instance, while DOC and Wellpath continue to disagree with DLC that there is no clinical distinction between a medication restraint and the involuntary administration of medication as a form of treatment (i.e., an ETO), Wellpath has commenced reporting information on each ETO, and I review ETO reports on a bi-weekly basis just as I do with reports on seclusion and restraint.

- DOC Regional Administrators have commenced a review of the biweekly reports submitted to review the corresponding documentation for accuracy, appropriate use, as well as notable trends for discussion of alternative interventions. Wellpath will also be providing additional data for irreversible deterioration orders, and court ordered medications when involuntary. This data will be submitted to the Health Services Division during bi-weekly Executive Staff Meetings.
- On each weekday, Wellpath convenes a meeting to review all incidents of seclusion, restraint, manual hold, ETO's, and medication restraint to ensure all documentation has been completed properly. DOC's Health Services Division (HSD) is represented, and staff will continue to attend these meetings.²
- DOC and Wellpath have made improvements to reporting practices to permit a more complete evaluation of the need for seclusion or restraint in a particular scenario. Training on these improved reporting practices has emphasized the need for a description of (1) the least restrictive interventions attempted prior to initiating a seclusion, restraint, or manual hold; (2) the events leading up to seclusion; (3) the assessment of the Person Served that resulted in the indication for seclusion. In addition, standard reporting now includes specially trained observer checklists which contain all relevant information, including Person Served engagement forms. These forms must be scanned and added to the electronic medical record. There has also been an increase in the use of Personal Safety /De-escalation Plans.
- Each Friday, Wellpath holds a Seclusion & Restraint Committee meeting to review the use, trends, and rate of seclusion, restraint, and manual holds. The Committee then educates, recommends, and supports the use of best practices for the safe use of seclusion and restraints, and the best methods to reduce the use of seclusion and restraints.
- Wellpath retained internationally recognized behavioral health expert Dr. Kevin Huckshorn to conduct an onsite analysis of BSH operations and implementation of policy and procedure as it related to seclusion and restraint, ETOs and utilization of peer support/patient advocates. Following Dr. Huckshorn's two days on site during the last week of April 2022, she issued a favorable report, which DOC will make available to DLC.

Persons Served are committed to BSH because they require strict security hospitalization, and as such, providing appropriate clinical treatment and assuring their well-being and the well-being of others in the facility presents a range of difficult challenges simply not present in other mental health treatment facilities. DOC and Wellpath are committed to providing the best possible care to Persons Served at BSH, including, where necessary, through the proper and lawful administration of ETOs and appropriate restraint and seclusion. For this reason, it was troubling to read DLC's description of several incidents that, based on DLC's characterization of video records, showed Wellpath administering involuntary medication under what would be clearly impermissible circumstances. DOC has identified all videos provided to DLC over the last six months and DOC will review the videos to make an independent evaluation of Wellpath staffs' compliance with ETO policy. DOC will direct Wellpath to take corrective actions where appropriate.

² The HSD is represented by one or more of the following: Regional Administrators, Director of Behavioral Health and Assistant Deputy Commissioner of Clinical Services.

The DLC report of these video records makes clear that DOC must add the auditing of video footage to its recent improvements in oversight of ETOs and restraint and seclusion practices. The recent training on reporting requirements and policies governing involuntary administration of medication has been helpful to staff and improved supervisors' ability to ensure compliance with Wellpath policies. Auditing of video footage by DOC will be an important addition to BSH's program to ensure proper care for Persons Served.

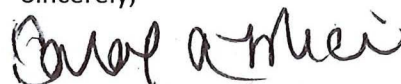
Language Access, Continuity of Care, and DMH

DLC's remaining criticisms concern matters over which DOC has limited or no control. The DLC July report raises, for the first time, a complaint that BSH provides inadequate language access for Persons Served who are non-English speakers, although as a member of the Governance Committee for BSH since 2018, DLC could have used that forum to highlight this issue at any time. DOC agrees that including more multi-lingual speakers on the Wellpath staff would be helpful both for Persons Served and BSH staff. At the same time, DOC and Wellpath face real constraints in this regard as there is a limited pool of applicants who are both bi-lingual and licensed clinicians who are also interested in providing care at a strict security psychiatric hospital, or even bi-lingual security staff applicants who are willing and qualified to work at BSH. DOC will, however, consult with Wellpath and the Commonwealth's Human Resources Division to identify initiatives that could increase bi-lingual applicants. DOC and Wellpath will also investigate DLC's suggestions regarding the posting of multi-lingual signage and improvements in staff training and education on communicating with non-English speaking Persons Served.

As to the remaining points in the DLC July report, DOC has no control over whether the Legislature will provide authorization and funding for a new facility for the BSH population or transfer care of Persons Served to the Department of Mental Health. DOC also has no control over which pharmaceutical products county correctional facilities choose to purchase. DOC has, however, already contributed to an improvement in the continuity of care for Persons Served by working with the State Office of Pharmacy Services and the county correctional facilities to align formularies for the purpose of increasing continuity of medications. DOC is also willing to work with other stakeholders to improve continuity of care whenever possible.

DOC and Wellpath remain committed to working collaboratively with DLC to identify and address areas of concern in a timely and productive manner to ensure that BSH patients receive the very best care. While great strides have been made in recent years, our professional and compassionate staff look forward to continuing that progress for our patients.

Sincerely,

A handwritten signature in dark ink, appearing to read "Carol A. Mici". The signature is fluid and cursive, with the first name "Carol" being more prominent.

Carol A. Mici

Commissioner

Department of Correction

Appendix C: Gordon Mycology Laboratory, Inc. Mold Inspection Report (January 11, 2023) and Laboratory Results



P.O. Box 310, Groton, MA 01450
Phone: 978-448-9954 www.moldtestingma.com

Mold Inspection Report

**Bridgewater State Hospital
20 Administration Road
Bridgewater, MA**

Project ID: 22-096GML
Inspection Date: December 5, 2022

January 11, 2023

Tatum A. Pritchard, Director of Litigation
Disability Law Center
11 Beacon Street, Suite 925
Boston, MA 02108

Dear Ms. Pritchard:

The following report details observations, laboratory results, and recommendations from a mold inspection performed by Gordon Mycology Laboratory, Inc. ('GML') on December 5, 2022 in several buildings of Bridgewater State Hospital located at 20 Administration Road in Bridgewater, MA. The goal of the inspection was to evaluate areas in which mold remediation, cleaning, HVAC system cleaning, asbestos abatement, and upgrades were performed within the last year as well as several other buildings/areas that had been previously inspected by GML for mold growth sources. Appropriate recommendations for any confirmed problems are provided in this report.

Inspection and Laboratory Procedures

GML inspected and tested several areas of the property in December 2019 and 2021. Most of the same areas inspected in those years were re-inspected visually and with testing during this inspection. Photographs were taken in all inspected areas. A calibrated Delmhorst Moisture Check moisture meter was used to measure moisture content in building materials and a calibrated Extech RH390 psychrometer was used to measure relative humidity levels.

Culturable surface swab samples were collected using sterile sampling supplies and industry-standardized sampling procedures from building materials in the basements of the Medical Administration, Carter, and Adams Buildings as well as HVAC system components in several buildings, to determine if mold growth was present and if so, what types and to what extent. Samples were sent to QLab in Metuchen, NJ (AIHA EMPAT Laboratory ID: 178794) for processing and analysis where they were cultured until mold types and quantities could be determined.

Airborne mold samples were not collected, as they were not warranted at this time. There was visible mold growth in many of the inspected areas, water/dampness in the basements, and a mold odor in the basements all of which are confirmation of mold growth sources and, therefore, airborne mold spores and mVOC's (microbial volatile organic compounds). The main goal of the inspection was to identify mold growth sources that may be remaining or may have recurred since the last GML inspection.

A sample of black dust on an HVAC system supply air diffuser was sent to Aerobiology Laboratory Associates, Inc. in Woburn, MA (MA ID# AA000156) to determine the components of the black dust.

Background Information

GML first visited the property for an onsite meeting on October 16, 2018 with building maintenance staff, attorneys, facilities director, and others involved with the project; the meeting supplied information regarding steam pipe releases and other water issues in the Administration and Medical Buildings, subsequent discovery of mold growth in those buildings, mitigation work, and mold inspection and testing services performed by other consultants/professionals. GML performed a visual inspection of remediated areas and several other buildings on December 5, 2019 in order to develop an accurate sampling plan. Surface sampling was then performed on December 19, 2019 based on the sampling plan developed two weeks earlier. According to staff members who accompanied GML during this inspection, several mitigation steps and updates had been performed since the December 2019 inspection.

GML inspected the site again on December 12, 2021 and confirmed few changes although professional mold remediation had reportedly been performed in several of the inspected and tested areas since the 2019 inspection. A written report describing laboratory results (confirming continued, and many of the same, mold growth sources) and a detailed scope of mold remediation, HVAC cleaning, and other necessary actions (asbestos abatement, repairing leaks, keeping basements dry, HVAC system regular maintenance, etc.) was provided.

