Disability Law Center

Massachusetts Protection and Advocacy

Public Report: The Commonwealth's Treatment of Individuals with Mental Health Disabilities Committed to Bridgewater State Hospital and Barriers to Continuity of Care Upon Discharge

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 2025 Budget (Line Item #8900-0001).

February 2025

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OVERVIEW AND RECOMMENDATIONS

This report discusses the Disability Law Center's (DLC) detailed findings from our monitoring of Bridgewater State Hospital (BSH), including the Bridgewater State Hospital Units at Old Colony Correctional Center (OCCC BSH Units), for the period from July 2024 through December 2024. BSH and the OCCC BSH Units are under the authority of the Department of Correction (DOC). DLC is a nonprofit organization and the Commonwealth's designated Protection and Advocacy agency (P&A) for persons with disabilities, granting DLC federal authority to investigate abuse and neglect of people with disabilities, monitor settings where people with disabilities live or receive services, and engage in advocacy to protect the rights of individuals with disabilities. Because of the high demand for DLC services and our limited staffing and resources, DLC's intensive ongoing monitoring of BSH, including onsite inspections with a mold expert and laboratory analysis, would not be possible without the support and expanded authority granted by budget Line Item #8900-0001.[1]

During the reporting period, DLC engaged in consistent communication with DOC and the Contracted Provider.[2] DLC sent almost weekly emails concerning issues DLC discovered during monitoring and had regular, informative meetings with the BSH administrators. DLC regularly engaged with DOC counsel concerning access to documentation and video footage, and consulted with DOC administrators on facility issues. DLC appreciated the opportunity meet on January 3, 2025 with the DOC Commissioner and Deputy Commissioner of Clinical Services & Reentry. On January 6, 2025, DOC formally responded to DLC's July 2024 report[3] in a letter attached hereto as **Appendix B**.[4] Despite open communication, Contracted Provider efforts to respond to DLC recommendations, and DOC's efforts to address issues with the BSH physical plant, countertherapeutic conditions and illegal practices continue to harm BSH Persons Served (PS), who are disproportionately people of color.

Acceptable treatment for people with disabilities involuntarily committed to BSH remains in stark contrast to the mental health care and living conditions offered to people committed to Department of Mental Health (DMH) hospitals. Massachusetts law explicitly provides DOC control of BSH, also known as "Massachusetts Correctional Institution, Bridgewater."[5] As a result, DOC, not DMH, rules and regulations apply. While improvements to some BSH policies in recent years have brought them into greater alignment with DMH protections, the continuing illegal restraint, seclusion, and involuntary medication practices by BSH clinical staff blunt their effect. At the same time, BSH is undeniably a state prison in form and function – apparent from dominating physical features like PS cells and security staff who assemble outside of PS cells for planned uses of force to administer involuntary medication.

DMH rules and regulations include extensive protections for patients related to health, safety, and quality of care that BSH PS do not receive. These include the 6 fundamental rights and

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[1] Complete Line Item languages is available at: https://malegislature.gov/Budget/FY2025/FinalBudget.
[2] DLC uses the term "Contracted Provider" throughout this report. The current provider now identifies as Recovery Solutions, but was known as Wellpath throughout the reporting period. Recovery Solutions' contract ends as of June 2024. The name of the contract holder as of July 2025 is unknown.
[3] *See* DLC, *Public Report: The Commonwealth's Treatment of Individuals with Mental Health Disabilities Committed to Bridgewater State Hospital and Continuity of Care Upon Discharge*, 36-37 (July 2024), https://www.dlc-ma.org/wp-content/uploads/2024/07/DLC-BSH-Public-Report-7.30.2024-w.-Apps.pdf [hereinafter "DLC July 2024 Report"].
[4] Department of Correction Response to Disability Law Center July 2024 Report on Bridgewater State Hospital (January 6, 2025) [hereinafter "Appendix C"].
[5] M.G.L. c. 125, § 18.

detailed restrictions on restraint and seclusion practices.[6] Moreover, rules prohibiting or defining acceptable staff planned uses of force and riot gear in patient interactions are so contrary to the mission and ethos of DMH that they need not even be written in agency policy.

The Commonwealth must stop waiting for change that will never come and protect BSH PS, a population widely recognized as including individuals with the most significant mental health disabilities in the state. The prison facility plagued with illegal restraint and seclusion practices, disproportionate and unnecessary uses of force, and a punishing correctional environment – even while subject to intensive DLC monitoring, investigations, and advocacy – will not become a licensed, accredited psychiatric hospital. The dehumanizing and destabilizing daily traumas that PS face will not end. DLC's decade of work at BSH has shown that even the most promising reform has been temporary under the authority of DOC. With this in mind, DLC again urgently calls on the Commonwealth to transfer oversight of BSH to DMH so that the rules and regulations that apply to all other Massachusetts psychiatric hospitals apply at BSH, and to commit to construction of a modern DMH hospital facility to serve the BSH population

DLC RECOMMENDATIONS

Only 2 actions can adequately protect the rights and health of the current and future BSH population:

1. **The Commonwealth must immediately place BSH operations under the authority of DMH to ensure current and future PS access to trauma-informed, person-centered mental health treatment; and**
2. **The Commonwealth must urgently construct a modern DMH hospital facility designed to provide all individuals in need of "strict security" psychiatric evaluation and/or treatment in a safe, therapeutic environment and finally close BSH.**

[6] *See, e.g.,* M.G.L. c.123, § 23; 104 CMR 27.

I. BSH Care and Treatment: Stark and Dangerous Disparities

It has long been true that individuals with mental health disabilities committed to BSH do not receive mental health care and treatment commensurate with the care provided to people committed for inpatient evaluation and treatment in DMH hospitals. **Four major interrelated factors within BSH contribute to the disparities in care and treatment for PS:**

(1) BSH is a state prison, rather than a hospital;

(2) BSH is not subject to DMH regulations;

(3) BSH policies and procedures differ from those of DMH; and

(4) Practices and decisions of BSH providers.

Throughout this report, DLC describes treatment, staff conduct, and physical plant features that only exist – or are permitted to persist – at BSH because it is a prison. DOC's January 6, 2025 response to DLC's July 2024 report misstates that BSH is a "Joint Commission-accredited behavioral health hospital."[7] BSH has a Behavioral Health Care and Human Services accreditation from the Joint Commission.[8] BSH is not and has never been accredited by the Joint Commission as a hospital of any kind. DMH hospitals and units that serve similar – and often the exact same – individuals with mental health disabilities must meet the more stringent requirements of hospital accreditation by the Joint Commission.

In addition, DOC states that BSH is "a Department of Public Health-licensed hospital."[9] Upon an inquiry from DLC, the Department of Public Health (DPH) Division of Health Care Facility Licensure and Certification confirmed that DPH does not license BSH. DPH makes the "list of facilities licensed or certified by the Division of Health Care Facility Licensure & Certification" publicly available on its website.[10] The spreadsheet, current as of January 16, 2025 lists over 3,500 licensed and certified facilities, including 70 acute care hospitals, 26 non-acute hospitals, and over 450 satellite hospital, emergency facility, and inpatient units.[11] As a correctional facility, BSH is subject to inspection by DPH's Community Sanitation Program for compliance with regulations that establish required minimum standards for correctional facilities.[12] During

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[7] Appendix C at 2.
[8] For the BSH accreditation listing on the Joint Commission website, *see* https://www.jointcommission.org/who-we-are/who-we-work-with/find-accredited-organizations/#q=Bridgewater%20state%20hospital&numberOfResults=25. According to publicly available information from the Joint Commission, there are 166 entities in Massachusetts that have the Behavioral Health Care and Human Services Accreditation, which include entities that provide "mental health services, addiction treatment, eating disorder treatment, ID/DD services, and social service/human services agencies serving children and families." The Joint Commission, Settings and Services, https://www.jointcommission.org/what-we-offer/accreditation/health-care-settings/behavioral-health-care/learn/eligibility/.
[9] Appendix C at 1.
[10] DPH, *Find information about licensed or certified health care facilities*, https://www.mass.gov/info-details/find-information-about-licensed-or-certified-health-care-facilities.
[11] DMH, *Massachusetts Licensed or Certified Health Care Facility/Agency Listing* (January 16, 2025), https://www.mass.gov/doc/list-of-health-care-facilities-licensed-or-certified-by-the-division/download.
[12] DPH, *Correctional facilities – Community Sanitation,* https://www.mass.gov/lists/correctional-facilities-community-sanitation.

the last DPH inspection of BSH, the Community Sanitation Program found hundreds of health and safety violations, including 413 repeat violations.[13]

Failures in care and treatment of BSH PS, including actions that violate the law, implicate DOC, the Contracted Provider, and individual BSH providers alike. Of course, DOC cannot contract away its legal responsibilities to provide constitutionally adequate health care and conditions or to comply with other applicable state and federal laws, but DOC's involvement does not end there. DOC is closely involved in the running of BSH and aware of the happenings within. For example:

- State law grants the DOC Commissioner the authority to appoint the Medical Director of BSH and requires the medical director to provide care "in accordance with rules and regulations approved by the [DOC] commissioner."[14]

- DOC plays an essential role in the creation of all BSH policies; the Contracted Provider may draft policies, but they cannot issue formally until DOC has approved the final language.

- State law requires that BSH send all restraint and seclusion forms and attachments to the DOC Commissioner "who shall review and sign them within 30 days of receipt." DOC must also maintain statistical records of the use of restraint and seclusion at BSH.[15]

- BSH policy governing the "Use of Seclusion and Restraint" requires that BSH "submit copies of all Seclusion and Restraint documentation, any attachments thereto, and an aggregated report of each individual use of Seclusion and Restraint, to the DOC Commissioner and the BSH Superintendent for review, within 30 days of each incident, on a bi-monthly basis (i.e. twice monthly)."[16]

- BSH "Serious Incident Reporting" policies include requiring prompt notification of certain events to the BSH Superintendent and/or DOC Office of Investigative Services and presentation of summaries of "[a]ll findings, actions taken, and follow up related to [Serious Clinical Episodes] … to the DOC Health Services Division (HSD) Executive Staff Meeting on the first and third Wednesday of each month."[17]

DMH rules and regulations include extensive protections for patients related to health, safety, and quality of care that BSH PS do not receive. These include the 6 fundamental rights and detailed restrictions of restraint and seclusion practices.[18] Moreover, prohibitions against regular staff violence and use of tactical gear in patient interactions need not even be written into DMH rules and regulations because such practices would be so contrary to the mission and ethos of the agency.

Without the much-needed controls of DMH regulations and agency oversight, BSH and the BSH Annex Units at OCCC exist as islands in DOC. On these islands, the Contracted Provider and

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[13] DPH, *Letter to Superintendent Stephen Kennedy*: *Facility Inspection – Bridgewater State Hospital* (April 2, 2024), https://www.mass.gov/doc/bridgewater-state-hospital-march-21-2024/download.
[14] M.G.L. c. 125, § 18.
[15] M.G.L. c. 123, § 21.
[16] BSH Policy and Procedure Manual, PC 400-08 Use of Seclusion and Restraint.
[17] *See* BSH Policy and Procedure Manual, LD 100-01 Serious Incident Reporting, § 5.12; PC-300-13 Serious Clinical Episode – Review Process, § 5.5.6.
[18] *See, e.g.,* M.G.L. c.123, § 23; 104 CMR 27.

the individual providers it employs are not subject to appropriate oversight and controls. For instance, BSH providers applied the former BSH policies governing restraint and seclusion and the use of involuntary psychotropic medication, which plainly violated Massachusetts law, for years before DOC finally issued the updated policy in 2024. Now, although the policy language has changed, records indicate that certain BSH providers – including those in leadership positions – feel empowered to continue ordering seclusion and involuntary medications in circumstances not permitted by law, as discussed in greater detail below.

1. Troubling and Illegal Restraint, Seclusion, and Involuntary Medication Practices

DLC gathered more evidence of systemic improper restraint, seclusion, and involuntary medication practices absent a court-ordered treatment plan at BSH during this reporting period. These practices regularly occur in violation of clear limitations established by state law that applies to BSH and DMH-operated and licensed hospitals alike, and of the constitutionally protected liberty interest of PS.[19] At the same time, these practices constitute abuse,[20] and are too often committed via planned uses of force by staff involving shocking physical violence.

Restraint and seclusion are interventions of last resort to be used only when less restrictive measures have proven ineffective in addressing emergency circumstances, "such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide."[21] The interventions should never be used a means of coercion, punishment, or convenience.[22] Strict limitations on use of seclusion and all forms of restraint exist for good reason:

> Studies have shown that the use of seclusion and restraint can result in psychological harm, physical injuries, and death to both the people subjected to and the staff applying these techniques. Injury rates to staff in mental health settings that use seclusion and restraint have been found to be higher than injuries sustained by workers in high-risk industries. Restraints can be harmful and often re-traumatizing for people, especially those who have trauma histories. Beyond the physical risks of injury and death, it has

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[19] *See, e.g.,* M.G.L. c. 123, § 21; *Rogers v. Okin*, 738 F.2d 1, 5-9 (1st Cir. 1984); *O'Sullivan v. Sec'y of Hum. Servs*., 402 Mass. 190, 194, 198 n.10 (1988); *Rogers v. Comm'r of Dep't of Mental Health*, 390 Mass. 489 (1983); *In re: Guardianship of Roe*, 383 Mass. 415 (1981).

[20] In our capacity as the P&A, DLC applies the definition of abuse set forth in regulations applicable to the Protection and Advocacy for Individuals with Mental Illness Program:

> Abuse means any act or failure to act by an employee of a facility rendering care or treatment which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with mental illness, and includes but is not limited to acts such as: rape or sexual assault; striking; the use of excessive force when placing an individual with mental illness in bodily restrains; the use of bodily or chemical restraints which is not in compliance with Federal and State laws and regulations; verbal, nonverbal, mental and emotional harassment; and any other practice which is likely to cause immediate physical or psychological harm or result in long-term harm if such practices continue.

42 C.F.R. § 51.2.

[21] M.G.L. c. 123, § 21; 104 CMR 27.12 ("Such emergencies shall only include situations where there is a substantial risk of, or the occurrence of, serious self-destructive behavior, or a substantial risk of, or the occurrence of, serious physical assault. As used in the previous sentence, a substantial risk includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such harm, where there is the present ability to effect such harm"); *see also* 42 CFR §§ 483.352, 483.356(a).

[22] *See* 42 CFR § 483.356(a

been found that people who experience seclusion and restraint remain in care longer and are more likely to be readmitted for care.[23]

Medication restraint and other forms of involuntary medication are limited further based on additional substantive and procedural rights granted by Massachusetts law.[24] "[T]here are 'few legitimate medical procedures which are more intrusive than the forcible injection of antipsychotic medication."[25] "In addition, "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."[26] Thus, individuals who are civilly committed by the Commonwealth on the basis of mental illness have the right to make their own treatment decisions, unless they are subject to involuntary medication in one of the following circumstances:

1. **Per a court-ordered *Rogers* guardianship**: After a court has made a substituted judgement decision that the individual would accept the medication if competent and approved a treatment plan;[27]
2. **As a chemical restraint:** 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 alternative to forced antipsychotic drugs available*[28] and "*the statutory and regulatory conditions for the use of chemical restraints must be followed*"[29]; and
3. **To prevent irreversible deterioration of serious mental illness:** 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.'"[30]

Despite these well-established legal protections and recognition of harmful consequences, BSH consistently, as DLC has reported for years, orders and administers restraint, seclusion and involuntary medication outside of the confines of the law and outside of the bounds of the acceptable standard of care in a psychiatric hospital.