GML was brought back on December 5, 2022 for an inspection and mold testing in the same areas that were previously inspected and tested. According to staff members present during the inspection, professional HVAC cleaning was performed in one building, although details were not fully known about the process. Asbestos abatement was performed by Select Demo Services out of Boston ('Select') and the areas cleared by Arcadis U.S., Inc. ('Arcadis'). Select Demo Services also performed mold remediation services in the basement mechanical rooms in the Administration and Medical Buildings as well as "Housing Units" A, B, and C according to the Arcadis report.

Arcadis developed their mold remediation protocol based on a visual inspection and information in several sources they cited. What was not cited in the Arcadis report, however, was the most accepted and widely used document in the mold remediation industry, the IICRC/ANSI Document S520: Standard and Reference Guide for Professional Mold Remediation (2015). The mold remediation protocol described in the Arcadis report and followed by Select was inadequate, lacking important steps for fully removing the mold contamination sources (see Observations and Results sections below). Arcadis cleared the mold remediation project with only a visual inspection and airborne mold samples. Collecting only airborne mold samples is not an effective or correct method for clearing a space that has been remediated for mold; airborne mold samples have a high risk for false negatives as well as the inability to provide information about remediated surfaces. Air sampling cannot detect whether remediated surfaces still contain mold growth or high levels of settled mold spores, visible or not, and is therefore only one aspect of a clearance mold inspection.

Inspection Observations

- Administration Building Basement
 - No mold odor detected
 - The basement had a few items stored there currently but for the most part, the basement was empty and reportedly unused
 - Remaining evidence of accumulated/chronic moisture was noted by rusted metal surfaces, rust staining on floors where metal items had been stored, and water

damaged wall materials at their base; none of these stained materials appeared to have been cleaned or removed

- Most surfaces had been painted but it was noted that in some areas, rust and mold growth had been painted over (this condition remained unchanged from the 2021 inspection)
- Self-contained modular air filtration unit in the ceiling of the Room AD11 was filthy (this condition remained unchanged from the 2021 inspection); the unit is not in operation any longer, but based on its condition, it should be removed
- Men's and women's bathrooms, not in use currently, were clean and free from visible mold growth except for the men's shower (see next bullet); rust was noted on metal surfaces from chronically elevated relative humidity levels presumably from when the showers were used and compounded by the steam release event several years ago
- Men's shower had current leaks/condensation from two metal vents running through the room; water was running down tiles walls onto the concrete floor, which contained debris and trash that can grow mold when wet
- Wood door framing and baseboard trim was water damaged and moldy; wood door trim and baseboards should be replaced with metal and tile, respectively (this condition remained unchanged from the 2021 inspection)
- HVAC system supply diffusers were filthy and still contained a significant amount of accumulated black dust/debris; this condition remained unchanged from the 2021 inspection
- No dehumidifier was present in any basement room
- Relative humidity levels averaged below 35%, which is typical during the heating seasons
- Hallway by the mechanical room and custodian's closet
 - Metal doors rusted at their base
 - Wood doors were water damaged, delaminated, and moldy at their base
 - Small patch of ceiling in an already patched area was water damaged and wet; the leak should be identified and repaired immediately (this condition remained unchanged from the 2021 inspection)
 - Custodian closet with the same old, moldy record books stored on a rusty shelf that were reportedly being discarded after the 2021 inspection but they remained as of the 2022 inspection; the ceiling vent was completely blocked with dust
- Mechanical room
 - Wet areas and standing water on the floor
 - Floor drains were clogged
 - Ripped fiberglass pipe wrap; some insulation appeared to have been re-taped or replaced by Select (mentioned in the Arcadis report) but not all
 - Large, open sump with wastewater (tampons and other wastewater components visible) in 2021 remained unchanged, allowing contaminants (mold, bacteria) to continually get into the basement air; there cannot be any open wastewater sources indoors
 - Water damage on many surfaces, including pipe insulation wrap, walls, and external surfaces of HVAC system ductwork
 - Visible mold growth on pipe wrap outer covering
 - Visible mold growth on wall materials, both porous and painted concrete
 - Significant amount of rusted surfaces
 - Many areas of rusted pipes/fittings, but the worst appeared to have been replaced since the 2021 inspection
 - Metal door framing was rusted out at its base

- Bucket with a flexible tube draining into it was dry during this inspection, but the moldy bucket and tubing remained the same as in the 2021 inspection; there should not be any open containers of standing water
 - Adjacent electrical/tech room
 - Mold growth on the walls
 - Mold growth on a deteriorated/water damaged cardboard tile box
 - Old rag on the floor was covered in mold growth
 - Wood materials housing utilities were moldy
 - Walls were water stained up at least 2 feet from the floor
 - Accumulated debris on the floor had been wet and was moldy
 - Large piece of mechanical equipment on the far wall was rusted out at its base
 - Most of these conditions remained unchanged from the 2021 inspection
 - The room (and small adjacent room) did not appear as if they had been professionally remediated
 - The current water and mold damage could not have occurred in the nine months since the remediation; the damage was too great
 - Comparison photos from the 2021 inspection confirm that most of the current water and mold damaged materials were not removed or remediated by Select in March 2022
 - Professional mold remediation in the mechanical room and small adjacent room are therefore, concluded to have been unsuccessful
- Administration Building Roll Call Room
 - HVAC system supply air diffusers contained heavy black dust/debris as did the ceiling around the diffuser; this condition was worse than in 2021
 - Mini-split ductless HVAC unit had been installed on the wall
 - Air purifier was being used
 - Relative humidity was 29% and temperature was 70.2%
- Medical Building Basement
 - Mold odor detected
 - Basement was mostly empty; what was present during this inspection was the same as in 2021: rusty, moldy file cabinets, building supplies on wood pallets and metal shelves, equipment and tools, etc.
 - Moldy wood pallets on the main room floor
 - A large piece of cardboard was lying on the floor where it will absorb moisture from the slab and grow mold; there ideally should be no cardboard in basements
 - A hole in one storage room ceiling that had been covered with plastic and tape as of the 2019 and 2021 inspections remained in the same condition
 - Drip marks on the back wall of Room HO1 ran from the ceiling to the floor
 - Storage rooms and the main room had been painted; some mold growth was noted beneath the paint and on surfaces where the paint had not fully covered
 - Bubbling and peeling ceiling paint in the green storage rooms appeared to be from water (no current evidence found) but could also be due to calcimite ceilings and there was mold growth above the peeling paint; this condition remained unchanged from the 2019 and 2021 inspections
 - HVAC ductwork in the main room had been painted in the past but the paint was peeling and visibly moldy throughout this condition remained unchanged from the 2021 inspection
 - Light fixtures were rusty and moldy
 - Considerable evidence of accumulated/chronic moisture was noted by rusted metal surfaces, rust staining on floors where metal items had been stored, water damaged building materials, peeling foundation paint, and visible mold growth; many of these conditions remained unchanged from 2019 and 2021

- HVAC vents in the green rooms were dirty with black dust and debris; this condition appeared marginally better than in the 2021 inspection although still not acceptable for HVAC system components
- Remaining pipe insulation was visibly moldy in the main room; this condition remained unchanged from the 2021 inspection
- Door frames were rusted along the bottom few inches
- The rusted out back exit door was replaced
- Door casings with peeling paint and visible mold growth beneath the paint
- A high capacity, commercial grade dehumidifier was installed in the doorway to one of the green storage rooms prior to the 2021 inspection; the dehumidifier can dry the green rooms and main room but would not be able to effectively dry the mechanical room or the electrical/technology room with their closed doors
- Electrical/technology room
 - The room had old paint on the walls, which was moldy
 - Significant evidence of chronically elevated relative humidity levels was noted by rusted metal surfaces, water damaged building materials, peeling foundation paint, and visible mold growth
 - Heavy mold growth on the painted plywood housing electrical panels (exactly as it had been during the 2021 inspection)
 - Heavy mold growth on the underside of a particleboard table; the table edge was swollen and delaminated from exposure to moisture
 - Trash and debris on the floor that has been wet, resulting in mold growth
- Mechanical room
 - Largely, the mold and moisture condition of this room remained the same as during the 2019 and 2021 inspections although mold and asbestos abatement had been performed by Select in March 2022
 - Large, partially open sump with standing water the surface of which was covered with microbial growth
 - Right exterior wall with paper-covered fiberglass insulation was ripped, deteriorated, water stained and covered in mold growth; this condition remained unchanged since the 2019 and 2021 inspections
 - An open vent (to the outdoors) has been bringing in air of highly variable temperatures and relative humidity; this is strongly discouraged in a basement that needs to be maintained at a consistently low relative humidity and consistent temperature to prevent condensation and mold growth
 - Ceiling was still moldy
 - Pipe insulation was water stained and covered in mold growth; several areas of iron pipes were missing insulation and were badly rusted from chronic condensation
 - Wet, sludgy material on the floor along with numerous other wet areas and dripping pipes
 - The floor, walls to the right of the HVAC system air handler, and top of the air handler were saturated and dripping with condensation; the still, and unnecessarily, open outdoor air intake for the unused air handler has been bringing in air of widely varying temperatures and humidity, causing excessive amounts of condensation resulting in significant mold growth
 - Questionable asbestos containing materials although Select performed asbestos abatement in this room
 - Surfaces were rusted throughout from chronic dampness
 - Evidence of chronic moisture on the walls, particularly at their base
 - Accumulated trash and debris strewn about on the floor, some of which was moldy
 - Unused HVAC system located in this room

- Outdoor air was blowing through the unit still, causing the blower wheel to turn
 - Ductwork remained and vents were open causing moldy air from the room (and potential asbestos fibers from loose/ripped sections of pipe wrap still present) to be drawn into the system and spread into the rooms/areas supplied by the ductwork (even if the system is not running)
 - The filthy and moldy air handling unit remained open allowing moldy, damp air into the system and, subsequently into the occupied spaces above where vents remained open
 - Some significantly moldy ductwork wrap/tape remained exactly as it had been in 2021 even though professional mold remediation had been performed in this room
 - Moldy towels/rags, a blanket, and other debris sitting on top of the air handler
- Relative humidity/temperature measurements:
 - Room H01 26.2% / 72°F
 - Electrical/Tech Room 26.7% / 78.7°F
 - Mechanical Room 31.9% / 80.3°F
 - Mechanical Room at open vent 29.5%/65.6°F
- Carter Building
 - Second floor common rooms with filthy HVAC system ductwork, unchanged from 2019 and 2021; exposed surfaces of the diffusers had been painted but the inner surfaces were rusted, filthy, and moldy
 - Common room self-contained modular air filtration unit remained and was filthy
 - Basement
 - Large grate over the access opening; it was unclear why these basements containing air handling systems and other mechanical equipment were open to the elements, but it is strongly not recommended
 - Large amount of standing water on the floor
 - Numerous leaks were occurring, hot water was dripping at a fast rate from several fittings and pipes onto the floor and other plumbing components
 - Pipe insulation was ripped, falling off, and missing altogether in areas
 - Relative humidity was 32.6 at 73.7°F, not as high as expected with the active leaks; the basement was wide open to the outdoors via the open access grate and HVAC system large return vent (air handler was not sealed so cold, dry air was continually coming in)
 - All metal surfaces were rusted, some completely corroded
 - Widespread mold growth, particularly on the external HVAC system ductwork paper wrap that looked exactly as it had in 2021
 - A lot of trash and other debris on the floor, most of which was moldy
 - HVAC systems
 - Air handlers were filthy, covered inside and out with accumulated organic debris that was or will be growing mold (leaves, dirt, dead insects, trash, etc.)
 - Visible mold growth on several components
 - Internal components were badly rusted
 - Filter compartments were open, introducing wet and moldy basement air into the already filthy system; the combination of chronic moisture and organic dirt/debris provides conditions that promote and support unacceptable mold growth inside an actively used air handling system

- One inch filters in the bottom unit (there were only 2 when there should have been a row of stacked filters across the unit) were filthy and black with accumulated dust, debris, and mold growth; cardboard filter frames were wet
 - Copper pipes were oxidized from chronic moisture exposure
 - Pipe and ductwork insulation wrap was ripped, deteriorated, and moldy
- Adams Building
 - Second floor common rooms with filthy HVAC system ductwork, unchanged from 2019 and 2021; exposed surfaces of the diffusers had been painted but the inner surfaces were rusted, filthy, and moldy
 - Common room self-contained modular air filtration unit remained and was filthy
 - Basement
 - Open access grate
 - Standing water on the floor
 - Leaks were occurring from some fittings/pipes onto the floor and other plumbing components
 - Pipe insulation was ripped, falling off, and missing altogether in areas
 - A large, uncovered sump with two large, corrugated pipes (which were crimped) draining into it held hot water; at regular intervals, large bursts of steam were released
 - Relative humidity in the room was 40.9 at 77.3°F, not as high as expected with the active leaks and open sump with hot water; the basement was wide open to the outdoors via the open access grate and HVAC system large return vent (air handler was not sealed so cold, dry air was continually coming in)
 - Relative humidity at the uncovered, hot water sump was 78.4% at 83.0°F
 - All metal surfaces were rusted, some completely corroded
 - Widespread mold growth, particularly on the external HVAC system ductwork paper wrap that looked exactly as it had in 2021
 - A lot of trash and other debris on the floor, most of which was moldy
 - HVAC systems
 - Ductwork and diffusers were cleaned three months prior to this inspection
 - Air handlers were filthy, covered inside and out with accumulated organic debris that was or will be growing mold (leaves, dirt, dead insects, trash, etc.)
 - Visible mold growth on several components
 - Internal components were badly rusted
 - Filter compartments were open, introducing wet and moldy basement air into the already filthy systems; the combination of chronic moisture and organic dirt/debris provides conditions that promote and support unacceptable mold growth inside an actively used air handling system
 - No filters were inside either unit
 - Copper pipes were oxidized from chronic moisture exposure
 - Pipe and ductwork insulation wrap was ripped, deteriorated, and moldy
 - Trash, ripped fiberglass insulation, and debris on top of the bottom unit where it can enter the system, which was missing filters

- Attucks Building
 - Areas of water damaged ceilings from chronic roof leaks; it was not known if the leaks had been repaired or were ongoing
 - The dining hall HVAC vents were rusty, filthy with black dust/debris, and were visibly moldy; this condition was unchanged from 2019 and 2021
 - Self-contained modular air filtration units remained in the ceiling and were filthy
 - HVAC vents in all inspected areas were filthy, all containing the heavy black dust/debris; this condition was unchanged from 2019 and 2021
 - Technology/computer room had mold growth on the peeling ceiling; relative humidity was 20.6% at 76.7°F
 - Relative humidity in the lobby was 29.8% at 68.2°F
 - Library relative humidity was 22.8% at 75.9°F
 - Developmental Disabilities room was converted to a storage room and is no longer occupied
 - The significantly moldy window air conditioner that caused so much mold growth in the room (because it was running on high in December last year) remained in the window, but was not currently running
 - Mold growth on the surface of the ceiling was removed but the water damaged, peeling/bubbled calcimite ceiling remained; the ceiling should have been removed due to the roof leak and excessive mold growth
- Lenox Building
 - HVAC vents were filthy containing significant black dust/debris that was also accumulating on the adjacent ceiling material; this condition was unchanged from 2019 and 2021
 - Shower room
 - Strong mold odor
 - Moldy fiberglass wall and ceiling panels
 - Standing water on the floor; the floor is not pitched properly to the drain so the water does not all drain, resulting in chronically high humidity
 - Relative humidity during the inspection was 41.6% at 66.5°F
 - Rusted door framing in the shower and adjacent hallway was painted over

Laboratory Results

Surface Mold Sample Results (Please refer to the AccuScience report)

Surface swab results are reported as colony forming units per square inch (CFU/in²), in other words, the total count of living mold spores per square inch of tested material. A colony forming unit (CFU) is a mass of growth on a culture plate large enough to see and typically begins with one spore. For example, if the mold level on a surface is found to be 500 CFU/in², and the sample contained only the mold *Penicillium*, the result can be interpreted as 500 living *Penicillium* spores per square inch of the tested material.

Swab sampling defined **elevated mold levels** on the following tested materials:

- Administration Building basement room AD-11 – supply air diffuser
- Medical Building basement boiler room – mold on ductwork wrap
- Medical Building basement IT room – mold on underside of particleboard table
- Lenox Building shower hallway – supply air diffuser
- Attucks lobby – supply air diffuser

- Attucks dining hall – supply air diffuser, at water damaged ceiling
- Attucks library – supply air diffuser
- Adams Building Day Room – supply air diffuser (cleaned 3 months ago)
- Adams Building basement – mold on ductwork wrap
- Adams Building hallway to rooms – return air grille

Mold levels defined by culture analysis these surfaces far exceed those expected on the same materials if they had not been exposed to chronic moisture from multiple sources. All but one HVAC system samples confirmed unacceptable mold levels and types, along with even more accumulated black dust/debris than was observed during the 2021 inspection. The Adams Building Day Room supply air diffuser was cleaned three months prior to this inspection but contained a high mold level and a lot of accumulated black dust/debris; this either means the cleaning was inadequate or the mold and black dust is coming from farther into the system where cleaning was not performed. The air handlers were not included in the cleaning.

The visual inspection confirmed **abnormal and unacceptable mold growth** on the following surfaces, which included many that had been professionally remediated:

- Administration Building basement mechanical room – visible mold on ductwork wrap
- Administration Building Roll Call Room – supply air diffuser
- Medical Building basement main room – mold on painted HVAC ductwork seams
- Medical Building basement boiler room – mold on pipe insulation wrap
- Medical Building basement IT room – mold on electrical panel plywood
- Carter Building basement – mold on ductwork wrap

All but one of these samples (Roll Call Room supply air diffuser) were collected from visibly moldy surfaces that had been professionally remediated nine months ago. The samples did not result in high levels of culturable molds, which is a strong indication that the remediation company soaked/heavily sprayed surfaces with a sanitizer. The sanitizer killed most of the mold on these surfaces however, even if molds are killed, they must still be removed; dead mold spores and structures contain the same harmful components and chemicals as those that are alive. Select remediated these materials that were then cleared with a visual inspection by Arcadis. There cannot be visible mold growth (dead or alive), dust and debris, or water damaged materials after professional mold remediation has been completed. The visual inspection by GML failed all remediated areas.