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[23] Substance Abuse and Mental Health Services Administration, *Trauma and Violence,* https://www.samhsa.gov/trauma-violence#:~:text=Seclusion%20and%20restraint%20were%20once,safety%20is%20at%20severe%20risk; *see* American Psychiatric Association, *APA Resource Document: Seclusion or Restraint* (February 2022), https://www.psychiatry.org/getattachment/e9b21b26-c933-4794-a3c4-01ad427eed91/Resource-Document-Seclusion-Restraint.pdf; American Psychiatric Nurses Association; *APNA Position: The Use of Seclusion and Restraint* (Revised 2022), https://www.apna.org/apna-position-the-use-of-seclusion-and-restraint/.

[24] *See* M.G.L. c. 123, § 21; *Rogers v. Okin*, 738 F.2d at 5-8; *Rogers v. Comm'r,* 390 Mass. at 494-504, 505-506, 510-511

[25] *Rogers v. Comm'r*, 390 Mass. at 502 n.16, quoting *Matter of Guardianship of Roe*, 383 Mass. 415, 436 (1981)

[26] *Rogers v. Comm'r*, 390 Mass. at 503, 503 n.19.

[27] *Id*. at 512-513.

[28] *Id.* at 490-491, 509-511; M.G.L. c. 123, § 21 (emphasis added).

[29] *Id.* at 509. "Neither doctors nor courts have the power to expand the circumstances in which a patient may be restrained." *O'Sullivan*, 402 Mass. at 194, citing *Rogers v. Comm'r*, 390 Mass. at 510.

[30] *Rogers v. Comm'r.* 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.

A. Failed Implementation of BSH's New Medication Restraint Policy and Illegal Medication Restraint

In our 2024 public reports, DLC highlighted BSH's new policies on "Use of Involuntary Psychotropic Medication" and "Use of Seclusion and Restraint" enacted after years of DLC advocacy against illegal medication practices enshrined in past policy language.[31] These policies, developed with input from DLC, contained long-overdue revised language concerning medication restraint that finally comports with Massachusetts' restraint law. Both policies went into effect in June 2024.

Since June 2024, DLC has been alarmed by improper application of the new policies. Based on DLC's review of medical records, restraint forms, and security footage, BSH staff continue to subject PS to involuntary emergency medication sans emergency circumstances, despite the new policy's narrow definition of the circumstances allowing for restraint in keeping with state law. In addition, the prevalence of medication restraints continues to rise with each reporting period. As set out in greater detail in tables below, **BSH medication restraint administrations jumped to 311 on 126 unique PS during this reporting period, amounting to 1.71 medication restraints per day. This is a 25% increase in medication restraint from the last reporting period.**

B. Staff Noncompliance with Updated Policies

Many BSH staff appear to ignore the dictates of current policy. The reasons for this vary. DLC's observations suggest that some BSH psychiatrists may know of the policy language but choose to flout it because they do not agree with the law's restrictions on their ability to order to force medicate PS as they see fit. Other staff do not understand the differences in the updated policy or are altogether unaware of the policy change. In daily 24-hour nursing reports sent to BSH clinical staff and executive leadership, as well as PS medical records, staff frequently reference "ETOs" (Emergency Treatment Orders") – the illegal category of involuntary medication removed from current policy in effect since June 2024. Despite BSH leadership's exposure to these daily notes, regular mentions of "ETOs" have persisted, whereas mentions of "medication restraint" remain few and far between. DLC notified BSH administrators, including the Medical Executive Director, directly of these concerns twice during this reporting period. During these meetings, BSH administrators assured DLC that they understood the gravity of the issue and would address it with psychiatric providers and nursing staff. Nonetheless, nursing reports containing numerous references to the former illegal policy continued to be disseminated broadly to BSH staff.

DLC interviewed 8 direct care staff during the last month of this reporting period about their understanding of the new involuntary medication policy. Responsibilities of these direct care staff include: reporting significant changes in PS presentation and behavior to the psychiatrist who ordered the medication restraint; explaining medication orders; reporting back to ordering clinicians if the medication restraint is no longer appropriate; and administering medication

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[31] DLC, Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served (February 2024) at 7-9, https://www.dlc-ma.org/wpcontent/uploads/2024/03/DLC-BSH-Public-Report-3.13.2024.pdf [hereinafter "DLC February 2024 Report"].7-9; DLC July 2024 Report at 11-12.

restraints. Without fail, each staff member assured DLC that ETOs were still frequently used at BSH. Five of these staff members had never heard of medication restraints. The 3 staff who reported having heard of medication restraints said that they were the same as ETOs. These responses are cause for grave concern with respect to PS care as well as to the training and oversight of clinical staff at BSH.

In sum, BSH has failed to fully implement its new policies issued specifically to prevent continued illegal practices that violate the rights of and traumatize PS. While DOC bears ultimate responsibility for this failure, based on DLC's observations, much of the direct responsibility can be attributed to BSH leadership employed by the Contracted Provider, including the long-term Medical Executive Director.

C. *Unresolved Issues with the BSH Medication Restraint Order Form*

The failure of the Executive Medical Director and other BSH administrators and clinicians to implement BSH policy concerning medication restraint is exacerbated by the still flawed Medication Restraint Order form, entitled "BSH S/R – Medication Restraint. The form, which replaced the "Emergency Treatment Order Form," has been in use since September 2023 despite DLC reporting major concerns about its compliance with M.G.L. c. 123, § 21 and messaging to staff that illegal restraint in non-emergency circumstances is still acceptable at BSH.[32] In our critique, DLC pointed to DMH's existing Emergency Restraint or Seclusion Form as guidance in improving the BSH form. Unfortunately, despite further conversations with the Contracted Provider and clear instances of clinicians writing legally deficient medication restraint orders, it is DLC's understanding that an improved BSH form is only in draft form.

Concern 1: "Type of Emergency"

> *The BSH S/R - Medication Restraint form contains four checkboxes for the [Contracted Provider] staff ordering the restraint to indicate rationale under "Type of Emergency": Potential harm to self"; "Actual harm to self"; "Potential harm to others"; and "Actual harm to others." The use of "potential harm" as justification for medication restraint is more permissive than the language of M.G.L. c. 123, § 21 limiting use of restraint to "cases of emergency, such as the occurrence, or serious threat of, extreme violence, personal injury or attempted suicide."*[33]

As DLC feared, psychiatric providers are frequently indicating only "potential harm to self," "potential harm to others," or the two in combination under the "Type of Emergency." According to the standard provided in Massachusetts law and the new BSH policy which parrots it, "potential harm" does not justify a restraint.

Concern 2: "Indication for Emergency Medication Order"

> *Though framed as a form for medication restraint, the BSH form includes a section for staff ordering the restraint to indicate what they determine to be the "Indication for Emergency Medication Order" with two checkboxes: "Treatment of Acute Symptoms" and "Restraint to Prevent Harm…" [T]he language is*

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[32] DLC February 2024 Report at 13-14.
[33] *Id.* at 13.

misplaced on a form recording the circumstances surrounding a medication restraint. While all restraint is intended in some way "to prevent harm," that intention should not be confused for a justification. In addition, "treatment," as discussed extensively in previous DLC reports covering ETO administration, is not a legal basis for medication restraint under state law. Inclusion of past language used to justify illegal restraint in the guise of ETOs should be struck from the current form to prevent staff confusion and a continuation of illicit restraint practices.[34]

Unsurprisingly, BSH psychiatric providers frequently mark "treatment of acute symptoms" alone, or in combination with "restraint to prevent harm," under "indication for emergency medication order." DLC observed these trends in our review of all BSH Medication Restraint Order forms this reporting period. As illustration, below are the "Indication[s]" BSH clinicians cited for 13 medication restraints that occurred in a randomly selected week (September 1 to September 7) during the 18-week reporting period:[35]

- 6 forms selected only "Treatment of acute symptoms";
- 6 forms selected both "Treatment of acute symptoms" and "Restraint to prevent harm"; and
- 1 form selected only "Restraint to prevent harm."

Even if this week were an outlier, the form's continued reinforcement of illegal medication restraint practices by BSH clinicians is clear.

Concern 3: "Describe Situation Creating the Risk" and "Describe the Risk if Medication is Not Administered"

The BSH form provides space for providers to describe what gave rise to the medication restraint and why it needs to be administered. Unfortunately, the form's language suggests that a situation creating "risk" is sufficient to justify medication restraint. As already discussed, M.G.L. c. 123, § 21 does not permit any form of restraint based on risk alone – there must be, at the least, a serious threat of extreme violence, personal injury or attempted suicide. The DMH form, on the other hand, clearly calls for the providers to "Describe Behavior Requiring Emergency Use/Continuation of R/S." [36]

BSH psychiatric providers frequently cite past circumstances – often behaviors that may have occurred days or months earlier – as the "situation creating the risk" justifying medications restraint, while disregarding the lack of current emergency circumstances.

Concern 4: "Least Restrictive Means Attempted"

The BSH form provides eight checkboxes of "Least Restrictive Means Attempted" prior to the administration of medication restraint on a PS: "Verbal de-escalation," "Taking space/time-out," "Relaxation exercise," "Low stimulation setting," Comfort room," "Sensory modulation intervention," "PRN Medication," and "Other."[37]

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[34] DLC February 2024 Report at 13
[35] This reporting period, the average number of medication restraints per week is 11.97.
[36] DLC February 2024 Report at 13
[37] DLC February 2024 Report at 13-14

As in the last reporting period, DLC's review of Medication Restraint Order forms indicated that, in practice, several options are underutilized and those commonly checked off are not, in actuality, indicative of meaningful interventions. "PRN medication" is almost always checked, as are "Taking space/time-out" and "Low stimulation setting," euphemisms for the seclusion in PS cells that takes place prior to administration of medication restraint at BSH. While "Verbal De-escalation" is also often marked, in DLC's observations, this can merely amount to telling someone to stop a behavior. Thus, DLC is concerned that medication restraint is not limited to use when it "is the least restrictive, most appropriate alternative available," as § 21 mandates.

DLC urges DOC and its Contracted Provider to modify the Medication Restraint Form to guard against further violations of Massachusetts law and the BSH Use of Involuntary Psychotropic Medication policy.

In response to the issues DLC raised in its July 2024 report concerning the form, DOC's January 6, 2025 response states that "the form has been reviewed by multiple agencies, including DMH and the Joint Commission, to ensure that it meets all legal standards."[38] DLC acknowledges that, if BSH psychiatrists and other clinical staff properly adhered to Massachusetts law and the Contracted Provider and DOC provided appropriate oversight, the form would not be cause for concern in and of itself. Unfortunately, however, psychiatrists – many of whom have been working at BSH for over a decade – and other medical professionals and mental health staff involved in medication restraint at BSH have consistently exhibited a misunderstanding or refusal to comply with well-established legal limitations on restraint. Reviewing the form in a vacuum, ignoring this context, is not effective.

D. Unjustified Medication Restraint in the Absence of Emergency Circumstances

DOC's Contracted Provider regularly administers involuntary psychotropic medication to PS locked in their cells when there are no emergency circumstances present. Based on numerous PS interviews, review of documentation of restraint throughout the reporting period, review of 8 sets of PS medical records, and review of 34 videos of forced medication administration, DLC continues to find that BSH practices do not comport with legal requirements and give rise to abuse of PS.

Remarkably, during this reporting period DLC could identify only 1 example of a medication restraint being discontinued before administration. In other words, over 6 months and out of 311 medication restraints administered, there was a single instance of BSH staff recognizing that the conditions underlying the order had changed sufficiently to cancel the restraint. The Contracted Provider chooses not to track these instances.

Based on the available documentation, even this instance was still highly problematic. According to the Medication Restraint Order form, the restraint was indicated only for "treatment of acute symptoms," not "restraint to prevent harm," already placing it at odds with Massachusetts restraint law. The psychiatrist recorded that the "situation creating the risk" was: "Patient was throwing meal trays in his room, paranoid, delusional ("why are you keeping me in this cage?"), needed IM to be safely moved to another room." The provider then describes the "Risk if Medication is Not Administered": "If meds not administered, patient would likely have been violent (punching at, swinging at) staff when they tried to move him from his room to another room. He is not able to currently stay in his room d/t unhygienic conditions (food over

[38] Appendix C at 2.

windows/doors).” The provider fails to justify how any of the confusingly presented concerns (food around the PS cell, throwing of meal trays, or *anticipated* violence to a staff intervention) constitute an emergency according to M.G.L. c. 123, §21.

Despite the provider’s assumption, the PS was eventually moved to a clean cell by the Contracted Provider’s security staff, known as Therapeutic Safety Technicians (TST) using a manual hold and *without* administering the medication restraint. Neither the Nurse Initiation of Seclusion/Mechanical Restraint form nor the Medication Restraint Order form provide a reason for why this was done, or an acknowledgment that the medication restraint was unnecessary. Nursing notes do state that, once in the clean cell, the medication restraint was cancelled because “PS bilateral strides observed to be unsteady with signs of fatigue present” along with "concerns of minimal PO intake,” meaning the PS had not been eating or drinking enough.

The examples below illustrate common scenarios in which PS are subjected to medication restraint: where emergency circumstances were never present; where emergency circumstances no longer existed at the time of the medication restraint due to delay in administration; or where the medication restraint is applied for a secondary purpose, such as a cell change. DLC highlights that each of these scenarios, in addition to showing a lack of requisite emergency circumstances, also indicate BSH’s failure to explore less restrictive alternatives to medication restraint, as required by law.

i. PS “Alwyn”

According to medical records, PS Alwyn was “agitated, uncooperative, was causing climate issue refusing to return a toothbrush that could be used as a weapon, threatening to harm peers or staff, disorganized, and making unreasonable demands.” BSH staff placed him in a manual hold to take him to the unit seclusion room cell, rather than his cell. The seclusion room cell holds only a four-point restraint bed. According to the Medication Restraint Order, the unit psychiatrist ordered an intramuscular medication restraint at 9:50am – only 15 minutes after he begins his seclusion, a less restrictive alternative to medication restraint. However, the medication restraint was not administered until nearly an hour and a half later.

DLC reviewed the video footage of this incident and observed the prolonged lead up to Alwyn’s medication restraint in non-emergency circumstances.