Mold types identified growing on the tested surfaces included *Alternaria*, *Aspergillus flavus*, *Aspergillus niger*, *Aspergillus ochraceus*, *Aspergillus sydowii*, *Aspergillus versicolor*, *Chaetomium*, *Cladosporium*, *Curvularia*, *Epicoccum*, *Memnoniella*, *Penicillium*, *Phoma*, and *Trichoderma*. Non-sporulating and xerophilic fungi (unable to mature on culture plates for identification but require similar growth conditions as molds) along with environmental yeasts were also present. The significant evidence of chronic moisture and current plumbing leaks/problems have been more than sufficient to support mold growth on these and many other not tested but visually inspected surfaces.

Aspergillus is one of the most clinically important mold groups that is commonly found indoors when conditions are favorable for their growth; *Aspergillus* growth confirmed on most of the tested surfaces in the buildings, including HVAC systems. *Aspergillus* can cause chronic lung and sinus infections, produces mycotoxins, and is a common allergenic mold. Chronic exposure to these and the other molds confirmed in the buildings can cause a myriad of health problems, many of which may not initially be attributed to mold; colds that take longer to clear, chronic sinus infections, persistent coughing, itchy and runny eyes, sore throats, exhaustion, lethargy, mental foggy, etc. People with underlying health conditions and weaker immune systems are most affected by chronic mold exposure. The 2019 and 2021 inspections confirmed mold contamination sources that

remained as of this 2022 inspection. Yearly visual inspections (2020 omitted due to Covid) and laboratory results confirm that there has been and still is chronic mold exposure potential for staff members and persons served.

Particulate Analysis Results (Please refer to the Acrobiology Laboratory Report)

One sample of the black dust/debris inside the HVAC system supply air diffusers was collected for particulate analysis. The black dust was already confirmed to contain abnormally elevated levels of mold spores but the dust was full of larger particles/fibers. The sample contained 2% fiberglass particles but the rest of the sample was labeled as non-fibrous minerals. It is recommended to have further analysis performed to identify the other 98% (minus the mold) of the particulates.

Recommendations

The following remediation recommendations have been adapted from current literature from the EPA, AIHA, ACGIH, IICRC/ANSI, New York City Department of Health, and other applicable organizations that have developed plans for effectively managing indoor mold growth. Mold sensitivity can develop over time and the length of time leading to mold sensitivity or symptoms related to mold exposure is not known and can vary greatly between individuals. Once indoor mold growth is confirmed, it must be removed using the appropriate procedures to minimize/prevent potential mold exposure risks. The accepted protocol for indoor mold growth is to remove contaminated, porous building materials and remediate (described below) less porous and non-removable materials. Current standards state that mold growth must be eliminated (not fogged, sprayed, ozonated, painted over, killed but left in place, or encapsulated).

Please note that although asbestos abatement had been done, there were still suspect materials in several basements that should be tested by a licensed and independent asbestos consultant. When 'insulation removal' is recommended in the mold remediation procedures below, GML is referring to non-asbestos containing insulation as the recommendations are written for a mold remediation company only.

All sources of water intrusion and accumulation need to be identified and fully resolved. The amount of water coming into/accumulating in the basements and several other areas of the buildings is unacceptable. Pipes were leaking, basements were flooding with rain and ground water, sumps were open including one with raw sewerage and one with water coming from boiler pipes, mechanical equipment draining into open buckets, unconditioned outdoor air allowed to come in where it was causing significant condensation problems, inadequate or the absence of dehumidification, etc. These moisture sources are the direct cause for abnormal and unacceptable mold growth and cannot be allowed to continue.

A specialized mold remediation company is needed to remove mold growth sources and remediate remaining materials/surfaces in the basements of the Administration and Medical Buildings as well as basements of the Adams and Carter Buildings; isolated areas in the Attucks Building also need to be remediated. This type of company is skilled in containment and decontamination procedures and is familiar with the currently accepted mold remediation standards, procedures, and safety guidelines. Secure engineering controls (containment barriers, negative air pressure system, HEPA filtered air scrubbers) and safety procedures (personal protective equipment—PPE) for people performing the work will be necessary to prevent cross contamination and exposure risk while the work is being conducted. A qualified remediation company knowledgeable and experienced in the field and who follows the IICRC/ANSI Document S520: Standard and Reference Guide for Professional Mold Remediation (2015) will do the necessary work using procedures and guidelines outlined in this document to achieve complete and successful remediation of contaminated areas.

Remediation recommendations are based on onsite observations and reported information. GML is presenting guidelines for amounts of materials to be removed and remediated; the remediation company may ultimately decide how much material to remove and remediate in the affected areas based on further assessment once the remediation process has begun. Many of the following steps were outlined in the 2021 report, but because they were not agreed upon by people making the decisions or the Arcadis consultant and were not followed/performed by Select, they are being reiterated here.

The following protocols can begin only after secure engineering controls have been established and are maintained. Safety procedures and gear for personnel performing the work will be needed for everyone who goes into the contained areas. A negative air pressure system may be difficult in the basements because there were no windows; the exterior doors or access openings can possibly be used but the system must be sealed in the doorway or access opening, which will prevent people from coming into or leaving the space while the work is being done. Discuss the options with the remediation company to be sure everyone has an understanding of the process and expectations. Old record books in the Custodian's room should be moved out before remediation begins.

Administration Building Basement Remediation Protocol

- Seal all sumps but particularly the wastewater sump with hazardous raw sewerage
- Remove all exposed, water damaged, fiberglass pipe insulation (new and all of the original)
- Remove all HVAC system ductwork insulation and tape at seams (unless they are asbestos containing)
- Remove all paper/fabric-type wall coverings (unless they are asbestos containing)
- VCT floor tiles should be removed as they showed evidence of water damage; moisture was able to get beneath the tiles resulting in mold growth on the underside of the tiles as well as the installation adhesive
- Wood baseboard and door trim in the Women's and Men's bathroom should be discarded
- Hollow-core or laminate doors should be discarded and replaced with metal or solid wood, both of which are somewhat less likely to deteriorate or become as moldy in a water event
- Open the still water damaged/wet section of the mechanical room hallway ceiling; continue removing materials 2 feet in all possible directions beyond evidence of moisture or mold
- Discard vinyl cove-base on walls that were exposed to moisture; the vinyl and adhesive readily grow mold as well as trap moisture between the vinyl and painted walls where the paint can then support mold growth
- Remove all exposed wood in the Men's shower where the vents/pipes were actively leaking
- Discard all trash and debris on all floors
- Discard extraneous, porous building materials
- Discard the bucket and moldy drain tubing in the mechanical room; this should be replaced with a system that directly drains the water into a closed drain or pump
- Rusted shelving units or cabinets should be discarded
- Scrape off any/all loose paint on surfaces
- Abandoned/unused HVAC system equipment or air movers should be removed along with their ductwork; cleaning the ductwork of an abandoned system is not cost effective, although an alternative option is to have the ductwork sealed if it is not to be removed
- Materials to be removed should be bagged and the bags sealed and wiped down before taking out of the basement to be discarded
- Once removed materials are discarded, all remaining building materials from floor to ceiling which includes wire brushing/scrubbing/wiping (different materials require varying cleaning techniques), application of an EPA approved sanitizing agent, HEPA vacuuming, and sanding or grinding if necessary
- Materials to be remediated include, but are not limited to, the following:

- Concrete (floors, walls, ceilings)
- Porous wall materials
- All wood materials
- All pipes, particularly PVC that support mold growth
- Utilities, mechanical equipment, appliances, technology equipment, etc.
- Support columns/beams
- Exterior surfaces of HVAC systems, particularly painted surfaces
- Doors and framing
- Unfortunately, there is no effective method other than sanding or ice blasting to remove top layers of paint so mold growth on the underlying layers of paint cannot be remediated; regularly monitoring and sanitizing painted surfaces will be necessary (mold growth cannot be painted over as the mold will continue to grow on the newly painted surfaces)
- Damp wipe and HEPA vacuum all other surfaces in the basement to remove settled mold spores and demolition dust released during the process
- HEPA filtered air scrubbers should run for at least 48 hours after the work is completed

Medical Building Remediation Protocol

- Seal all open sumps
- Remove all pipe insulation (unless it is asbestos containing)
- Remove all fabric/paper/absorbent/porous wall materials (unless they are asbestos containing)
- Remove all rotted/rusted out building materials
- Remove all wood pallets or other absorbent, organic materials on the floors
- Abandoned/unused HVAC equipment or air movers should be removed along with the ductwork (and outdoor air intakes permanently sealed—if needed, these should be fully ducted); cleaning ductwork of an abandoned system is not cost effective, but an alternative is to have the ductwork sealed
- Discard all trash and debris on the mechanical room and other floors
- Discard extraneous, porous building materials
- Scrape off any/all loose paint on surfaces
- Remove plastic covering the hole in the storage room's ceiling; once open, remove water damaged and/or moldy materials as needed or remediate if no removal is needed
- Discard tables and chairs as most were visibly moldy and water damaged
- Discard or remediate file cabinets
- Discard/remove moldy plywood in the electrical/technology room
- Remove all external coverings, tape, paper, insulation, and peeling paint from HVAC system ductwork and units (if not asbestos containing)
- Discard all cardboard and pallets in the basement
- Once removed materials are discarded, all remaining building materials from floor to ceiling, should be remediated which includes wire brushing/scrubbing/wiping (different materials require varying cleaning techniques), application of an EPA approved sanitizing agent, HEPA vacuuming, and sanding or grinding if necessary
- Materials to be remediated include, but are not limited to, the following:
 - Concrete (floors, walls, ceilings)
 - Porous wall materials
 - All wood materials
 - All pipes, particularly PVC that support mold growth
 - Utilities, mechanical equipment, appliances, technology equipment, etc.
 - Support columns/beams
 - Exterior surfaces of HVAC systems, particularly painted surfaces
 - Doors and framing

- Unfortunately, there is no effective method other than sanding or ice blasting to remove top layers of paint so mold growth on the underlying paint can be remediated; regularly monitoring and sanitizing painted surfaces will be necessary (mold growth cannot be painted over as the mold will continue to grow on the newly painted surfaces)
- Damp wipe and HEPA vacuum all other surfaces in the basement to remove settled mold spores and demolition dust released during the process
- HEPA filtered air scrubbers should run for at least 48 hours after the work is completed

Basements of the Adams and Carter Buildings Remediation Protocol

- Mold remediation should take place in all of the basements of these and other buildings with wet environments
- All dirt, trash, and debris must be removed from the floors
- All HVAC system ductwork insulation/wrap/tape/paper materials must be removed (unless they are asbestos containing)
- All pipe insulation/wrap must be removed (unless it is asbestos containing)
- Once removed materials are discarded, all remaining building materials from floor to ceiling should be remediated which includes wire brushing/scrubbing/wiping (different materials require varying cleaning techniques), application of an EPA approved sanitizing agent, HEPA vacuuming, and sanding or grinding if necessary
- Materials to be remediate include, but are not limited to, the following:
 - Concrete (floors, walls, ceilings)
 - Other wall materials
 - All wood materials
 - All pipes, particularly PVC that support mold growth
 - Utilities, mechanical equipment, appliances, technology equipment, etc.
 - Support columns/beams
 - Exterior surfaces of HVAC systems, particularly painted surfaces
 - Doors and framing
- HEPA filtered air scrubbers should run for at least 48 hours after the work is completed

Attucks Building Remediation

- The mold remediation company should remove and discard the window air conditioner in the storage room off the library; it could also be discarded by in-house personnel as long as it is discarded through the window and not brought into the building
- Moldy sections of the Technology/computer room should be removed and remediated
- Water damaged/stained sections of ceilings throughout the building (lobby, dining hall, etc.) should be removed, with removal extending at least 2 feet in all possible directions past visual evidence of water or mold damage
- Once removed materials are discarded, all remaining building materials from floor to ceiling, including floors, walls, and ceilings, should be remediated which includes wire brushing/scrubbing/wiping (different materials require varying cleaning techniques), application of an EPA approved sanitizing agent, HEPA vacuuming, and sanding or grinding if necessary
- HEPA filtered air scrubbers should run for at least 48 hours after the work is completed

General Building Recommendations

- Scrub and sanitize moldy wall, ceiling, and floor materials in the Lenox shower; sanitizing should be done more regularly based on the amount of shower usage
- Remove and replace any water stained ceiling tiles

- Appropriately label rooms with chemicals; the words “Toxic Closet” are not appropriate and can be dangerous if there is a fire (fire fighters need to know what types of chemicals are stored)
- Regularly clean and sanitize bathrooms and showers; do not run shower water excessively, particularly if no one is showering
- Avoid mopping floors so they become so wet as to rust metal surfaces at the floor level; many rooms/areas did not have reported water events but had had considerable rusted surfaces at the floor because of frequent mopping with too much water
- Water pipes must be fully insulated, including around joints and fittings; if there are gaps in insulation, condensation will occur leading to rust and mold growth
- It is strongly advised to close off the Medical Building basements from the elements; all basements should be as water and air tight as possible and dehumidified or mold growth will recur
- Wastewater sumps cannot be left open or hazardous and pathogenic bacteria will enter the basements; all sumps should have sealed but removable covers to prevent evaporation into the basements which must be dehumidified
- Repair all leaking pipes, fittings, valves, and equipment; any accumulating water will increase the relative humidity and be counterproductive to the dehumidification systems as well as cause mold growth on surfaces that get wet

HVAC Cleaning Protocol

All in-use HVAC systems (including mini-splits) in all buildings need to be professionally cleaned by a NADCA certified air handling system cleaning specialist. HVAC cleaning can only take place once the mold remediation has been successfully completed and pipe leaks repaired. Cleaning the systems will include all components of the air-handlers (unless they are being discarded or replaced), which will likely need to be disassembled, based on their current conditions, to access all necessary parts, metal ductwork, diffusers and vents (must be removed and hand cleaned) throughout the buildings, pipes/tubing, external surfaces, etc. Replace badly rusted components. Seal all openings and gaps in air handlers or ductwork. All fiberglass linings inside air handlers and ductwork should be removed and replaced with an alternative insulating material such as Armaflex. New, allergen-trapping, high efficiency filters (highest MERV rating the systems can accommodate) should be installed after the cleaning is completed. Two inch filters are designed to be changed between 3 – 4 months, depending on their MERV rating and amount of system usage. Filter compartments must be sealed with removable covers to ensure that external air, particularly basement air, is not circumventing the filters and getting into the systems. Cleaning HVAC systems as described here is recommended every 5–7 years. Regular inspection of HVAC systems is important for early detection of problems.

Conclusion

Many of the sources of mold growth identified during the 2019 and 2021 inspections of the Bridgewater State Hospital buildings and HVAC systems were confirmed to still be present (visually and with laboratory data) during the current 2022 inspection. This indicates that the necessary mold remediation, cleaning, and maintenance actions have not been performed (or kept up with as regularly as they need to be). HVAC systems observed during the inspection continued to be in deplorable condition, some with air handlers in wet and flooded basements with rampant mold growth. The black dust/debris inside HVAC system air handlers and supply diffusers remained, seemingly untouched, along with unacceptable levels of mold growth; the air coming through these systems is what persons served and building staff members must breathe on a daily basis. Even one section of an HVAC system that had been professionally cleaned was confirmed to be filthy and riddled with active mold growth.

Significant and long-term basement water problems have been and were still occurring at the time of this inspection. The leaks have gone, for the most part, unnoticed and/or were ignored based on the amount of rust, water damage, corroded pipes, and widespread mold growth). HVAC system air handlers in wet basements and systems with major problems (absence of filters, unfiltered and unconditioned outdoor air coming directly into the systems, absence of regular maintenance and specialized cleaning, etc.) have resulted in significant mold growth within the systems that provide air to people living and working in the buildings. There has been neglect of critical building systems. Mold remediation performed by an unqualified company who did not follow industry standards and procedures was proven to be inadequate, unsuccessful, deficient. Arcadis wrongly cleared remediated basements that still have pervasive and obvious visible mold growth on remediated surfaces. There also are remaining questions regarding the completeness of the asbestos abatement performed by Select prior their mold remediation work; there appeared to be potentially asbestos-containing materials in the basements that should be investigated by an independent (not Arcadis) asbestos inspector.

Overall, this inspection suggests that inappropriate and harmful actions pertaining to the control and remediation of mold growth in the buildings of Bridgewater State Hospital continue and many of the 2019 and 2021 recommendations were largely ignored. These inactions have caused the mold problems to become worse in certain areas observed and potentially more harmful to those who work and live in the facility.

Please contact our office if you have any questions. Thank you.

Sincerely,

Deborah J. Gordon
Microbiologist, Owner
Gordon Mycology Laboratory, Inc.

Disclaimer/Limitations:

The conclusions presented in this report are based only on the services described in this report and not on scientific procedures beyond the scope, time, and budgetary constraints imposed by the client. The information presented in this report is based in part on the observation of conditions in the field and communications with those persons involved in the project. GML makes no conclusions regarding those areas of the site that may have been inaccessible or unavailable during the investigation.

General Mold Information

Molds are simple, microscopic organisms that have a vital role in nature of decomposing decaying organic debris (dead leaves, plants and trees, etc.). Molds originate outdoors and are found in almost every type of environment. However, abnormal mold growth indoors on a “food” source (nourishment for mold growth) is of great importance to property owners and building occupants.