At **9:32am**, Alwyn is placed in the unit seclusion room cell. He alternately walks around the restraint bed, talks to staff through the door, and occasionally looks in the mirror.
Alwyn lies down on the restraint bed from **9:44am** until **9:48am**. He then changes his clothes, paces and talks to staff until **9:59am**, when he lies down on the bed again until **10:01am**. A TST appears outside his door and Alwyn speaks to the TST with his open palms facing up in what appears to be a frustrated, pleading manner. At **10:05am,** Alwyn sits down on the bed and continues to make a pleading hand gesture towards the door.
At **10:09am**, PS Alwyn lies down on the bed. For roughly 10 minutes, he lies down, sits up, applies deodorant, and paces in the cell.
At **10:21am** PS Alwyn lies in a fetal position on the bed with his buttocks exposed for over a minute. He then alternately dances, jumps on the bed, and pantomimes administering an injection to his own buttocks.
At **10:49am**, a TST comes to the seclusion room door and attempts to speak with PS Alwyn while he is moving around the cell. At **10:51am**, PS Alwyn lies down on the bed in a fetal position, then shifts to lie on his stomach with his hands behind his head.

At **10:54am**, 4 TSTs dressed in riot gear enter the seclusion room and hover their hands over PS Alwyn as he remains still. The unit nurse enters and administers 3 intramuscular injections to PS Alwyn's buttocks without a manual hold.

Records of this incident note that staff offered Alwyn an oral PRN and he refused. Alwyn informed DLC that the PRN was offered when his seclusion began and that he was given no warning that refusing this voluntary oral medication might result in an involuntary medication injection well over an hour later. In addition, Alwyn had not refused the PRN – he asked for additional cups of water with which to take the PRN, but staff withdrew the PRN offer when he made this request.

Consistent with the video footage, the Restraint/Seclusion Checklist describes Alwyn as pacing and agitated from 9:34am through 9:54am. He is never described or observed to be engaging in any behavior that posed a serious threat of extreme violence or person injury. Only once he is told at 10:04am that he will receive a medication restraint is he noted at 10:14am as "making vague threats towards staff if he gets meds" while contained inside the seclusion cell. Until 10:54am, PS DF is noted on the Restraint/Seclusion Checklist only as talking "loudly" and talking to himself.

On the Medication Restraint Order form, the psychiatrist describes the "situation creating the risk" as "[u]nstable psychotic symptoms exacerbated by treatment nonadherence; this morning described by staff as agitated, uncooperative, refusing to return property that *could be* used as a weapon, threatening to harm other patients *or* staff, disorganized, paranoid and irrational in terms of making unreasonable demands of the unit and other pts behavior" (emphasis added). None of these observations describe emergency circumstances present at the time of the 9:50am order. Nor did emergency circumstances required by law arise.

BSH staff did not administer the medication restraint to PS Alwyn until 10:56am, undercutting any assertion of emergent circumstances to justify the Medication Restraint Order. Indeed, for over 30 minutes before the intramuscular injections and during, Alwyn showed his compliance. The incident illustrates the gratuitous intimidation and forced medication practices that distress PS – a medication restraint that was not warranted in the first place, and administered over an hour late.

ii. PS "Barton"

Nursing notes state that PS Barton had been "in the day room pacing, yelling, spitting at staff, causing a climate issue." When TSTs arrived, he was "cooperative and willing to go to his room to promote safety and for nursing assessment." Barton went inside his cell at 10:40am; there was no clinical seclusion order. In assessing Barton, medical records indicate that "PS remained with unstable behavior, laughing erratically on and off, shouting in a high pitched squeak like manor (sic) on and off." Records also noted that "[a]gitation increased with the presence of staff PS appeared less agitated when left alone." The psychiatrist ordered a medication restraint at 11:05am; BSH staff administered the medication restraint an hour later.

Again, a review of the video footage shows no legal basis for the Medication Restraint Order or the later administration of medication restraint due to the absence of emergency circumstances as well as the psychiatrist's failure to consider any less restrictive alternatives.

At **10:40am**, PS Barton enters his cell. Between **10:40am** and **10:42am**, Barton is yelling, pacing, and kicking his door 6 times. He then talks to 2 staff members and continues to pace, occasionally appearing to talk to himself and yell toward the hallway.
At **10:47am**, Barton briefly leans against the wall and then appears to calm down and move slowly around the cell, looking out his window to the yard and the cell door window into the hallway. Barton throws multiple small cups full of water under his door beginning at **10:57am**. Afterwards, he stares out the cell door window and paces slowly in his cell.
At **11:03am**, Barton briefly sits on the edge of his bed and then he lies down. Barton appears to be sleeping in the bed until **12:06pm**.
At **12:06pm**, Barton is lying in bed on his stomach. A staff member knocks on the cell door, but Barton does not move. A group of 4 TSTs in riot gear enter his cell and hover their hands over Barton, who remains lying still on the bed while a nurse enters and administers 2 intramuscular injections in his buttocks. Barton does not change position until nearly a minute after staff leave his room and shut his door at **12:08pm**.

On the Medication Restraint Order endorsed at 11:05am, the psychiatrist completed the "Describe Situation Creating the Risk" field as follows:

> Patient agitated and spit on TST and continued to make paranoid statements and threats towards staff. He also declined medication stating that it was poison and ruined his face(?). Declined PO. Then threw water into the hallway from his door.

While Barton was agitated in the day room 25 minutes prior to the Medication Restraint Order and, after voluntarily locking into his cell, he again appeared upset and acted out, at no time did his behavior rise to an "occurrence of, or serious threat, of extreme violence, personal injury, or attempted suicide."[39]

As "Least Restrictive Means Attempted," the psychiatrist checked off only "Verbal de-escalation" and "Taking space/time out" on the Medication Restraint Order, making clear that he made no meaningful effort to discern whether "chemical restraint [wa]s the least restrictive, most appropriate alternative available."[40] Indeed, Barton calmed down on his own in his cell such that he was on his bed at the time of the Medication Restraint Order.

Unfortunately, either BSH staff did not provide the psychiatrist with an update about Barton's status during the next hour where he appears to be sleeping, or the psychiatrist ignored this and did not terminate the order. Even when TSTs in riot gear came to Barton's cell for administration of the medication restraint 60 minutes later and found him asleep, there was no reconsideration of the order. The disregard for the requirements of the law is striking.

iii. PS "Carling"

Over the course of one morning, PS Carling exhibited behavior while locked in his cell that led the unit psychiatrist to order a medication restraint. According to nursing notes, the medication restraint was administered at 10:25am. The video footage DLC reviewed, covering 10:00am to 11:30am, captured the restraint but none of the behavior used to justify the medication restraint.

DLC's review of the video footage revealed that BSH staff removed a compliant Carling from his cell using a manual hold, took him to another cell, and gave Carling a medication restraint via

[39] M.G.L. c. 123, §21.
[40] M.G.L. c. 123, §21.

intramuscular injection 30 minutes *after* he was moved. Throughout the hour and a half of footage, Carling's subdued behavior is in stark contrast to the depiction of his state in the records. The circumstances below depict an illegal medication restraint when a cell change and cleaning would have sufficed.

At **10:00am**, Carling is lying on his back in bed resting with a blanket wrapped around his legs. There is a small amount of paper litter and a partially filled laundry bag by the door, one Styrofoam container on the table, and another container on the floor. The toilet water is at a normal level and appears brown, and there is a puddle of water in the middle of the floor with ample dry floor surrounding it.

At **10:04am**, a staff member talks to Carling through his cell door for about 20 seconds, during which time he sits up in bed. Occasionally, Carling pats himself lightly and repeatedly on the head with one or both hands. A staff member opens his door's wicket and places a Styrofoam container on the ledge just before **10:06am**. Carling retrieves the tray and sits calmly on the edge of his bed as the staff member talks to him through the door.

At **10:07am**, an RTA opens the cell door and Carling stands up and walks out of the cell. He stands in the hallway talking to the RTA for about 30 seconds while tapping his head, and walks into a clean cell across the hall that had been opened for him. He places his food on the desk as the RTA locks the door behind him. From **10:08am** to **10:10am**, Carling sits at the desk and eats slowly, then turns and leans against the wall, taking a break from eating.

Carling gets up and talks to an RTA at his door at **10:15am** for about 30 seconds, retrieves a carton of milk through the wicket, and returns to the desk to continue eating. Carling finishes eating and leans, still seated, against the wall at **10:20am**. He intermittently sits forward and looks out the window or looks at the floor.

At **10:29am**, a staff member comes to the cell door. Carling looks at her, turns towards her, and they speak for about 1 minute. At **10:30am**, Carling rises from the seat and walks to the door to speak with different staff members, including the lead TST. Carling stands calmly with his arms crossed in the doorway, occasionally talking. At **10:37am**, Carling throws his arms up, walks away from the door, and lies on his bed. Thirty seconds later, Carling flips onto his side, seemingly at the direction of the lead TST in the window. Carling appears frustrated.

At **10:38am**, 4 TSTs in riot gear enter the cell and hover their hands above Carling lying on the bed. The nurse and nurse manager enter and administer 3 intramuscular injections. The nurses, followed by TSTs, leave quickly. Carling remains in bed with his hands on his chest until **10:42am**. Thereafter, Carling intermittently paces, looks out the window, and stretches until **10:49am**, when he stands leaning against the wall. At **10:52am**, Carling lies down on his bed until staff open the cell door at **11:16am**. Carling leaves the cell to return to his original cell, where the litter has been picked up, the laundry bag has been moved to the seat, and the toilet has been flushed. The puddle is still on the floor. Carling lies down, covers himself in blankets, and appears to go to sleep.

A review of records shows inconsistencies as well as lack of sufficient detail concerning the timing of behaviors referenced and the imminence of any suggested risk to substantiate emergency circumstances. The BSH psychiatrist who issued the Medication Restraint Order at 10:00am made no effort to reasonably link Carling's *current* behaviors to emergency circumstances when he "Describe[s] Situation Creating the Risk":

> Mr. [Carling] remains untreated for severe psychosis; he has engaged in self harm including using feces & urine inappropriately putting him at extreme risk for septicemia & other deleterious consequences including being assaulted by other patients on the Unit due to his extremely disruptive behavior that has been acutely worsening due to remaining untreated for acute psychosis.

The psychiatrist twice references the fact that Carling is not receiving treatment for psychosis – it is the prevailing view at BSH that psychiatric medication is the only form of mental health "treatment" – and the only "Least Restrictive Means Attempted" prior to the order was "PRN medication." Under "Indication for Emergency Medication Order," the psychiatrist checks only the "treatment of acute symptoms" box, leaving the "restraint to prevent harm" box unchecked and highlighting the continuing extralegal rationale for forced medication at BSH. Further, the psychiatrist "Describe[s] the Risk if Medication is Not Administered" based on hypothetical risk posed by his dirty cell: "Extreme harm by others intending to assault him and harm to self due to the squalid conditions." DLC notes that this psychiatrist, per the Board of Registration in Medication, has no reported board certifications.

Meanwhile, other medical records, also lacking clarity and consistency, do not contain a description of anything beyond disruptive and unsanitary behaviors:

- "PS was causing a disturbance in the unit. He spilled water in his room, leading to a large puddle in the hallway. His room looks inhabitable [sic], with Styrofoam trays and clothing everywhere."

- "Water had spilled everywhere in PS's bedroom, and the toilet was full of clothes, sheets, and Styrofoam trays."

- Carling "was engaging in inappropriate behaviors leading to unsanitary environment and climate issues, throwing urine and feces under his door."

Even if one were to accept that Carling's cell required a cleaning for his safety, the cell change alone addressed this issue. A Medication Restraint Order based on unhygienic conditions was unreasonable.

Moreover, no BSH records explain that, for over 30 minutes prior to the medication restraint, Carling was calm and compliant – eating, calmly interacting with staff, relaxing, and even cooperatively walking to a different cell so that his cell could be cleaned. Carling's medical records confirm that he "complied" with staff and received an intramuscular medication restraint in which "no manual hold was required." Contrary to reality, however, a progress note and a 24 hour nursing note falsely indicate that he moved to the other cell *after* receiving the medication restraint.

The forced, painful medication administration is unjustifiable. This example shows, at best, a failure to properly evaluate requisite emergency circumstances prior to administration of a medication restraint and, at worst, that BSH uses medication restraint to punish or as a mechanism for psychiatrists to impose treatment at will without regard to legal requirements.

E. Failure to Offer Oral Medication Before a Medication Restraint Via Intramuscular Injection

The alarming trend of BSH staff failing to offer a PO – *per os*, meaning by mouth – medication prior to administering medication restraint by intramuscular injection continues, missing another opportunity to deescalate, explore less restrictive alternatives, and avoid the added trauma of forced injections. During this reporting period, 7 PS informed DLC that they received medication restraints via intramuscular injection without being offered oral medication first. Four of those PS reported that they were forcibly administered intramuscular medication without an oral medication offer on more than one occasion. 3 PS reported that they asked for oral medication in lieu of injected medication and were denied. This practice is another way BSH routinely fails to exhaust less restrictive and traumatizing alternatives before resorting to the most extreme interventions and coerces future compliance through punitive tactics.

F. BSH Medication Restraint Data – Increased Usage and Indications of Disproportionate Use on Black and African American PS

Medication Restraint data, reported only since BSH policies were updated to comport with applicable legal requirements, continues to show an increase in reliance on forced medication under the leadership of the Medical Executive Director and other BSH administrators.

Table 1. Medication Restraints by Month (June 16, 2024 – Dec 15, 2024)		
Month	**Number of Days**	**Number of Administrations**
June (16-30)	15	33
July (1-31)	31	52
August (1-31)	31	63
September (1-30)	30	49
October (1-31)	31	51
November (1-30)	30	41
December (1-15)	15	22
Total (Jun 16 – Dec 15)	**182**	**311**
Unique PS Receiving Medication Restraints		**126**
Medication Restraints Per Day		**1.71**

DLC calculated the average rate of medication restraint per day during this past period. **During this reporting period, BSH administered 1.71 medication restraints per day** compared to 1.37 medication restraints per day from last reporting period (December 16, 2023 to May 25, 2024) and 1.26 per day from the previous period (June 16, 2023, to December 15, 2023). **Based on these rates, BSH's overall rate of medication restraint increased 25% during this reporting period and 36% compared to a year ago.**

Individuals who are Black and/or African American are chronically overrepresented in the BSH population compared to the general population. Data publicly reported by DOC shows that, with 39% of BSH PS identified as Black or African American, this overrepresentation is now more

pronounced than in the DOC population as a whole (30%) and in any other individual DOC facility.[41]

Table 2. BSH Population and MA Population by Race/Ethnicity		
Race/Ethnicity	**BSH Population[42]**	**Massachusetts Population[43]**
White	44% (112)	79%
White, not Hispanic or Latino	Not tracked	68.8%
Black or African American	39% (99)	9.6%
Hispanic or Latino	11% (29)	13.5%
Asian or Pacific Islander	3% (7)	8%
American Indian and Alaska Native	Not tracked	0.6%
Two or more races	Not tracked	2.8%
Unknown	3% (8)	Not tracked

Table 3. Medication Restraints by Race/Ethnicity (June 16, 2024 – Dec 15, 2024)			
Race/Ethnicity	**BSH Population[44]**	**Number of Administrations**	**Unique PS Receiving MR**
White	112 (44%)	122 (39%)	53 (42%)
Black or African American	99 (39%)	169 (55%)	63 (50%)
Unknown/Did Not Specify	8 (3%)	13 (4%)	6 (5%)
Hispanic	29 (11%)	N/A	N/A
Asian or Pacific Islander	7 (3%)	6 (2%)	4 (3%)
Other (American Indian and Alaska Native, two or more races)	N/A	N/A	N/A
Total	**255 (100%)**	**311**	**126**

Black and African American PS continue to be overrepresented in medication restraint administration at BSH. **Black and African American PS received 55% of all administrations and represented 50% of unique PS receiving medication restraints during this reporting period, despite only comprising 39% of the BHS population.** During the last reporting period, Black and African American PS, with 34% of the BSH population, received 41% of administrations and made up 42% of unique PS receiving medication restraints. The current period's numbers represent a nearly 128% increase in the percentage overrepresentation of Black and African American PS receiving medication restraint administrations, and a 38% increase in the percentage overrepresentation of unique Black and African American PS receiving medication restraints. These troubling numbers demonstrate that Contracted Provider,

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[41] DOC Institutional Fact Cards present demographic information of the population of all DOC facilities, including BSH. DOC, *July 2024 MA DOC Institutional Fact Cards*), https://www.mass.gov/doc/institutional-fact-cards-july-2024/download. Please note that percentage calculations in the Institutional Fact Card for BSH are inaccurate and corrected herein.
[42] *July 2024 Institutional Fact Cards.*
[43] U.S. Census Bureau, *QuickFacts: Massachusetts* (July 1, 2024), https://www.census.gov/quickfacts/fact/table/MA/PST045224#PST045224.
[44] *July 2024 MA DOC Institutional Fact Cards*.

under the oversight of DOC, continues to utilize practices that disproportionately impact PS of color who are already overrepresented at BSH.