Mold growth is not normal for any indoor environment and only occurs when mold spores (found everywhere, but invisible to our eyes in low levels) land on food sources that provide them with enough moisture to grow. Under ordinary circumstances, microscopic mold spores in work environments, health care facilities, homes, cars, and schools go unnoticed and do not present a problem; mold spores are inadvertently removed each day by traditional cleaning methods (dusting, vacuuming, washing surfaces).

Indoor food sources for mold include carpet materials, clothing, leather, cardboard and paper products, Sheetrock, wood, insulation, over-watered plants, plastics, paints and other surface coatings, among so many others. Mold spores left on a food source that remains wet or is simply located in a humid environment, will continue to grow, producing billions of new spores allowing mold contamination to spread. This is the primary motivation for identifying and quickly resolving moisture issues. If building materials or belongings are not dried within 48 hours, mold growth begins to develop.

Because mold spores are so small, a surface can be contaminated without visual evidence of the growth; once mold growth becomes visible, it has already become a larger problem. Contrary to the stereotype, moisture that can promote and support mold growth is not limited to ‘flooding’ or ‘wet basement’ situations. Chronically elevated relative humidity, roof leaks, foundation seepage, washing machine leaks, carpets wicking moisture from foundation floors, steam production in kitchens and bathrooms, slow-drip pipe leaks, and window condensation are examples of moisture sources that often result in mold growth if they are not managed quickly and appropriately.

General Basement Recommendations

Foundation Floors and Walls

Breaches in foundation floors and walls must be sealed/made as watertight as possible. Cracks in floors and walls should be filled/sealed with an appropriate product. Gaps and holes around where pipes exit the foundation should be sealed. Areas with efflorescence indicate moisture penetration from outdoors; evaluate for problems with gutters, drainage, and landscaping. Consult with a foundation specialist, engineer, or mason on the problems and solutions. Sumps should have concrete bottoms and be covered at all times with plastic or metal well-fitted covers to prevent evaporation. Dirt floor crawlspaces or sections of exposed dirt must be permanently sealed with either a thick, corrugated plastic system sealed to the walls or layer of concrete.

Exterior Systems

Evaluate landscape, drainage, walkways and patios, and the gutter system and have work done to prevent/minimize water from accumulating at the foundation, where it can potentially come into the basement. The ground and artificial surfaces (walkways, driveways, patios, etc.) should pitch away from the house, the gutter system must have effective downspout extenders and be monitored to be sure sections remain connected and clear of debris, different types of fill and exterior drainage pipes can be installed if warranted, and dense vegetation and shrubs against the

house should be cut back to prevent water from splashing and accumulating along the foundation. Basement window wells should remain clear of vegetation and organic debris.

Basement Dehumidification

Consistent and effective dehumidification in all basement rooms/areas is essential to provide continuous drying, which will significantly decrease the chances for mold growth in the future. The target relative humidity level in basements is below 50% throughout the year and can be monitored with hygrometers (relative humidity meters). It is recommended to put hygrometers in several areas to be sure the dehumidification system is keeping all areas below 50%. If hygrometers read above 50% for prolonged periods, additional dehumidification will be needed. GML strongly recommends the use of high capacity, self-draining dehumidifiers (i.e. Santa Fe Classic by Thermastor) to provide uninterrupted and effective drying; energy efficient models with evacuation pumps are now available so they can be put where they are needed (not simply near the drain location as is usually the case with the types that do not have pumps). Ducted dehumidification systems are also available for finished basements with multiple rooms. Dehumidifiers should ideally have a back-up battery system to prevent spikes in relative humidity in the event of power failures. While dehumidifiers are running, basement windows and exterior doors should remain closed.

Basement Storage

It is recommended to store contents whenever possible in plastic containers with lids that can be taped shut, or plastic bags that can be sealed, and all contents should be stored off the floors, away from foundation walls, and on metal or plastic shelves and racks with legs that hold them off the floor. Furniture in particular, should be pulled away from walls several inches to allow for air circulation, preventing moisture build-up; having furniture that sits on raised legs rather than directly on the floor is important as well. Cardboard boxes should be emptied, their contents switched to plastic containers that are sealed, and the cardboard discarded. Air circulation around and under belongings in the basement is essential for preventing mold growth.

Basement Flooring

It is recommended to install only non-absorbent flooring, such as ceramic or stone tile, directly on foundation floors. Raised flooring (even small areas in closets or platforms at the base of staircases), carpeting, hardwood, cork, laminate, Dri-Core, and other absorbent materials are strongly discouraged in basements because they trap moisture, supply food sources for mold and bacteria, and provide a substrate for trapped particulates such as food, house dust, skin cells, pet hairs, etc. that even the best vacuum cleaners cannot remove. Linoleum and rubber-type flooring including rubber-backed mats are not recommended because of their water resistant nature; moisture will be trapped beneath promoting mold growth on the underside of the material itself as well as the adhesive used for installation. Natural moisture migration through the concrete slab should be allowed to occur, the moisture will pass through the non-absorbent yet porous tiles and grout, and then be removed by the dehumidification system instead of being absorbed or trapped by other flooring types. Area rugs with pads that can be discarded if they become wet or moldy can be used on top of the tile floors; these can even be as large as the room itself to emulate wall-to-wall carpeting but are much more easily and cheaply replaced if needed. Be sure to ventilate the raised platform at the base of the staircase during the reconstruction.

Basement Wall Materials

Mold growth may be avoided on the base of walls if wallboard is not in contact with the concrete floor. Traditional gypsum board acts like a sponge and will wick moisture up from the concrete, promoting and supporting mold growth on the painted and paper sides. Gypsum board should be

replaced with a cement board-type or other non-absorbent product (fiberglass wallboard, fiber-rock, etc.) that does not contain a mold food source, at least along the bottom 4 feet of basement walls. Leaving wall materials at least 1/2 inch off the concrete floor can effectively prevent moisture wicking (mold can grow on finished painted surfaces of even the products mentioned above). Baseboards will hide this gap, which can also be made out of a material that is less or non-absorbent (plastic, composite, vinyl) further decreasing the risk for mold growth. Metal wall framing cannot absorb water or support mold growth and is, therefore, an excellent choice when finishing or renovating a basement.

Mycologix™ Hidden Mold Detection (HMD) Technologies
Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**
QLAB Job No.: ME221207-12

Client: Gordon Mycology Laboratory, Inc.
Groton, MA

Date Sampled: 12/5/2022

Contact: Gordon, Deb

Date Received: 12/7/2022

Project ID: 22-096GML Bridgewater-3

Date Reported: 12/15/2022

Reviewed by: WT

Approved by: Wei-Chih Tang, Ph.D., Lab Director

Lab Sample No.	ME221207-12(1)				ME221207-12(2)				ME221207-12(3)			
Sample ID	S1				S2				S3			
Sample Location	Admin. Bldg. basement room AD-11 – supply air diffuser				Admin. Bldg. basement mechanical room – mold on ductwork wrap				Admin. Bldg. Roll Call Room – supply air diffuser			
Sample Type / Device	Surface/SpongeSWAB (S)				Surface/SpongeSWAB (S)				Surface/SpongeSWAB (S)			
Media (Temperature: 25°C)	Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA				Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA				Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			
Date Analyzed	12/15/2022				12/15/2022				12/15/2022			
Amount of Sample Prepared	3 in²				2 in²				3 in²			
Dilution Factor	100				100				100			
Detection Limit (DL)	DL = 33 CFU/in²				DL = 50 CFU/in²				DL = 33 CFU/in²			
Culturable Fungi Conc.*	1,600 CFU/in²				200 CFU/in²				370 CFU/in²			
Identification	Adj. Ct.*	CFU/in²	%		Adj. Ct.*	CFU/in²	%		Adj. Ct.*	CFU/in²	%	
Major Hydrophilic Fungi**												
Acremonium												
Aureobasidium												
Chaetomium	34	1,100	69									
Stachybotrys												
Memnoniella												
Yeast, non-specified									5	170	45	
Rhodotorula (yeast)												
Sporobolomyces (yeast)												
Trichoderma [Spreader]***	5	170	10									
Mucor [Spreader]***												
Other Fungi												
Cladosporium	1	33	2		1	50	25		1	33	9	
Penicillium	2	67	4						1	33	9	
Aspergillus versicolor	3	100	6									
Aspergillus sydowii												
Aspergillus ochraceus					1	50	25					
Aspergillus niger												
Aspergillus fumigatus												
Aspergillus flavus												
Paecilomyces												
Alternaria												
Epicoccum												
Pithomyces												
Curvularia												
Non-sporulating fungi	3	100	6		2	100	50		4	130	36	
Xerophilic Fungi Screening	1	33	2			ND				ND		
DG18 (and/or MEA) Dilution Factor:	100 (DL = 33 CFU/in²)				100 (DL = 50 CFU/in²)				100 (DL = 33 CFU/in²)			
Note												

*: Adjusted Counts less than 1 are converted from colony counts read from lower dilutions plates. All concentrations (conc.) are rounded to two digits of significant figures. Total concentrations/percentages may not be equal to the sum of individual concentrations/percentages due to rounding. **: Water-loving fungi, minimal Aw ≥ 0.89. *** Spreader: Trichoderma, Rhizopus, Mucor & Chrysonilia are fast growing fungi on MEA agar plate, which may inhibit the growth of other fungi on the same plate. Mycologix™ HR-MEA can significantly reduce the colony size of spreaders. ND: None detected

Mycologix™ Hidden Mold Detection (HMD) Technologies
Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**
QLAB Job No.: ME221207-12

Client: Gordon Mycology Laboratory, Inc.
Groton, MA

Date Sampled: 12/5/2022

Contact: Gordon, Deb

Date Received: 12/7/2022

Project ID: 22-096GML Bridgewater-3

Date Reported: 12/15/2022

Lab Sample No.	ME221207-12(4)			ME221207-12(5)			ME221207-12(6)		
Sample ID	S4			S5			S6		
Sample Location	Medial Bldg. basement main room – mold on painted HVAC duct seam			Medial Bldg. basement boiler room – mold on pipe insulation wrap			Medial Bldg. basement boiler room – mold on ductwork wrap		
Sample Type / Device	Surface/SpongeSWAB (S)			Surface/SpongeSWAB (S)			Surface/SpongeSWAB (S)		
Media (Temperature: 25°C)	Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	12/15/2022			12/15/2022			12/15/2022		
Amount of Sample Prepared	2 in²			3 in²			2 in²		
Dilution Factor	100			100			100		
Detection Limit (DL)	DL = 50 CFU/in²			DL = 33 CFU/in²			DL = 50 CFU/in²		
Culturable Fungi Conc.*	150 CFU/in²			130 CFU/in²			1,800 CFU/in²		
Identification	Adj. Ct.*	CFU/in²	%	Adj. Ct.*	CFU/in²	%	Adj. Ct.*	CFU/in²	%
Major Hydrophilic Fungi**									
Acremonium									
Aureobasidium									
Chaetomium	1	50	33	3	100	75	33	1,700	94
Stachybotrys									
Memnoniella							1	50	3
Yeast, non-specified									
Rhodotorula (yeast)									
Sporobolomyces (yeast)									
Trichoderma [Spreader]***									
Mucor [Spreader]***									
Other Fungi									
Cladosporium	1	50	33						
Penicillium									
Aspergillus versicolor									
Aspergillus sydowii									
Aspergillus ochraceus									
Aspergillus niger				1	33	25			
Aspergillus fumigatus									
Aspergillus flavus									
Paecilomyces									
Alternaria									
Epicoccum									
Pithomyces									
Curvularia									
Non-sporulating fungi	1	50	33				1	50	3
Xerophilic Fungi Screening		ND			ND			ND	
DG18 (and/or MEA) Dilution Factor:	100	(DL = 50 CFU/in²)		100	(DL = 33 CFU/in²)		100	(DL = 50 CFU/in²)	
Note									

*: Adjusted Counts less than 1 are converted from colony counts read from lower dilutions plates. All concentrations (conc.) are rounded to two digits of significant figures. Total concentrations/percentages may not be equal to the sum of individual concentrations/percentages due to rounding. **: Water-loving fungi, minimal Aw ≥ 0.89. *** Spreader: Trichoderma, Rhizopus, Mucor & Chrysonilia are fast growing fungi on MEA agar plate, which may inhibit the growth of other fungi on the same plate. Mycologix™ HR-MEA can significantly reduce the colony size of spreaders. ND: None detected

Mycologix™ Hidden Mold Detection (HMD) Technologies
Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**
QLAB Job No.: ME221207-12

Client: Gordon Mycology Laboratory, Inc.
Groton, MA

Date Sampled: 12/5/2022

Contact: Gordon, Deb

Date Received: 12/7/2022

Project ID: 22-096GML Bridgewater-3

Date Reported: 12/15/2022

Lab Sample No.	ME221207-12(7)			ME221207-12(8)			ME221207-12(9)		
Sample ID	S7			S8			S9		
Sample Location	Medial Bldg. basement IT room – mold on electrical panel plywood			Medial Bldg. basement IT room – mold on underside of table			Lenox Bldg. shower hallway – supply air diffuser		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	12/15/2022			12/15/2022			12/15/2022		
Amount of Sample Prepared	1 in²			1 in²			2 in²		
Dilution Factor	100			10,000			100		
Detection Limit (DL)	DL = 100 CFU/in²			DL = 10000 CFU/in²			DL = 50 CFU/in²		
Culturable Fungi Conc.*	300 CFU/in²			270,000 CFU/in²			3,200 CFU/in²		
Identification	Adj. Ct.*	CFU/in²	%	Adj. Ct.*	CFU/in²	%	Adj. Ct.*	CFU/in²	%
Major Hydrophilic Fungi**									
Acremonium									
Aureobasidium									
Chaetomium	1	100	33						
Stachybotrys									
Memnoniella									
Yeast, non-specified									
Rhodotorula (yeast)									
Sporobolomyces (yeast)									
Trichoderma [Spreader]***									
Mucor [Spreader]***									
Other Fungi									
Cladosporium	1	100	33	1	10,000	4	51	2,600	80
Penicillium				2	20,000	7	1	50	2
Aspergillus versicolor									
Aspergillus sydowii				23	230,000	85	1	50	2
Aspergillus ochraceus									
Aspergillus niger							1	50	2
Aspergillus fumigatus									
Aspergillus flavus									
Paecilomyces									
Alternaria							5	250	8
Epicoccum							3	150	5
Pithomyces									
Curvularia									
Non-sporulating fungi	1	100	33	1	10,000	4	2	100	3
Xerophilic Fungi Screening		ND			ND			ND	
DG18 (and/or MEA) Dilution Factor:	100	(DL = 100 CFU/in²)		100	(DL = 100 CFU/in²)		100	(DL = 50 CFU/in²)	
Note									

*: Adjusted Counts less than 1 are converted from colony counts read from lower dilutions plates. All concentrations (conc.) are rounded to two digits of significant figures. Total concentrations/percentages may not be equal to the sum of individual concentrations/percentages due to rounding. **: Water-loving fungi, minimal Aw ≥ 0.89. *** Spreader: Trichoderma, Rhizopus, Mucor & Chrysonilia are fast growing fungi on MEA agar plate, which may inhibit the growth of other fungi on the same plate. Mycologix™ HR-MEA can significantly reduce the colony size of spreaders. ND: None detected

Mycologix™ Hidden Mold Detection (HMD) Technologies
Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**
QLAB Job No.: ME221207-12

Client: Gordon Mycology Laboratory, Inc.

Date Sampled: 12/5/2022

Groton, MA

Date Received: 12/7/2022

Contact: Gordon, Deb

Date Reported: 12/15/2022

Project ID: 22-096GML Bridgewater-3

Lab Sample No.	ME221207-12(10)			ME221207-12(11)			ME221207-12(12)		
Sample ID	S10			S11			S12		
Sample Location	Attucks lobby – supply air diffuser			Attucks dining hall – supply air diffuser, at water damaged ceiling			Attucks library – supply air diffuser		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	12/15/2022			12/15/2022			12/15/2022		
Amount of Sample Prepared	3 in²			3 in²			3 in²		
Dilution Factor	100			1,000			100		
Detection Limit (DL)	DL = 33 CFU/in²			DL = 330 CFU/in²			DL = 33 CFU/in²		
Culturable Fungi Conc.*	1,800 CFU/in²			18,000 CFU/in²			800 CFU/in²		
Identification	Adj. Ct.*	CFU/in²	%	Adj. Ct.*	CFU/in²	%	Adj. Ct.*	CFU/in²	%
Major Hydrophilic Fungi**									
Acremonium									
Aureobasidium									
Chaetomium	2	67	4				1	33	4
Stachybotrys									
Memnoniella									
Yeast, non-specified	4	130	7	7	2,300	13			
Rhodotorula (yeast)									
Sporobolomyces (yeast)									
Trichoderma [Spreader]***									
Mucor [Spreader]***									
Other Fungi									
Cladosporium	31	1,000	57	34	11,000	64	19	630	79
Penicillium	12	400	22	3	1,000	6	1	33	4
Aspergillus versicolor									
Aspergillus sydowii									
Aspergillus ochraceus									
Aspergillus niger									
Aspergillus fumigatus									
Aspergillus flavus									
Paecilomyces									
Alternaria	3	100	6	1	330	2	2	67	8
Epicoecum				3	1,000	6			
Pithomyces									
Curvularia	2	67	4	5	1,700	9			
Non-sporulating fungi									
Xerophilic Fungi Screening									
		ND			ND		1	33	4
DG18 (and/or MEA) Dilution Factor:	100	(DL = 33 CFU/in²)		100	(DL = 33 CFU/in²)		100	(DL = 33 CFU/in²)	
Note									

*: Adjusted Counts less than 1 are converted from colony counts read from lower dilutions plates. All concentrations (conc.) are rounded to two digits of significant figures. Total concentrations/percentages may not be equal to the sum of individual concentrations/percentages due to rounding. **: Water-loving fungi, minimal Aw ≥ 0.89. *** Spreader: Trichoderma, Rhizopus, Mucor & Chrysonilia are fast growing fungi on MEA agar plate, which may inhibit the growth of other fungi on the same plate. Mycologix™ HR-MEA can significantly reduce the colony size of spreaders. ND: None detected

Mycologix™ Hidden Mold Detection (HMD) Technologies
Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**
QLAB Job No.: ME221207-12

Client: Gordon Mycology Laboratory, Inc.