In our July 2024 report, DLC expressed concern that BSH data provided by DOC does not allow for PS to identify as a person with Hispanic or Latinx heritage and by their primary race. While DLC cannot pinpoint the total number of Hispanic/Latinx PS who received medication restraint with the available data, controlling for primary language, there were 16 medication restraints administered to PS whose primary language is Spanish during this reporting period– 5% of all administrations. These restraints were administered to 10 unique PS – 8% of PS who received medication restraint during this reporting period. Of these PS who identified Spanish as their primary language, 7 have a race categorization of White, 2 of Black/African American, and 1 of Unknown in the data provided to DLC. In November 2024, DOC began reporting Hispanic or Latino or Not Hispanic or Latino status along with its regular data provision to DLC. Moving forward, DLC plans to report medication restraint administration data using these demographics.

G. Improper Irreversible Deterioration Orders

DLC observed a marked increase in the use of Irreversible Deterioration Orders (IDOs) at BSH during this reporting period and that use of IDOs was in violation of Massachusetts law. BSH policy places the responsibility for authorizing IDOs on the Medical Executive Director or designee, "after consultation with the PS treating provider." Given the Medical Executive Director's past practices and regular commentary criticizing the legal requirements limiting psychiatrists' unfettered discretion to medicate people regardless of their consent, it is no surprise that DLC has gathered information indicating that IDO practices do not comport with the letter or spirit of established law.

IDOs are involuntary antipsychotic medications administered, based on the state's *parens patriae* power, "in rare circumstances" to prevent "immediate, substantial, and irreversible deterioration of a serious mental illness.'"[45] There is no requirement of a court order for a single IDO administration, but the law requires that, if doctors expect to continue to treat the patient with antipsychotic medication over the patient's objection, the doctors must seek adjudication of incompetency, and, if the patient is adjudicated incompetent, the court must formulate a substituted-judgment treatment plan."[46]

Per the Contracted Provider, during this reporting period (June 16, 2024 to December 15, 2024), 9 unique PS received IDOs. **However, rather than authorizing only immediate forced medication as intended by established law, these 9 IDOs were issued to cover extended periods of time – ranging from 18 days up to 108 days – during which PS were subjected to repeated instances of forced medication.**[47] Indeed, despite only 9 individual orders, the BSH Medical Executive Director estimated that 2 to 4 PS are force medicated based on an IDO on any given day.[48] Unfortunately, DLC is not able to get clarity on the number of IDOs to which people have been subjected – total or per order – because the Contracted Provider "does not track the number of [IDO] medication administrations."[49]

[45] *Rogers v. Comm'r*, 390 Mass. at 503, 511-512.
[46] *Id.* at 512; *see* M.G.L. c. 123, § 8B.[46]
[47] Contracted Provider email to DLC (1/9/2025).
[48] DLC/Contracted Provider Meeting (12/13/2024).
[49] Contracted Provider email to DLC (1/9/2025).

To justify these practices, the Contracted Provider has taken great liberties interpreting the language of the BSH Involuntary Psychotropic Medication Policy to formulate its "IDO protocol." Per the Contracted Provider:

- The IDO protocol is for PS who "require *sustained* treatment to alleviate the symptoms resulting in the risk of immediate, substantial and irreversible deterioration, while they are simultaneously awaiting a court hearing regarding a judicial determination of their competence and treatment needs."[50]

- "The determination to place a patient on our IDO protocol follows a clinical review with the Medical Executive Director and/or designee" and can only be initiated if the PS provider submits "paperwork for adjudication of incapacity and a treatment plan."[51]

- **"If the IDO protocol is approved, the patient is notified they will not be permitted to refuse their medication**."[52]

- "The patient's status on an IDO protocol is tracked in treatment team rounds and the patient is seen at least weekly by their psychiatrist." [53]

- "In general, once the patient is made of aware of this protocol, they accept medications by mouth and with sustained treatment their mental health symptoms will improve so that they no longer require this protocol, or (less frequently) their 8b is heard and the patient is provided with a court authorized treatment plan."[54]

This IDO protocol runs afoul of the high bar established for doctors to force medicate people under this limited legal exception. The mere concept of a protocol for authorizing sustained irreversible deterioration treatment is incongruous with the key legal principal that involuntary medication under the *parens patriae* power is permitted only "in rare circumstances" based on a determination at the time of the medication administration that the individual has an immediate and critical need for treatment to prevent their irreversible deterioration such that "even the smallest of avoidable delays would be intolerable."[55] The Contracted Provider's statement indicating that the protocol is no longer required once "sustained treatment" improves PS' mental health symptoms exceeds the intended purpose of this limited exception – to prevent *irreversible* deterioration. Moreover, a protocol that informs PS that they "will not be permitted to refuse their medication" and can be subjected to unlimited intramuscular injections for the foreseeable future absent a determination that they lack competence to refuse medication and a court-ordered treatment plan is illegitimate.

Beyond the general overreaching of the IDO protocol in violation of Massachusetts law, DLC has concerns that the Contracted Provider's determinations of threat of PS irreversible deterioration are grounded in limited observations, selectively or vaguely described behaviors, and/or behaviors that could be attributed to purposeful noncompliance. DLC has also observed

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[50] *Id.*
[51] *Id.*
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] *Rogers v. Comm'r*, 390 Mass. at 512 (1983), quoting *Matter of Guardianship of Roe*, 383 Mass. 415, 441 (1981); 104 CMR 27.10(1)(e) ("[T]he right to refuse such medication may be overridden prior to an adjudication of incapacity and court approval of a treatment plan only in rare circumstances to prevent an immediate, substantial and irreversible deterioration of the patient's mental illness.")

records that the Contracted Provider, contrary to its protocol, does not strictly adhere to the requirement that it promptly file a petition seeking a court-ordered treatment plan.

Meanwhile, direct care staff display basic misunderstanding of what differentiates an IDO from other types of forced medication. For example, BSH 24-hour Nursing Reports regularly refer to IDOs as "court-ordered medication." Multiple PS receiving IDOs reported to DLC that Contracted Provider staff informed them directly that IDOs were "court-ordered medication." This indicates, again, a concerning lack of nursing staff education unchecked by BSH leadership who receive 24 hour nursing reports daily or, possibly, an intentional effort to obtain compliance from PS under false pretenses.

The Long-Term IDO of PS "Damon"

Upon admission, PS Damon was described by staff as "appearing catatonic." "He appeared calm but refused to talk." BSH staff could not complete the intake process. The same day, BSH placed Damon in a dry cell – a prison cell with no running water or toilet – and the psychiatrist, in consultation with the Director of Psychiatry, ordered an intramuscular injection of Lorazepam as an IDO.

In the coming weeks, despite numerous examples in the Damon's medical records of him verbally communicating with staff, staff continued him on the IDO protocol based on "catatonia," forcing him to take Lorazepam tablets two times per day or an intramuscular Lorazepam injection upon refusal of the oral medication. PS Damon was subjected to this regimen every day of his nearly 50-day admission.

BSH filed the initial 8b petition for court-ordered medication 15 days after the PS admission and IDO. Despite the fact that it violates the dictates of Massachusetts law, Damon's attorney informed DLC that such a delay is not atypical for PS on the IDO protocol.

Although he had not been to court since his BSH admission, Damon reported that BSH staff consistently told him that the irreversible deterioration order medication was court ordered. "That definitely caught me off guard," he told DLC. On occasion, when staff told him that the oral medication was optional and he declined it, they would tell him it was "court-ordered" and administer an injection if he did not relent. He repeatedly stated that he was taking the oral medication "with a gun to my head." He reported that the medication often made him feel hungry and sick. DLC reviewed BSH nursing notes and found that 3 out of the 6 notes written about this PS and the IDO medication he received inaccurately reference "court-ordered medication." DLC also noted 5 references in intermittent progress notes in which the nurse writer references Damon's Lorazepam prescription as court-ordered medication.

H. Violence in Restraint and Involuntary Medication Administration

As DLC has reported since 2022, BSH security staff regularly use undue force on PS. This should come as no surprise when BSH standard procedure and practice for administering involuntary medication emulates a prison planned use of force. At the same time, the assembly of the "use of force" team of TSTs takes time, delaying medication restraint when it is clinically warranted and leaving PS in the dark about what is coming and when.

After several years of reviewing video footage of involuntary medication, DLC has observed dozens of violent incidents in which TSTs run into cells, tackling PS or ramming into PS bodies with riot shields, and forcefully holding PS down on their beds, jerking PS bodies into position for the nurse to administer intramuscular injections. Such practices would not be acceptable in a legitimate psychiatric hospital. The stark correctional nature of these interactions has a significant impact on staff culture, the overall environment within BSH, and PS mental health and wellbeing.

One of the most troubling elements of these practices is the use of riot gear – helmet, chest pad, groin protector, knee pads, and large riot shield. In handheld footage of one incident DLC viewed this reporting period, a PS stood still with his arms crossed a few feet from his door; when the lead TST opened the door and the first TST with the shield entered, the PS raised his arms to protect himself before being struck by the shield. The handheld camera footage captures an audible thumping sound as the TST smashed the shield into the PS's body, making him fall backwards onto his bed as the TSTs proceed to tackle and contort his body into submission.

During this reporting period, DOC and the Contracted Provider updated the BSH policy on staff use of "protective gear." The policy requires authorization of the Medical Executive Director for the shield to be used in most cases:

> If the safety and treatment teams feel the acuity of the emergency is such that a shield is needed for safety, the Medical Executive Director must be contacted to authorize the use of this equipment. In an acutely emergent situation in which there is clear and imminent risk of serious harm to the PS or others, the decision may be made by the TST Shift Supervisor, and the medical director must be promptly notified afterwards. In the event a shield is not authorized or utilized, the assigned TST will remain on standby.[56]

The Medical Executive Director is the same BSH administrator who the Contracted Provider has assigned responsibility for approving implementation of the IDO protocol and approved use of the inhumane cage in the booking office for seclusion of medically vulnerable PS.[57] In an "acutely emergent situation," that decision may be made by a TST Shift Supervisor, a member of security staff. While DLC recognizes the Contracted Provider's effort to reduce usage of the shield, its continued use, the lack of clear criteria for allowing its use, and the persons granted the authority to approve its use are cause for concern.

According to the Contracted Provider, from June 16, 2024 through December 15, 2024, there were 619 "planned events"; TSTs were approved to wear protective gear in 219 events and were approved to utilize the shield in 9.

The descriptions below combine DLC's observations from both handheld video footage of "planned events" and stationary security camera footage from PS cells.

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[56] Bridgewater State Hospital Policy and Procedure Manual, PC 300-12 Serious Clinical Episode – Use of Protective Gear, § 5.1.1.
[57] See below at pp. 43.

i. PS "Eli"

At **5:52:56 pm**, the lead TST stands at the door of PS Eli's cell. Eli, a short young man, stands behind the door and is visible through the window. After a brief exchange about whether Eli will "comply" with medication, the lead TST notifies the four (4) TSTs in riot gear lined up behind him that PS Eli is right by the cell door.

The lead TST rattles his keys and opens Eli's door at **5:53:26pm**. The 4 TSTs run into PS Eli's cell in single file. The first TST, who is notably larger than Eli, tackles Eli onto the bed. Crashing sounds are audible on the handheld footage. The TST appears to throw his entire weight on top of Eli, violently bending his arm as he places one of his knees on the bed to get more leverage. At the same time, a TST at the foot of the bed controlling Eli's leg appears to be pressing with his full body weight. The lead TST walks around the bed, yelling to the TSTs in riot gear, "Easy, easy, easy. Get that arm, fellas!" The 4 TSTs hold Eli in a prone position on the bed. The first, large TST and a second TST pin Eli's right hand to his right shoulder blade, contorted behind his body. The second TST also appears to be holding Eli's left arm, which is under Eli's torso.

Starting at **5:53:47pm**, Eli gives a loud, guttural wail followed by 5 higher, escalating screams of pain. The lead TST calls in the nurse. Eli yells, "My arm, my arm, my arm. Please no... oh... oh, fuck..." Two nurses enter and administer intramuscular injections in Eli's buttocks. Eli continues to alternately scream in pain, whimper, and breathe heavily during the medication administration.

At **5:54:36pm**, the nurses leave the cell. The lead TST orders the TSTs to exit, yelling "move, move, move!," and orders Eli to stay on the bed where he remains moaning. The lead TST closes the cell door at **5:54:50pm**.

The excessive force used in this incident is shocking to witness, even on video. The size discrepancy between the diminutive Eli and the first TST to enter is remarkable. Throughout the encounter, none of the staff involved – TSTs or nursing staff – interrupt or adjust the process to ask PS Eli where it hurts or assess him for injuries, even in response to his screams and complaints.

Contrary to the video evidence, entries in Eli's medical records describe him as "fighting and trying to hit staff" and "saying that he doesn't take meds." The 24 hour nursing report describes him similarly: "PS resisting/fighting and trying to hit staff during medication administration*."* DLC did not see or hear any of these behaviors or utterances on the video footage – what DLC did see is a display of utter dominance and brutality.

At the same time, consistent with the delays in examples discussed above, the psychiatrist ordered this medication restraint at 5:00pm, but it was not administered until 5:52pm. The psychiatrist[58] who ordered the restraint specified that the "Indication for Emergency Medication" was only "Treatment of Acute Symptoms." In documenting the "Risk if Medication Not Administered," the psychiatrist wrote that "Assaults are front & center plus manic exhaustion is a known factor for psychiatric lethality clearly present in this moment." Massachusetts law does not permit medication restraint on an individual because of concerns of assaults *by others* – particularly while someone is alone in their cell – or vague risks of poor medical outcomes. This Medication Restraint Order is invalid.

[58] Per the Board of Registration in Medicine, this psychiatrist has no Board certifications.

Furthermore, DLC reviewed more than 2 hours of footage; it does not depict emergency circumstances. From 3:30pm until the TSTs in riot gear enter at 5:52pm, the footage shows Eli walking calmly and slowly around his cell, usually talking or rapping to himself or towards the security camera. He frequently sits on the bed or the stool, sometimes placing his head in his hands on his desk. At times, Eli talks to the 1-1 staff outside his door. Throughout this period, he eats spoons full of what appears to be yogurt from a plastic single-serving cup. It is only at 5:32pm when staff such as nurses and TSTs begin to appear at his door to speak to him, presumably about the medication restraint he will receive, that he begins to appear agitated, removing and putting his shirt back on multiple times and flexing his muscles. Until the moment leading up to his violent encounter with TSTs, Eli appears calm and at no risk of injury or life-threatening fatigue.

ii. PS "Ford"

PS Ford has been awake since **8:05am** cleaning his room, sitting on his bed, lying in bed and, most recently, eating breakfast.

At **9:24:58am**, the lead TST is standing at the door of PS Ford's cell while Ford is standing on the other side. Another TST, in riot gear, standing next to the lead TST, pulls the clear visor of his helmet down over his face. The lead TST says, "I need you to do me a favor. I need you to lay down on the bed for me, please." While Ford's reply is inaudible through the cell door, he motions with his hand towards his mouth. The lead TST turns to his right and says, "Uh, he's asking about a PO." The response from another staff member is inaudible. The lead TST again asks Ford to lay down on his bed and Ford again has an inaudible response. The lead TST then replies, **"**Ya, we can't do that, it's gonna be a shot. I'll give ya one more chance, you gotta lay down on the bed, please."

Ford backs up slightly. The lead TST asks him to lay down on his bed once more. Ford turns around, then backs up again until he is at the foot of the bed. The lead TST opens the door slightly, then slams it with a loud metallic clang. The TST closest to the door rocks back and forth as if preparing for the start of a race.

At **9:26:11am**, the lead TST opens the door and the first TST runs in and pushes Ford to the bed. Once he hits the bed, Ford's expression appears shocked. The TST then pulls Ford by the upper arms toward the head of the bed. The other 3 TSTs walk into the cell. The TST closest to Ford's head aggressively pulls Ford by the back of his sweatshirt to reposition him. He places his knee on the bed to get more force in jerking Ford in his direction, then crosses Ford's arms and holds them to his chest. Another TST grabs Ford's legs, crosses them, grips Ford's pants at the waist, and forcefully pulls Ford away from the wall while turning him towards it. This TST then pulls down Ford's underpants and pants around his legs to expose his buttocks. Ford does not appear to be resisting the TSTs the entire time. The group of TSTs hold Ford in position.

At **9:26:30am**, the lead TST calls in the nurse. Once the nurse administers a single injection and exits the cell, the lead TST directs the 4 TSTs to exit. They run out of the room and the lead TST shuts the door at **9:27:09am**. Ford is still on the bed, his pants and underwear are still around his legs, looking shocked and bewildered by what has happened.

Ford's medical records indicate that he arrived at BSH 2 days prior to this incident and was placed on a so-called IDO protocol. According to records, he had refused a PO offer pursuant to the IDO. The records make no mention of Ford requesting and being denied a PO once staff returned with the team in riot gear.

The physical force used by 4 TSTs in this video is gratuitous – violently pushing, dragging, lifting, and contorting Ford's body as he offered no apparent resistance. This shows the correctional approach of managing risk with overwhelming control in action.

In its January 6, 2025 response to DLC's July report, DOC references BSH policy, touting the Contracted Providers approach to "the use of protective gear with a multidisciplinary decision making and trauma informed lens, with the goal of achieving the safest possible outcome for the person served and staff members."[59] DOC then expressed support for the Contracted Provider's "current review of protective gear utilized in other behavioral health settings" and "welcomes DLC's assistance in surveying other high acuity involuntary psychiatric hospitals where protective equipment for staff is utilized."[60]

DLC cannot provide any support for such practices because the assembly and deployment of planned staff use of force teams and staff use of protective gear are simply not acceptable daily features of a psychiatric hospital. **The multidisciplinary approach involving clinical and security staff – rather than a purely clinical approach to serious treatment interventions – emphasizes the continuing correctional approach at BSH.**

I. Undocumented and Unauthorized Seclusion

As previously reported, every BSH PS spends extended periods of time locked in their cell each day because it is a DOC facility. **At a minimum, every PS is locked in their cell daily from 9:20pm to 7:20am, regardless of their behavior, treatment compliance, commitment status, or an individualized assessment of the impact of isolation in a prison cell on their mental health. Just accounting for these 10 hours, in a year BSH PS automatically spend over 900,000 hours in seclusion each year.** PS must also participate in the facility count 3 times each day, like people incarcerated in every other DOC facility. During this reporting period, the Contracted Provider rolled out to all housing units efforts to add flexibility during the 12:00pm and 5:00pm counts by permitting PS to stay in the unit day room until count clears. The Contracted Provider recognized that "even brief periods of time being locked in a room can have deleterious mental health consequences."[61]

BSH policy excludes these hours from its definition of seclusion based on required prison protocols. In legitimate psychiatric hospitals in Massachusetts, all seclusion must be documented and ordered pursuant to the requisite finding of emergency circumstances under M.G.L. 123, § 21. Consistent with prior reporting periods, DLC observed that PS living in the Bradford units that house new admissions and those in the maximum-security units, Hadley and Lenox, experience even more undocumented seclusion that is unauthorized by BSH policy.

i. Improper Post-Count Seclusion

DLC continues to observe deficiencies with respect to the Contracted Provider's adherence to unit schedules, resulting in additional undocumented seclusion that is not authorized by DOC regulations, BSH policy, or BSH providers. BSH staff regularly wait to let PS out of their cells until well after the conclusion of institutional counts. These seclusions also occur in the morning, after evening lock-in, and sporadically during recreation periods. This reporting period, the

[59] *Id.* at 3.
[60] *Id.* at 3.
[61] Hospital Administrator's Report, BSH Governing Body Packet (September 2024).

Contracted Provider instituted a new policy allowing PS to remain in their unit dayrooms during count, which DLC recognizes as a gradual measure working against the correctional norms of DOC culture. The Contracted Provider also began to insert into loudspeaker announcements that count has cleared a command that staff release PS from their cells. Despite these incremental developments, staff report that excessive and unauthorized seclusion remains one of the most common PS complaints.

During weekly site visits, DLC observed units secluding PS at the conclusion of count for up to 15 minute – a total of 8 hours of seclusion for a typical unit of 32 PS. When DLC asked unit staff about these delays, they reported a range of reasons related to staffing: colleagues taking shift breaks through count clearing; colleagues "pulled for an IM" (i.e. to assist with involuntary medication administration) on other units; deficient unit staffing patterns (assigning only 2 TSTs to each unit regardless of acuity); and, most commonly, general TST understaffing.

ii. Additional Unauthorized and Undocumented Seclusion Throughout the Day

PS also continue to report unauthorized seclusion throughout the day, particularly on the maximum security units – Lenox and Hadley – and the Bradford units. Because the seclusion is undocumented and the Contracted Provider has not heeded DLC's requests to devise a system for post-documentation, BSH records omit any mention of it. Still, DLC continues to receive concerning reports:

1. A PS reported to DLC that he had been locked in his cell for long periods on Bradford 1. On 2 days he was released from his cell in the afternoon after hours in seclusion; on another day he was not allowed out of his cell at all. At the time he reported this to DLC, the PS had been in the Bradford 1 unit for 16 days.

2. A PS reported that he was twice locked in his cell for an entire day. He reported that on other days he received only 30 minutes of out-of-cell recreation time.

3. A PS reported that he was allowed out of his cell between 2 and 4 hours per day on Bradford.

4. Multiple unit staff and PS reported to DLC that PS were routinely kept in seclusion during lunchtime due to being "unit restricted." DLC reached out to BSH administration multiple times about these reports. Contracted Provider administrators responded that "this is not an accepted practice" and "a reminder was sent out to all units."

2. Necessary Reform with the 2025 BSH Provider Contract

The current contract for BSH services will end on June 30, 2025. In December 2024, DOC posted a bid solicitation for the BSH services starting on July 1. The deadline for potential providers to submit bid intent and background forms was January 6, 2025; DOC held a mandatory bidders conference and tour scheduled for January 24.[62] According to public records produced by DOC, the following potential corporate providers submitted bid intent forms by the deadline: Recovery Solutions; Centurion of Massachusetts, LLC; Correctional Psychiatric

[62] COMMBUYS, Bid Solicitation: BD-25-1025-DOCFS-9004-107428, https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-25-1025-DOCFS-9004-107428&external=true&parentUrl=bid [hereinafter "2025 COMMBUYS"].

Services, PC (CPS Healthcare); Spectrum Health Systems, Inc.; VitalCore Health Strategies, LLC; and Wexford Health Sources, Inc. Because over a decade of monitoring and investigation has shown that only transfer of BSH oversight to DMH will ensure PS access to appropriate treatment and conditions, DLC offers no comment on the bidding corporations.

BSH has had the same Contracted Provider since February 2017, although it has gone through several name changes and corporate restructurings. In February 2017, Correct Care Recovery Solutions, a division of Correct Care Solutions, took over management of BSH, including mental health, medical, and internal security services after DOC corrections officers transitioned out.[63] That fall, private equity firm H.I.G. Capital acquired Correct Care Solutions and merged it with Correctional Medical Group Companies to create Wellpath; DOC revised the contract to reflect the new company name, maintaining the June 30, 2022 contract end date.[64] In 2022, DOC entered into a 2-year extension contract with Wellpath, followed by a 1-year extension in 2024.[65] Notably, DOC entered into the contract extensions despite repeated DLC reports detailing substandard treatment, abusive practices, and repeated violations of Massachusetts law within BSH. Moreover, while DOC saw fit to extend the BSH contract in 2024, it ended its DOC-wide contract with Wellpath covering medical and mental health services for 10 state prisons and instead entered into a contract with VitalCore. Wellpath filed for Chapter 11 bankruptcy in November 2024. In January 2025, Wellpath received court approval to sell its Recovery Solutions division, which handles provision of BSH services, allowing it to function as an independent entity.[66] DLC understands that Recovery Solutions will continue to provide these services through the end of the current contract.

As part of the procurement process for the 2025 BSH contract, DOC informed DLC that it assembled "a Strategic Sourcing Team (SST) consisting of subject matter experts including: The Department's contracts office, health services division, legal division, and the BSH administration" that was drafting the Request for Response (RFR) to solicit bids. DOC invited DLC to provide input into any suggested areas of improvement or specifications at BSH, which the SST would consider for inclusion in the RFR. As DOC would not provide access to the draft RFR to allow DLC to provide pointed comments, DLC referred DOC to our many public reports and gave a list of three essential items for DOC to incorporate into the new RFR:

(1) The RFR must require board certification(s) in relevant areas of medical expertise for the Director of Medicine and all other medical doctors/psychiatrists who provide care at Bridgewater State Hospital;

(2) The RFR must explicitly state that the contractor shall strictly adhere to the requirements of Massachusetts law concerning the use of all forms of seclusion, restraint, and involuntary medication, including M.G.L. 123, § 21; and

(3) The RFR must emphasize that BSH shall function as a secure psychiatric hospital facility, rather than a state prison, despite DOC acting as the oversight agency.

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[63] *See* COMMBUYS, Master Blanket Purchase Order PO-17-1025-DOCFS-FISCM-10000, https://www.commbuys.com/bso/external/purchaseorder/poSummary.sdo?docId=PO-17-1025-DOCFS-FISCM-10000&releaseNbr=0&external=true&parentUrl=close [hereinafter "2017 COMMBUYS"].
[64] *See* 2017 COMMBUYS (SCF_BSH executed document.pdf; Contract Amendment 3-BSH Amendment 3_executed.pdf)
[65] *See* 2017 COMMBUYS (BSH Amendment 11 Executed; BSH Amendment 12 Executed).
[66] *See* Dietrich Knauth, *Wellpath spins off behavioral health unit in bankruptcy sale* (January 8, 2025), REUTERS, https://www.reuters.com/legal/government/wellpath-spins-off-behavioral-health-unit-bankruptcy-sale-2025-01-08/.

DLC appreciates the SST's efforts in preparing the new RFR, which contains language that is responsive to DLC's input. Unavoidably, however, the document as a whole emphasizes the dominant role that DOC administrators and DOC regulations and policies play in the running of BSH. Still, DLC does believe that there are key changes to the status quo at BSH that may help address the legacy of poor treatment, abuse, and legal violations at BSH while the facility is still under the authority of DOC.

Any new provider must establish new expectations for staff qualifications, conduct, and accountability; prioritize stringent adherence to Massachusetts law concerning the use of all forms of seclusion, restraint, and involuntary medication; and adopt policies, procedures, and training that reinforce that BSH must operate as and provide care consistent with a psychiatric hospital. At the core of these changes is bringing in new BSH medical and psychiatric providers, including those in leadership roles.

Meeting the mental health treatment needs of the BSH population, or any inpatient psychiatric population, requires up-to-date specialist knowledge in psychiatry. Similarly, care for the diverse and often unique medical needs of PS presents challenges that can only be addressed appropriately with an understanding of modern treatment modalities. Over the years, DLC reports have detailed denials and serious delays in access to medical care for BSH PS.[67] Obtaining relevant board certifications is considered by many Massachusetts hospitals to be a necessary qualification for physicians on staff. In addition to requiring passage of an exam, maintaining a board certification requires continuing medical education. DLC appreciates that the open RFR includes provisions that the "Medical Director of Bridgewater State Hospital" (current title: Medical Executive Director), the Medical Services Director (current title: Director of Medicine), and all psychiatrists shall be board certified.[68] DLC notes, however, that the prior RFR contained similar language.[69] Currently, DLC is aware of 5 physicians at BSH – 2 of whom hold leadership positions – that have no reported board certifications per the Massachusetts Board of Registration in Medicine (BORIM):[70]

- The Director of Medicine, responsible for providing medical care to PS as well as overseeing medical and dental services at BSH.
- An internist who provides medical care to PS.

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[67] *See* DLC July 2024 Report at 36-37; DLC, *Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served* 31-35 (February 2024), https://www.dlc-ma.org/wp-content/uploads/2024/03/DLC-BSH-Public-Report-3.13.2024.pdf [hereinafter "DLC February 2024 Report"]; DLC, *Public Report: Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served,* 36-37 (July 2023), https://www.dlc-ma.org/wp-content/uploads/2023/08/DLC-BSH-Public-Report-7.31.2023.pdf [hereinafter "DLC July 2023 Report"]; DLC, *Public Report: Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served*, 42 (January 2023), https://www.dlc-ma.org/wp-content/uploads/2023/02/DLC-BSH-Public-Report-1-31-2023.pdf [hereinafter "DLC January 2023 Report"].

[68] *See* 2025 COMMBUYS (Request for Response Bridgewater State Hospital Services Final, §§ 3.5.3.A-B, 3.5.3.20.4.A-B). Aside from the Medical Services Director, a "primary care physician need not be Board Certified." *Id.*

[69] *See id.* at § 6.4.4.