Date Sampled: 12/5/2022

Groton, MA

Date Received: 12/7/2022

Contact: Gordon, Deb

Date Reported: 12/15/2022

Project ID: 22-096GML Bridgewater-3

Lab Sample No.	ME221207-12(13)			ME221207-12(14)			ME221207-12(15)		
Sample ID	S13			S14			S15		
Sample Location	Carter Bldg. basement – mold on ductwork wrap			Adams Bldg. Day Room – supply air diffuser (cleaned 3 months ago)			Adams Bldg. basement – mold on ductwork wrap		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	12/15/2022			12/15/2022			12/15/2022		
Amount of Sample Prepared	1 in ²			3 in ²			1 in ²		
Dilution Factor	100			100			100		
Detection Limit (DL)	DL = 100 CFU/in ²			DL = 33 CFU/in ²			DL = 100 CFU/in ²		
Culturable Fungi Conc.*	200 CFU/in ²			1,500 CFU/in ²			1,400 CFU/in ²		
Identification	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%
Major Hydrophilic Fungi**									
Acremonium									
Aureobasidium									
Chaetomium									
Stachybotrys									
Memnoniella									
Yeast, non-specified									
Rhodotorula (yeast)									
Sporobolomyces (yeast)									
Trichoderma [Spreader]***				1	33	2			
Mucor [Spreader]***									
Other Fungi									
Cladosporium				9	300	20			
Penicillium				31	1,000	69	2	200	14
Aspergillus versicolor									
Aspergillus sydowii									
Aspergillus ochraceus									
Aspergillus niger							12	1,200	86
Aspergillus fumigatus									
Aspergillus flavus									
Paecilomyces									
Alternaria									
Epicoecum									
Pithomyces									
Curvularia									
Non-sporulating fungi	2	200	100	4	130	9			
Xerophilic Fungi Screening									
DG18 (and/or MEA) Dilution Factor:	100	(DL = 100 CFU/in ²)		100	(DL = 33 CFU/in ²)		100	(DL = 100 CFU/in ²)	
Note									

*: Adjusted Counts less than 1 are converted from colony counts read from lower dilutions plates. All concentrations (conc.) are rounded to two digits of significant figures. Total concentrations/percentages may not be equal to the sum of individual concentrations/percentages due to rounding. **: Water-loving fungi, minimal Aw ≥ 0.89. *** Spreader: Trichoderma, Rhizopus, Mucor & Chrysonilia are fast growing fungi on MEA agar plate, which may inhibit the growth of other fungi on the same plate. Mycologix™ HR-MEA can significantly reduce the colony size of spreaders. ND: None detected



QLAB, 256 Bridge St, Metuchen, NJ 08840

info@qlabusa.com www.QLABusa.com

AIHA EMPAT Lab ID: 178794

Mycologix™ Hidden Mold Detection (HMD) Technologies**Analysis:** Culturable Fungi (FC-12MEA+) - **Surface/Bulk****QLAB Job No.:** ME221207-12**Client:** Gordon Mycology Laboratory, Inc.**Date Sampled:** 12/5/2022

Groton, MA

Date Received: 12/7/2022**Contact:** Gordon, Deb**Date Reported:** 12/15/2022**Project ID:** 22-096GML Bridgewater-3

Lab Sample No.	ME221207-12(16)				
Sample ID	S16				
Sample Location	Adams Bldg. hallway to rooms – return air grille				
Sample Type (Device)	Surface (SpongeSWAB (S))				
Media (Temperature: 25°C)	Media: MEA, DG18 Mycologix™ Media: RD-PDA, CA/Stachybotrys (SCUM) Agar, and/or Xero-MEA				
Date Analyzed	12/15/2022				
Amount of Sample Prepared	1 in²				
Dilution Factor	1,000				
Detection Limit (DL)	DL = 1000 CFU/in²				
Culturable Fungi Conc.*	18,000 CFU/in²				
Identification	Adj. Ct.*	CFU/in²	%		
Major Hydrophilic Fungi**					
Acremonium					
Aureobasidium					
Chaetomium					
Stachybotrys					
Memnoniella					
Yeast, non-specified					
Rhodotorula (yeast)					
Sporobolomyces (yeast)					
Trichoderma [Spreader]***					
Mucor [Spreader]***					
Other Fungi					
Cladosporium	5	5,000	27		
Penicillium	12	12,000	66		
Aspergillus versicolor					
Aspergillus sydowii					
Aspergillus ochraceus					
Aspergillus niger	0.1	100	< 1		
Aspergillus fumigatus					
Aspergillus flavus	0.1	100	< 1		
Paecilomyces					
Alternaria					
Epicoccum					
Pithomyces					
Curvularia					
Non-sporulating fungi	1	1,000	5		
Xerophilic Fungi Screening		ND			
DG18 (and/or MEA) Dilution Factor:	100	(DL = 100 CFU/in²)			
Note					

*: Adjusted Counts less than 1 are converted from colony counts read from lower dilutions plates. All concentrations (conc.) are rounded to two digits of significant figures. Total concentrations/percentages may not be equal to the sum of individual concentrations/percentages due to rounding. **: Water-loving fungi, minimal Aw ≥ 0.89. *** Spreader: Trichoderma, Rhizopus, Mucor & Chytridiomycota are fast growing fungi on MEA agar plate, which may inhibit the growth of other fungi on the same plate. Mycologix™ HR-MEA can significantly reduce the colony size of spreaders. ND: None detected



Deb Gordon
Gordon Mycology Laboratory, Inc.
P.O. Box 310
Groton, MA 01450

December 23, 2022

Dear Deb Gordon,

The enclosed analytical results have been obtained by using EPA 600/R-93/116 or EPA 600/M4-82-020. Calibrated Visual Estimate (CVE) is used by Aerobiology for the determination of the percentage of asbestos and other components in the sample. Point Counting is recommended when the sample contains less than 10% asbestos by CVE. Friable materials found to be less than 1% by CVE are automatically point counted (400 points) at no additional charge. Aerobiology recommends further analysis by a gravimetric method for non-friable materials that are less than 1% by CVE.

The Quality Control data related to the samples analyzed is available upon client's written request. Aerobiology Laboratory Associates, Inc., assumes no responsibility for potential sample contamination that may have occurred during the sample collection process or erroneous data provided by the client. As such, these results apply to the sample(s) as received. Unless otherwise indicated, all samples were received in acceptable condition.

The enclosed results may not be used under any circumstances as product endorsement by any US government agency including NIST/NVLAP.

All Laboratory records are retained for at least three years unless otherwise directed in writing by the client. The actual samples are retained for a period of two months and written request is necessary in order to be retained for a longer period of time. All analytical results and records are considered strictly confidential and will not be released under any circumstances to anyone except the actual client. The analytical results included in this report apply only to the items tested. This report may not be reproduced except in its entirety, without the permission of Aerobiology Laboratory Associates, Inc., Laboratory Manager.

If you have any questions please contact the Optical Manager or the Laboratory Manager.
Sincerely,

Aimee Cormier, Laboratory Manager

Enclosure: Version 2
LAB BATCH ID: B 131959 CLIENT PROJECT ID: 22-096GML
Client Ref: N/A
CT ID# PH-0209; MA ID# AA000156; ME ID# LB-055; NVLAP Lab Code 200090-0; RI ID # AAL-093;
VT ID# AL016876

Aerobiology Laboratory Associates, Inc.

Client Name: Gordon Mycology Laboratory, Inc.
 PO #: N/A
 Client Project #: 22-096GML
 Client Reference: N/A
 Method: EPA/600/R-93/116

Batch: B131959
 Date Sampled: 12/5/2022
 Date Received: 12/20/2022
 Date Analyzed: 12/21/2022
 Date of Report: 12/23/2022

Sample ID	Color	Asbestos %						Non-Asbestos %						
		CHR	AMO	CRO	ACT	TRE	ANT	FBG	MNW	CEL	HAR	SYN	OTH	NON
S11	Black	0	0	0	0	0	0	2	0	0	0	0	0	98
Description: Black Fibrous Debris from HVAC Supply Diffuser Location: N/A Comments: Is asbestos present? No. Analyzed: Yes														

Asbestos Codes: CHR = Chrysotile AMO = Amosite CRO = Crocidolite ACT = Actinolite TRE = Tremolite ANT = Anthophyllite
 Non-Asbestos Codes: FBG = Fiberglass MNW = Mineral Wool CEL = Cellulose HAR = Hair SYN = Synthetic OTH = Other NON = Non-Fibrous Minerals

Note: To create a unique lab sample ID, use the Batch # and the Sample ID (example: [Batch #] - [Sample ID]).

* All results are in percentage.

Analyst: Dan Pine

[Signature]