[70] Licensing and board information for Massachusetts doctors is available at BORIM, *Check a Physical Profile*, https://www.mass.gov/check-a-physician-profile-findmydoctormassgov.

- The Director of Psychiatry, responsible for overseeing psychiatrists and psychiatric treatment services at BSH.

- 2 psychiatrists who provide psychiatric treatment services on BSH housing units.

Perhaps even more concerning, there are many long-term physicians – including the Medical Executive Director and the Director of Medicine – who had direct personal involvement in the abuses and systemic legal violations that gave rise to DLC's initial investigation into BSH[71], class action and individual litigation[72], 2 settlement agreements in which DLC served as settlement monitor[73], and the 2017 transition that removed corrections officers from the BSH interior. In the years preceding 2017, both endorsed orders repeatedly, illegally extending PS seclusion in the BSH Intensive Treatment Unit (ITU) for days, weeks, months, and, for a few, years in the absence of existing emergency circumstances.[74]

The Medical Executive Director, a psychiatrist, had a leadership role in the ITU and assumed his position as the top BSH administrator overseeing all medical and psychiatric care at BSH in 2017. In recent years, the Medical Executive Director has presided over BSH implementation of policies allowing "Emergency Treatment Orders" in violation of state law,[75] failed implementation of legally compliant policies,[76] and an alarming increase in Medication Restraint Orders[77] and Irreversible Deterioration Orders.[78] Through these and other actions, the Medical Executive Director shows disregard for well-established legal limitations on forced medication. Further, through statements during this reporting period alone, the Medical Executive Director has repeatedly characterized the legal process for obtaining a court-ordered *Rogers* treatment plan as a hindrance for Massachusetts psychiatrists and a "due process violation" for PS because they cannot be subjected to involuntary medication at the will of BSH providers.[79]

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[71] *See* DLC, Letter to Gov. Deval Patrick Re: Investigation of Bridgewater State Hospital (July 11, 2014), https://www.dlc-ma.org/wp-content/uploads/2017/09/BSHReport.pdf.
[72] *See, e.g., Minich v. Spencer*, No. NOCV201400448, 2014 WL 3816980, (Mass. Super. July 2, 2014) (class action seeking declaratory and injunctive relief challenging excessive, illegal seclusion and restraint practices at BSH); *Minich v. Spencer*, No. SUCV201500278, 2016 WL 3479000, at *1 (Mass. Super. May 17, 2016) (damages class action resulting in $1.5 million dollar settlement for class members subject to excessive seclusion and restraint); Civil Rights Litigation Clearinghouse, *Case: Minich v. Spencer*, https://clearinghouse.net/case/17284/; *Doe v. Spencer*, No. 1684CV02136 (Mass. Super.) (lawsuit concerning excessive, illegal seclusion of individual who spend more than 14,900 hours in seclusion and medical malpractice that resulted in a significant monetary settlement following a medical malpractice tribunal fining in favor of plaintiff; the Medical Executive Director and Director of Medicine were named defendants).
[73] DLC Investigation Settlement Agreement (December 15, 2014), https://www.dlc-ma.org/wp-content/uploads/2017/11/DLC_Final_Agreement.pdf; *Minich v. Spencer*, Settlement Agreement, No. NOCV201400448 (December 15, 2014), https://clearinghouse-umich-production.s3.amazonaws.com/media/doc/103534.pdf.
[74] The ITU was a unit in the Lighthouse building where corrections officers brough PS for the purpose of seclusion or restraint.
[75] DLC January 2022 Report at 16-25; DLC, *A Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served*, 9-22 (July 2022). https://www.dlc-ma.org/wp-content/uploads/2022/07/DLC-BSH-Report-July-2022-Final.pdf; DLC January 2023 Report at 16-29; DLC July 2023 Report at 18-35.
[76] *See* above at pp.10-19.
[77] *See* above at pp. 19-21.
[78] See above at pp. 21-23.
[79] *See, e.g.,* BSH Governing Body Meeting (September 2024); DMH/BSH Quarterly Meeting (October 2024).

History indicates that noncompliance with Massachusetts law governing restraint, seclusion, and involuntary medication and acceptance of correctional practices are engrained in the culture of BSH. To accomplish meaningful change within BSH under any Contracted Provider, DOC and the Contracted Provider must commit to bringing in new BSH clinical leadership and individual providers who accept that the status quo at BSH is not acceptable.

3. Treatment and Conditions for Persons Served in the BSH Units at Old Colony Correctional Center

As in past reporting periods, DLC received reports of insufficient access to programming and concerning treatment of PS on the 2 OCCC BSH units designed to serve as an annex to BSH for men serving state prison sentences.[80] The ISOU, holding PS during the evaluation period, and the RU, for PS who have been committed to BSH, operate differently than BSH. Both units are staffed with DOC corrections officers for security, as opposed to Contracted Provider security staff. The Contracted Provider provides medical, mental health, and rehabilitation staff under DOC's BSH contract, whereas medical and mental health services are now provided in the other OCCC units by VitalCore. This adds a layer of necessary coordination and potential discord when making commitment and continuity of care decisions.

In the ISOU, the officers' presence is imposing. In a unit with only 18 single bed cells, there are 5 officers assigned to the unit during the day, generally congregated in the day room area. The unit is tense. Outnumbered treatment staff have expressed feeling intimidated and hesitant to contradict the directives of officers. DOC did not address any of DLC's reported concerns related to treatment, programming, or staff conduct in its January 6, 2025 response.

A. Access to Programming and Treatment

During this reporting period, the BSH annex units at OCCC attained close to full staffing. As of December, 3 out of 4 full-time clinician roles and 4 out of 5 full-time rehabilitation staff positions were filled.[81] The unit director for the ISOU and RU resigned in late November 2024 and BSH is now in the process of searching for a replacement.

Despite more robust staffing, PS on ISOU, which tends to house between 4 and 8 individuals at a time, report that there are only 2 groups offered each day. Others describe the unit as "tortuous" and "boring," with either nonexistent or subpar programming, no groups offered on weekends, and no therapeutic "talking" groups offered at all. ISOU PS report that engagement with mental health staff consists largely of playing cards. Unlike PS on the RU, PS on ISOU are not permitted to leave the unit. PS on RU report access to 4 on- and off-unit groups per day, as well as 2 hours of clubhouse in the evenings, where they can watch a movie and drink coffee off-unit.

During this period, RU PS rarely reported any issues with access to their clinicians, but ISOU PS continued to express concerns about the adequacy of their mental health care. PS in the ISOU are either currently or were recently experiencing mental health crisis – some form of self-harm generally precipitates their temporary commitment for evaluation, so many ISOU PS have

[80] Women serving state prison sentences who require psychiatric evaluation or commitment for treatment go to DMH hospitals.
[81] BSH Governing Body Packet (December 2024).

foreseeably acute needs. The ISOU standards conveyed to DLC requiring daily nursing contacts and a minimum of one weekly session with a clinician often fail to support these needs, even if PS have positive experiences with RTAs and rehabilitation staff. In keeping with prior reporting periods, ISOU PS report having difficulty with the off-site psychiatric nurse practitioner the Contracted Provider retains to be a primary provider for ISOU PS exclusively through video telemedicine appointments. PS express that the inherent limitations of virtual mental health care as well as the provider's behavior impede effective care.

B. Corrections Officer Conduct and Assignments

PS continue to share concerns regarding the conduct of corrections officers who work in the ISOU. PS reported to DLC that certain officers intentionally upset and "egg on" PS with verbal and physical abuse. One PS reported that a CO pushed him and told him to "go back to bed" while he was at the nurse's office asking for PRN medication. For years, DLC has heard PS and unit staff question the qualifications and training of officers who work in the ISOU and lament that officers in the BSH Annex Units have not been required to undergo sufficient specialized mental health training.

When the RU and ISOU opened as the BSH Annex in OCCC in 2017, DLC recalls DOC specially selecting officers based on their special skills in working with individuals with mental health disabilities and their desire to do so. Although this was not an infallible system, many officers assigned to the BSH Annex Units were able to build a positive rapport with PS. This has shifted drastically over time.

It is DLC's understanding that changes to the Massachusetts Correction Officers Federated Union's Collective Bargaining Agreement (CBA) have eliminated any discretion for DOC and BSH administrators in selecting officers for assignment to the BSH Annex Units. Instead, officers get to self-select and be placed in posts based on seniority. Once assigned to a post in the ISOU or RU, even when DOC administrators receive repeated complaints of PS mistreatment, officers will not be reassigned to a more suitable unit unless DOC's investigation into that conduct establishes just cause, as defined in DOC policy103 DOC 230.03.[82] Although DLC appreciates the importance of employee protections against unjust termination and demotion, the ability to transfer officers between units to prevent abuse of PS and other individuals with disabilities who live in specialized mental health and medical units is essential.

Given that the BSH Annex Units were created to provide psychiatric hospital-level evaluation and care, DLC recommends that DOC either: (1) commit to utilizing Contracted Provider security staff in the ISOU and RU; or (2) to ensure that future CBAs permit special selection of officers suitable to work with individuals with significant mental health needs and/or a lower threshold for reassignment to other OCCC housing units. DLC also recommends that DOC mandate that all officers assigned to the BSH Annex Units receive more intensive, ongoing mental health training than what DLC understands is currently required.

[82] 103 DOC 230.03.

II. BSH Prison Physical Plant: Health Risks and Antitherapeutic Conditions

Consistent with our efforts over the last decade, DLC observed and documented significant issues with the BSH physical plant this reporting period. DLC bases its repeated calls for BSH's closure and the construction of a modern psychiatric facility not only on chronic environmental conditions that place PS and staff health and safety at risk – toxic mold, extreme heat, and decaying infrastructure – but on the fact that it is structurally a prison facility.

DOC is responsible for maintenance of and improvements to the state prison facility, which requires continuing, expensive, and often creative fixes to outdated systems and decaying buildings that should simply be closed. DOC highlights its efforts, but, as in the sparse January 6, 2025 response to DLC's last report, it fails to acknowledge the seriousness of the health and safety risks the environmental contamination throughout the facility and stiflingly hot and humid conditions in housing units pose to the individuals with disabilities it imprisons.

The Commonwealth has decided to close three state prisons in the last two years in the name of DOC operational efficiency and cost savings solutions. Less than 6 months ago, DOC announced that it would be closing a facility on the Bridgewater complex – the OCCC minimum security men's facility "based on a thorough assessment of the facility's age, maintenance needs, and required renovations."[83] BSH too warrants closure based on economic inefficiency.

Along with stewardship of taxpayer dollars, the Commonwealth is responsible for protecting the mental and physical health and safety of people involuntarily detained in DOC facilities, including those committed to BSH. The Commonwealth does not and cannot meet this responsibility when it relegates persons with mental health disabilities to a state prison. In December 2024, the Governor signed into a law *An Act relative to treatments and coverage for substance use disorder and recovery coach* licensure, now Chapter 285 of the Acts of 2024.[84] The law includes a requirement to develop a plan, by December 31, 2026, to close the Massachusetts Alcohol and Substance Abuse Center (MASAC) – a DOC facility that holds men court-ordered, pursuant to M.G.L. c. 123, § 35, to involuntary substance use disorder treatment – and replace the MASAC beds in programs overseen by DMH or the Department of Public Health.[85]

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[83] DOC, *Massachusetts Department of Correction Announces Plan to Conclude Housing Operations at Old Colony Correctional Center-Minimum Security Facility: Decision results in savings of $2.6 Million in deferred capital investments* (August 22, 2024), https://www.mass.gov/news/massachusetts-department-of-correction-announces-plan-to-conclude-housing-operations-at-old-colony-correctional-center-minimum-security-facility.

[84] *Press Release: Governor Healey Signs Bill Making Substance Use Disorder Treatment and Recovery Support More Affordable and Accessible* (December 24, 2024), https://www.mass.gov/news/governor-healey-signs-bill-making-substance-use-disorder-treatment-and-recovery-support-more-affordable-and-accessible; Chapter 285 of the Acts of 2024, https://malegislature.gov/Laws/SessionLaws/Acts/2024/Chapter285.

[85] In pertinent part, Chapter 285 states:

> SECTION 30. (a) Notwithstanding any general or special law to the contrary, the Massachusetts alcohol and substance abuse center, hereinafter referred to as the center, shall be considered a secure facility under section 35 of chapter 123 of the General Laws for the purposes of commitments under said section 35 of said chapter 123 until December 31, 2026 or such time as the secretary of health and human services determines there is an adequate supply of beds pursuant to subsection (b).

DLC applauds the appropriate transfer of responsibility for treatment of the MASAC population from DOC to public health agencies. However, the appropriateness of this overdue reform shines a light on the gross, unequal treatment for men with mental health disabilities involuntarily committed to BSH. DLC calls upon the Commonwealth to take similar action to close BSH.

While construction of an appropriate hospital facility or units in existing facilities will take time, immediate transfer to DMH and wholesale application of DMH regulations and policies – that, for example, do not allow PS to be locked in nearly half of every day without individual clinical orders justifying seclusion – will have a significant impact in making conditions more humane. DMH standards and therapeutic focus would likewise inform maintenance and necessary remediation efforts. DLC hopes that a transition would entail engagement with new vendors, as mold remediation and prevention and industrial cleaning efforts by DOC vendors to date have not been effective, per DLC's mold expert.

1. Expert Again Confirms Environmental Contamination

DLC engaged mold expert Gordon Mycology Laboratory, Inc. (Gordon Mycology) this reporting period to conduct an onsite visual inspection and gather culturable surface swab samples at BSH for the fifth time since 2019. DLC returned to BSH with Gordon Mycology on November 7, 2024. Gordon Mycology details its findings from the inspection in the January 24, 2025 Mold Inspection Report, attached hereto with laboratory results as **Appendix D**.[86]

Every prior inspection has revealed mold throughout the facility, including in mechanical rooms that hold facility HVAC systems as well as PS housing units. Gordon Mycology has provided clear mold remediation and maintenance recommendations. In response, DOC reported in 2022

> (b) The secretary of health and human services shall develop a plan to end operations at the center as a secure facility accepting persons committed for treatment for alcohol or substance use disorder by not later than December 31, 2026; provided, however, that persons may continue to be committed to the center until the department of public health or the department of mental health have identified, licensed or approved facilities with sufficient capacity to ensure an adequate supply of beds for the treatment of individuals committed under said section 35 of said chapter 123. In developing the plan, the secretary shall consider geographic distribution of facilities when identifying, licensing or approving facilities.
>
> (c) The secretary shall submit the plan required under subsection (b) to the clerks of the senate and house of representatives and to the joint committee on mental health, substance use and recovery not later than 180 days after the effective date of this act. The secretary shall submit interim reports quarterly detailing the progress towards ending operations at the center to the clerks of the senate and house of representatives and to the joint committee on mental health, substance use and recovery. The quarterly reports shall include, but shall not be limited to the following: (i) a census of persons being treated at the center; (ii) the number of persons transferred from the center to other facilities licensed or approved by the department of public health or department of mental health; (iii) the location and bed capacity of each newly licensed or approved facility or existing facility that increases capacity; (iv) the type of facility and location of newly committed persons under section 35 of chapter 123 of the General Laws since the most recent quarterly report; and (v) the anticipated fiscal impact, if any, of complying with this section.

Chapter 285 of the Acts of 2024, https://malegislature.gov/Laws/SessionLaws/Acts/2024/Chapter285.

[86] Gordon Mycology Laboratory, Inc., Mold Inspection Report (January 24, 2025) and Laboratory Results [hereinafter "Appendix D"].

completing mold removal and repairs; adopting new cleaning methods and products; entering into a contract to conduct a quarterly facility cleaning program; purchasing UVS light and HEPA filtration units for areas including housing unit common areas, "staff critical areas," and mechanical rooms; and beginning a Division of Capital Asset Management and Maintenance (DCAMM) project with a projected cost of $2,496,000 to replace underground and steam condensate lines at BSH.[87] Between the 2023 inspection and November 2024, DOC completed additional work in mechanical rooms that included removal of pipe and HVAC ductwork insulation and trash previously present. Nevertheless, mold contamination at BSH remains a serious health issue for PS and staff alike.

Laboratory testing of swab samples taken in November 2024 from the locations listed below found "**elevated levels and/or unacceptable types** of active (living) mold."[88] "These samples, and the visual inspection, confirm that mold is still alive and actively growing year after year even with the cleaning or remediation efforts that have been performed."[89]

- Administration Building basement room AD-11 – HVAC system supply air diffuser
- Administration Building basement room AD-11 – HVAC system return air grille
- Administration Building Roll Call Room – HVAC system supply air diffuser
- Lighthouse basement main room – HVAC system return air grille
- Lighthouse basement main room – visible mold on painted HVAC duct seam
- Lighthouse Building first floor HVAC room – HVAC system, return side of filter
- Lighthouse Building first floor HVAC room – HVAC system, supply side of air handler
- Lighthouse Building first floor – HVAC supply air diffuser outside Nurse's Station
- Lighthouse Building first floor – HVAC system supply air diffuser in hallway H169
- Lenox – supply air diffuser in shower hallway
- Lenox basement – HVAC system, return side of filter
- Attucks dining hall – HVAC system supply air diffuser, at water damaged ceiling
- Attucks library – HVAC system supply air diffuser
- Carter Building – HVAC system supply air diffuser in day room (game room)
- Carter Building hallway – HVAC system return air grille
- Adams Building – HVAC system supply air diffuser in day room
- Adams Building basement – visible mold on cardboard/paper-covered cylinder on floor
- Adams Building basement – lower HVAC system filter, supply side[90]

In other areas listed below, Gordon Mycology's "visual inspection confirmed **abnormal and unacceptable mold growth** as well as large amounts of black debris" in HVAC air supply diffusers/vents.[91] Surface samples did not result in high levels of culturable mold because the visible mold was dead. "[H]owever, 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."[92]

- Administration Building basement mechanical room– visible mold on HVAC duct seam
- Lighthouse basement boiler room – visible mold on painted duct column with fan
- Lighthouse basement IT room – visible mold on electrical panel plywood
- Lighthouse basement IT room – water-stained painted concrete wall beneath ceiling pipe

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[87] DLC January 2023 Report at 9-10.
[88] Appendix D at 9-10 (emphasis in original).
[89] *Id.* at 10 (emphasis in original).
[90] *Id.* at 9-10.
[91] *Id.* at 10 (emphasis in original).
[92] *Id.* (emphasis in original).

- Attucks library – suspected mold growth on ceiling around HVAC supply air diffuser[93]

Laboratory testing identified a variety of mold types growing on the tested surfaces, including: Alternaria, Aspergillus niger, Aspergillus flavus, Aspergillus fumigatus, Aspergillus ochraceus, Aspergillus sydowii, Aspergillus versicolor, Aureobasidium, Chaetomium, Cladosporium, Epicoccum, Penicillium, Pithomyces, Rhizopus and Trichoderma.[94]

> Aspergillus growth confirmed on most of the tested surfaces in the buildings, including HVAC system components. Aspergillus, and particularly A. fumigatus found on several surfaces this year, 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 fogginess, etc. People with underlying health conditions and weaker immune systems are most affected by chronic mold exposure.[95]

"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."[96] In addition, black dust/debris observed and tested in 2023 remained.[97] The 2023 particulate analysis of this "black dust/debris from inside HVAC system supply and return ductwork/vents…confirmed the presence of irritating and dangerous particles."[98]

> Deteriorated fiberglass linings inside the air handlers and ductwork have not been removed even after repeated recommendations; the professional HVAC system cleaning that has reportedly been performed since GML began inspecting the buildings has not addressed any of the global problems with the systems. Loose/rough-edged fiberglass should not be inside air handling systems as the particles that are released get into the airstream and then into peoples' lungs, eyes, and sinuses. Fiberglass particles are irritating, exacerbate asthmatic conditions, cause irritation in the mucous membranes, and can cause other health problems according to the current medical literature.[99]

Additionally, Gordon Mycology noted that "although asbestos abatement had been done in some areas[,] there were still suspect materials in several areas that should be tested by a licensed and independent asbestos consultation."[100]

Of course, PS have co-occurring chronic and/or serious medical conditions, including respiratory conditions (e.g., asthma) and diseases that impact their immune systems (e.g., lupus, diabetes, hepatitis C). Moreover, studies indicate that exposure to mycotoxins may also be associated with "fatigue, musculoskeletal pain, headaches, anxiety, mood, cognitive

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[93] *Id*.
[94] *Id.*
[95] *Id.* at 10-11.
[96] *Id.* at 10.
[97] *Id.* at 11.
[98] *Id.*
[99] *Id*.
[100] *Id.* at 12.

impairments, and depression."[101] Many of these symptoms may readily be treated and medicated as mental health symptoms if they are not properly screened and addressed. DOC and the Contracted Provider have not followed DLC's past recommendations to provide regular health screenings for symptoms of mold and environmental toxin exposure.[102] BSH staff may also have underlying medication conditions that make them particularly susceptible to illness from continued mold exposure at BSH.

According to industry guidelines, ANSI/IICRC Document S520: Standard and Reference Guide for Professional Mold Remediation, Gordon Mycology characterized all inspected building at BSH as a "Condition 3 Environment."[103] Categorization as Condition 3 means that BSH is "[a]n indoor environment contaminated with the presence of actual mold growth and associated spores," in which "[a]ctual growth includes growth that is active or dormant, visible or hidden."[104] To address the mold contamination in particular, Gordon Mycology again provided detailed, extensive recommendations for remediating existing mold and preventing future growth that focus upon two major issues:

- Identifying and resolving all sources of water intrusion and accumulation. Gordon Mycology cites that presence of leaking pipes; basements flooding with rain and ground water; open sumps – "including one with raw sewerage components and one with steaming water coming from boiler pipes"; mechanical equipment draining into open buckets; unconditioned outdoor air coming in causing condensation problems; and the absence of dehumidification in all basement spaces. "These moisture sources are the direct cause for abnormal and unacceptable mold growth and cannot be allowed to continue."[105]

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[101] A. Ratnaseelan, et al., *Effects of Mycotoxins on Neuropsychiatric Symptoms and Immune Processes*, Clinical Therapeutics, Vol. 40, No. 6, 912 (2018), https://www.clinicaltherapeutics.com/article/S0149-2918(18)30229-7/fulltext.

[102] DLC January 2022 Report at 14-15.

[103] Gordon Report at 11. As there are no applicable federal regulations, ANSI/IICRC S520 provides the foundation the NIH mold program. *See* National Institutes of Health, *Moisture and Mold Remediation Standard Operating Procedures*, para. A.2 (2023), https://ors.od.nih.gov/sr/dohs/Documents/moisture-and-mold-remediation-sop.pdf. "The IICRC is the Institute of Inspection Cleaning and Restoration Certification, a non-profit organization for the Inspection, Cleaning, and Restoration Industries." IICRC, https://iicrc.org/abouttheiicrc/.

> The IICRC S520 Standard describes the procedures to be followed and the precautions to be taken when performing mold remediation in residential, commercial, and institutional buildings, and the systems and personal property contents of those structures. The ANSI/IICRC S520 is a procedural standard for the remediation of mold damaged structures and contents. The ANSI/IICRC S520 is based on reliable remediation and restoration principles, research and practical experience, and attempts to combine essential academic principles with practical elements of water damage restoration for technicians facing "real-life" mold remediation challenges. The S520 is written for use by those involved in the mold remediation industry, and is the result of collaboration among microbiologists and other scientists, public health professionals, industrial hygienists, remediation contractors, restoration service companies, cleaning and restoration training schools, trade associations that service the professional restoration industry, allied trade-persons and others with related professional and practical experience.

IICRC, *IICRC S520 Standard for Professional Mold Remediation,* https://iicrc.org/s520/#:~:text=The%20ANSI%2FIICRC%20S520%20is,mold%20damaged%20structures%20and%20contents.

[104] Appendix D at 11.

[105] *Id.* at 12.

- Removal of mold growth sources and remediation of remaining materials by a specialized mold remediation company that uses "[s]ecure engineering controls (contaminant barriers, negative air pressure system, HEPA filtered air scrubbers) and safety procedures (personal protective equipment – PPE) for people performing the work…to prevent cross contamination and exposure risk while the work is being conducted."[106]

In conclusion, Gordon Mycology summarized the persistent, serious issues that threaten the health of PS and BSH staff and implicate the inadequacy of DOC's expensive efforts to date:

> Many of the sources of mold growth identified during the 2019, 2021, 2022, and 2023 inspections of the Bridgewater State Hospital buildings and HVAC systems were confirmed to still be present (visually and with laboratory data) during the 2024 inspection. This indicates that the necessary mold remediation, cleaning, and maintenance actions have not been fully 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 mold growth and some remaining asbestos. 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 sections of HVAC systems that had been professionally cleaned were confirmed to be filthy and riddled with active mold growth after the cleaning.
>
> 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 (unfiltered and unconditioned outdoor air coming directly into the systems, open filter compartments, 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 long-term neglect of critical building systems. Mold remediation performed by an unqualified company who did not follow currently accepted industry standards and procedures was proven to be inadequate, unsuccessful, and deficient. There also are remaining questions regarding the completeness of the asbestos abatement; there appeared to be potentially asbestos-containing materials in the basements that should be investigated by an independent 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, 2021, 2022, and 2023 recommendations were largely ignored as of this 2024 inspection. 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. **Based on 5 years of Bridgewater State Hospital inspections by GML, 28 years of professional mold/indoor air quality inspection history and experience, industrial hygiene experience, and industry accepted guidelines for indoor spaces contaminated with mold, GML is concluding that the facility should not be occupied until these problems have been fully resolved and the buildings retested to verify that moisture and mold sources have been resolved and removed, respectively.**[107]

[106] *Id.*
[107] Appendix D at 17.

2. A Prison Environment Incompatible with Provision of Psychiatric Hospital Level of Care

When corrections officers left BSH in 2017– reform initiated by the Baker Administration in response to litigation and findings of rampant PS rights violations and abuse – BSH became no less a prison. BSH serves the same population as DMH but in a 275-bed prison surrounded by razor wire fencing. Entry into the prison and into each housing unit is through small corridors with large metal mechanical doors on either side operated by staff within an enclosed guard station. Once inside, housing units largely consist of a prison "day room" with seating and a mounted television and corridors lined with heavy metal prison cell doors. BSH PS cells contain a bed, a wall-mounted desk and seat, and a metal wall fixture with a toilet bowl and a sink built into the top of the tank. As discussed below, it is impossible to reconcile the facility's name and stated purpose with the reality inside.

The sounds of prison define the environment: staff yelling for PS to lock-in for institutional count 3 times a day, reverberating down the concrete hallways; the frequent scratchy mumble of security staff radios announcing happenings around the facility; the electric buzzing of the unit gate opening and the metal crash when it closes; and the metallic jangle of staff keying in and out of cell doors which are rarely left unlocked. Add to that, as DLC has previously reported, daily interactions PS have with BSH staff can be difficult and even harmful. DLC again received repeated reports of certain staff members engaging in verbal abuse and goading comments, imposing arbitrary restrictions on PS movement within their housing units, and refusing to identify themselves. It should come as no surprise that even PS with limited or no prior involvement with the legal system frequently refer to their peers as "inmates" rather than "patients." One would be hard-pressed to find the same language among patients in a DMH hospital.

Below, DLC discusses some of the features of BSH's physical plant that are uniquely "correctional" and their impact on the mental health and wellbeing of PS:

A. Prison Cells

As discussed above, periods that PS spend locked in their cells – whether initiated with clinical rationale or unauthorized and undocumented – in addition to restricting physical movement, may take a toll on PS mental health. While patients at DMH hospitals may also undergo seclusion, it is typically "open-door seclusion" in which a staff member stands outside, preventing the patient from exiting the room. In DMH settings, patient room doors do not lock from the outside. At BSH, in contrast, the heavy prison cell doors lock only from the outside. Staff slam and secure these doors behind PS after they shove PS into their cells for seclusion. Multiple former BSH PS described their experiences at BSH as claustrophobic and retraumatizing. At BSH, cell doors are a near-constant physical barrier between PS and the milieu, which often must be banged, kicked and screamed through to get the aid of staff who hold the keys. At the same time, the metal doors offer no privacy; PS must live life in a fishbowl where, unnervingly, anyone peering through the cell door window can watch them sleep, toilet, or do other regular activities in the only "personal" space BSH offers.

PS dependence on staff for adjusting their immediate environments extends beyond cell doors themselves. Unlike DMH patient rooms, BSH PS do not have control over their lights – they must ask and then wait for staff to turn their lights on and off. PS do not have control over their screened windows to the outdoors – they must ask and then wait for staff to open or close them and their requests may be denied based on the weather or other administrative considerations. As discussed further below, staff are able to turn PS water on and off. And, in the event of a

power outage, BSH policy dictates that PS are to remain secluded in their cells,[108] with staff releasing them manually, one by one, in the event an evacuation is deemed necessary.

Whether used for 10 hours of evening lock-in, institutional count, or clinical seclusion, the concrete-and-metal prison cells of BSH are counter-therapeutic and not to be found in any legitimate psychiatric hospital. For PS who have histories of trauma and/or who are experiencing acute symptoms related to mental health disability, the foreseeable negative impacts on their mental health at BSH cannot be overstated.

B. Cell Door Wickets

Wickets are small slots located on each cell door typical in prison facilities. Unless opened by staff a small lockable metal door covers the slot at all times. Other than papers occasionally slipped under a cell door, any needed resources are passed from the unit outside to the PS inside through this opening the width of a meal tray. Wickets are the sole site of physical exchange between staff and PS while they are locked in for at least 10 hours per day, a sign of PS' total reliance on staff.

Interactions through wickets can be a source of conflict between staff and PS. PS frequently report that staff forcefully push their meals through their wickets causing spills. PS sometimes stick their hands through the wicket to get staff's attention and amplify concerns with their treatment. Despite no known BSH policies prohibiting this, BSH security staff object to this and have initiated physical struggles with PS to force their arms back through the wicket. DLC's last report included an account of a TSTs prying a PS' hands off of his open wicket door, twisting and contorting his fingers, resulting in injury.

During this reporting period, another PS – PS "Griff" – reported to DLC that BSH staff had closed his hands in the wicket. DLC observed cuts and bruises on Griff's hands at the time. Although his medical records unsurprisingly did not detail BSH staff closing the metal wicket door on Griff's hands, multiple staff notes described Griff as refusing "redirection" and holding his wicket "hostage" – a simultaneously absurd and telling way for staff to characterize a PS locked in a prison cell putting his hands through a small slot in a metal cell door. On the Medication Restraint Order form, the psychiatrist described the "Situation Creating the Risk" as follows: "Patient was agitated, yelling, threatening and would not remove arms from out of the wicket causing safety risk for himself and other patients." This psychiatrist did not explain how Griff's actions posed a "safety risk to himself and other patients," designated only "potential harm to self" as the "Type of Emergency," and only "treatment of acute symptoms" (not "restraint to prevent harm") as the "Indication for Emergency Medication Order." BSH staff did not force medicate Griff pursuant to the Medication Restraint Order until almost an hour after his wicket was closed.

DLC brought this incident to the attention of the BSH Hospital Administrator, who confirmed that Griff received pain medication for discomfort. In addition, after viewing video footage of this incident, the BSH Hospital Administrator informed DLC that the Contracted Provider advised staff to stop attempting to close PS wickets when PS put their hands through and to instead notify the treatment team for assistance with de-escalation. While positive, this change comes too late and does not address the foundational issues underlying these dangerous and gratuitous power struggles – namely, BSH staff's correctional attitude emphasizing control and coercion and the dehumanizing correctional features of the BSH physical plant.

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[108] Bridgewater State Hospital Policy and Procedure Manual – Loss of Utilities Plan, §§ 5.1.4, 5.2.2.

C. Water Shut Off

Staff and PS interviews, PS medical records, and nursing notes frequently reference BSH staff shutting off the water function in PS cells, disabling both the toilet and sink. TSTs report typically doing this when PS are misusing the toilet or sink in their cell, creating standing water. Staff admitted to DLC that they should get approval from the PS' treatment team before turning off the water, but they do not always do so. Numerous PS complained to DLC about staff abusing this power, turning water off without due cause or leaving it off for extended periods of time, including during hot weather. For instance, in the example above regarding the wicket struggle, PS Griff reported that his reason for holding his wicket open was to draw staff's attention to the fact that his water was shut off and he needed to flush his toilet.

PS in the neighboring cell, who are not the intended targets of a water shut off, are also subject to having their toilet and sink disabled. In BSH housing units, automatic water shutoff switches placed between every two cells affect the cells on either side of the switch. According to one PS, his water was disabled in the middle of the night on multiple occasions during the July heat. He woke up unable to use the toilet or get a drink of water, all because staff had shut off the water for the cell adjacent to his. He described this as "group punishment."

BSH staff explained to DLC that there are manual controls limiting shut-off to a single cell, but signage in unit control panels directs staff to instead use the switch that turns off both abutting cells. According to a BSH facility maintenance manager, that is because using the manual controls can cause higher water pressure that damages the pipes. In order to mitigate the inhumane conditions and negative effects on the neighboring PS's wellbeing, BSH staff reported to DLC that they will briefly turn on their water, offer access to the communal bathroom, or bring them cups of water to drink. This, however, requires PS to get staff's attention to attend to their most basic bodily needs, which can already be quite difficult while locked behind a metal prison cell door. About their mitigation efforts, one staff member admitted to DLC that BSH staff ultimately "don't deal with it in the best way." He expressed that this feature of the facility and staff's management of it is inevitably a burden for the neighboring PS– not to mention the PS being targeted– leading to behavioral issues out of frustration and desperation.

When DLC raised our findings with the BSH Hospital Administrator and Medical Executive Director, the circumstances and frequency of staff suspending PS water access appeared to surprise them. Both indicated that unit staff do not have authority to shut off water absent a medical order or a maintenance need (e.g., a plumbing issue). Such lack of awareness and oversight of unit staff practices that impact PS health, hygiene, and human rights is highly concerning.

Whatever the rationale, water shut offs for PS are heavy-handed, and, for neighboring PS, they lack any justification. For these PS, their treatment is not person-centered care but rather predictable collateral damage in an outdated state prison facility. This is another example of how the prison physical plant of BSH and its use by staff is fundamentally dehumanizing, untherapeutic and different from a DMH hospital.

D. Booking Holding Cell

During this reporting period, DLC noted in daily nursing notes that staff began using what was referred to as the "booking cell" to seclude PS housed in the Lighthouse medical unit, which shares a building with the booking office. When DLC viewed this "booking cell," we discovered it is actually a freestanding single-occupancy metal cage in the corner of the booking office.

On the day DLC first observed the cage, a PS was secluded inside, sitting on a small seat in the middle, unable to lie down let alone move more than one step in either direction. A staff member sat in an office chair outside the cage on 1:1 observation of the PS on seclusion. Another staff member told DLC that, when PS locked in the cage needed to urinate, they were brought a plastic jug with a screw top.

DLC notes that a similar cage – commonly called "the bird cage" – was used for interviews, attorney visits, and family visits of BSH PS subjected to seclusion and restraint in the old ITU, the primary site of the abuse and illegal practices at BSH prior to its closure in 2017. Seeing such a cage in use again was nothing short of disturbing.

The Contracted Provider took individual Lighthouse PS, who are generally among the most medically vulnerable PS at BSH, to this metal cage for "therapeutic" seclusion. BSH staff explained that they were using this cage for seclusion because it was safer than the actual Lighthouse seclusion room, which contains a bathroom that is not visible by the staff member on 1:1. However, staff later reported to DLC that the cage was sometimes used simply because another PS was housed in the usual Lighthouse seclusion room at the time.

BSH administration, in response to DLC's concerns about the safety and mental health impacts of such a confined space, conveyed the following in early November: "We are in agreement that the holding cell is not a therapeutic space and it is not the accepted practice of the hospital to use this area for seclusion unless there are exigent and significant safety concerns identified that might warrant a time-limited use under the direct authorization of the Medical Executive Director."[109] After this exchange, DLC did not see further episodes of seclusion for Lighthouse PS in the "booking cell" documented in daily nursing notes. Three weeks later, DLC observed that a repurposed wooden door painted with the word "laundry" had been installed in the entrance to the seclusion room bathroom, addressing the safety concerns.

While it is fortunate that DLC's continuous monitoring allowed us to promptly investigate and advocate against disturbing practice, the Contracted Provider – with Medical Executive Director approval – had already used the cage 8 times between August 24, 2024 and October 18, 2024. **Total seclusion time in the cage across these 8 instances was 19 hours and 28 minutes, with the longest seclusion lasting 6 hours and the shortest lasting 29 minutes.** Who knows how many medically vulnerable Lighthouse residents would have been put in the cage had DLC not intervened. In any case, the Contracted Provider only had the option of using a dehumanizing human cage for seclusion because BSH is a prison. Worse still, the Contracted Provider chose to use the cage as a seclusion space, showing again a troubling comfort with compromising the dignity and safety of BSH PS in order to impose control. Such a calculation would be unthinkable under DMH and impossible in a modern hospital facility.

[109] Contracted Provider email to DLC (11/4/2024).

III. Continuity of Care Challenges for BSH Persons Served

DLC monitors continuity of care for PS and any barriers thereto through onsite visits to BSH, OCCC BSH Annex Units, DMH facilities, and county correctional facilities, PS interviews, facility staff interviews, and document review. During this reporting period, DLC conducted site visits at the Essex County Correctional Facility and 4 DMH hospitals – Worcester Recovery Center and Hospital, Lemuel Shattuck Hospital, Tewksbury State Hospital, and Mountain View Unit at Valley Springs Behavioral Health Hospital.[110] Based on recent reports we have received, DLC intends to expand our monitoring of PS continuity of care to the Residential Treatment Unit and the Intensive Stabilization Unit at OCCC.

PS continue to report that they receive insufficient information about their transfer to DMH facilities and county correctional facilities. Nearly half of those interviewed received no advance warning at all. Others received between a few days' notice and one person received a month's notice. Two-thirds of former PS DLC interviewed did not have a meeting about transferring to DMH with BSH staff prior to discharge. Most said that such a meeting would have been helpful in their transfer process, just as most PS who had such a meeting found it to be helpful.

Continuity of care is extremely important when managing mental health care. Not surprisingly, key aspects of continuity of care are patient engagement and care coordination between the discharging and receiving treatment providers to ensure that the new providers are familiar with the patient's pharmacological, psychiatric, and social histories. A transfer to a new setting, even under the best circumstances, can be destabilizing and lead to regression. Discharged PS – whether they are transferred to a DMH psychiatric hospital or a county correctional facility – are generally expected to adjust after abrupt transitions with little or no notice. Transfer to correctional facilities can be even more jarring, particularly due to differences in access to mental health care, mental health watch practices, and psychiatric medication formularies across county sheriff's departments.

1. Challenges with Continuity of Care: DMH Hospitals

From November 2023 through October 2024, there were 190 transfers from BSH to DMH hospitals.[111] As a primary concern, as in previous reporting periods, DMH hospital staff and administrators reported to DLC difficulties obtaining timely, complete PS medical and psychiatric records from BSH to aid in continuity of care. The records routinely provided are limited in scope. Psychiatric records arrive the day before or the day of arrival; however, helpful BSH discharge summaries can take weeks for DMH treatment teams to obtain. Records of medical care PS received at BSH often arrive late. DMH hospital staff report varying success when seeking consultations about PS with BSH providers and trying to secure outstanding records. BSH and DMH administrators meet every quarter; these meetings include discussion of step downs from BSH and DMH hospitals and suggest that there were no major issues with PS

[110] The Mountain View Unit is a contracted DMH unit for Western Massachusetts situated within the Valley Springs Behavioral Health Hospital in Holyoke. The unit was formerly located at Vibra Hospital.
[111] The 190 PS who were transferred to DMH fell under different legal statuses: 108 PS were subject to commitment per M.G.L. c. 123, §16 relating to incompetence to stand trial; 49 PS were committed per M.G.L. c. 123, §§7&8 for hospitalization unrelated in any open criminal matter; 7 PS had been found not guilty by reason of mental illness; and 26 PS were individuals from county correctional facilities who were committed for inpatient hospitalization per M.G.L. c. 123, §18a.

transfers. DLC notes that there has been little progress in updating the 2010 memorandum of understanding between DMH and BSH, which would foster improved collaboration.

Former BSH PS transferred to DMH hospitals find the care and conditions on the psychiatric units to be an improvement over the oppressive prison environment of BSH. In contrast to the over 10 hours BSH PS spend locked in a cell every day absent any legal basis, DMH patients are not locked in their rooms without a valid seclusion order. In DMH hospitals, former PS often report appreciating their own rooms with full bathrooms and appropriate privacy – a far cry from BSH prison cells with large cell door windows that provide staff and other passing PS a continuous view of both the bed and toilet. They also report appreciating their access to the therapeutic and recreational groups available, access to electronics, and the opportunity to progress in their treatment in community settings once they have progressed to clinically indicated off-ground privileges.

Unfortunately, many former BSH PS on the DMH units at Tewksbury Hospital and Lemuel Shattuck Hospital continue to report a lack of reasonable outdoor access and off-unit access. Based on interviews with former PS and other patients, hospital records review, and conversations with hospital staff, DLC understands that lengthy periods of unit restriction and access to only 20 minutes or less of outdoor access in a locked courtyard per day are now the norm for people on any bail status, without regard to any individualized determination of clinical needs. These restrictions may prevent access to clinically indicated programming, therapeutic activities, and community integration opportunities – all components of meaningful mental health treatment and discharge planning. In addition, the restrictions increase stress and tensions in the unit, denying meaningful access to the outdoors and exercise that can be key to former PS physical and mental health. As this is not consistent with previous department-wide guidance, DLC has engaged with DMH to confirm that agency policy dictates that bail status is one of many factors used to determine privilege status. DLC understands that DMH's Office of Inpatient Management will be providing clarification about DMH policy and practice applicable to all hospitals.

2. Challenges with Continuity of Care: County Correctional Facilities

Current and former BSH PS commonly report inadequate access to medical and mental health care and traumatic experiences on mental health watch (MHW). MHW in county correctional facilities is a significant part of PS continuity of care, as it is typically where PS are held before coming to BSH and where they may be placed when they are discharged from BSH. Mental health care standards vary widely across county sheriff's departments as do MHW practices when individuals are in crisis, need a higher level or care, express negative thoughts, or engage in self-harm. In recent years, DLC has engaged with 7 county correctional facilities[112] to view physical conditions firsthand and gather information pertinent to continuity of care for PS, including about mental health staffing, standards for mental health contacts, and existing MHW policy and practice.

[112] DLC has conducted onsite monitoring at the following county correctional facilities: Hampden County Correctional Center; Bristol County Jail and House of Corrections; Essex County Correctional Facility; Middlesex Jail and House of Correction; Plymouth County Correctional Facility; Suffolk County Jail; and Worcester Jail and House of Correction.

Based on this work, DLC again calls upon the Commonwealth to engage in increased oversight of the mental health care that county correctional facilities provide and establish minimum standards of mental health care and MHW practices for all individuals held in county correctional facilities. State regulatory changes are one potential avenue for moving things forward. Current regulations include troublingly few requirements and guardrails to ensure that people with mental health disabilities and individuals in mental health crisis receive adequate care in humane conditions in county facilities.[113] DLC recommends that, as a first step, the Executive Office of Public Safety and Security (EOPSS) work with DMH and other important stakeholders on new proposed regulations. In the meantime, DLC urges DOC to utilize its authority to audit county correctional facility compliance with existing regulations[114] to address disturbing conditions in cells used for MHW.

A. Essex County Correctional Facility

In November 2024, DLC conducted a site visit at the Essex County Correctional Facility (ECCF). During the site visit, administrators reported transferring relatively few individuals (1 to 3) to BSH per month compared to other counties. Administrators credited this to their frequent use of the Middlesex Emergency and Stabilization Unit (MESU), an intensive mental health treatment unit at the Middlesex Jail & House of Correction that takes referrals from eastern Massachusetts county sheriff's departments, providing a therapeutic environment meant to address psychiatric crises.

ECCF administrators reported having productive communications with BSH clinical staff as well as the BSH directors of clinical services and social services. They attend quarterly meetings with other county mental health directors as well as representatives from BSH. ECCF administrators said that they work with BSH frequently on Inter-Facility Case Conferences when more intensive coordination is required for a PS being transferred to ECCF. While ECCF has persistent issues with BSH's timely provision of records for transfers, ECCF reports that PS typically arrive with documentation – a significant improvement in records access compared to about 5 years ago.

ECCF maintains 4 MHW cells, all located in the facility's Health Services Unit. Each cell is equipped with in-cell surveillance cameras and correctional staff monitor the camera feeds from a station in the hallway. Cell dimensions are 8'6" x 12'2" x 8'0" and each cell is equipped with a toilet-sink combination and a single slit window to the outdoors. The walls of 2 out of the 4 cells are made of a firm rubber material, while the other two cells' walls are cushioned. There are no seats or beds in the cells except for one that contains a bolted-down metal bed frame used for 4-point restraints.

In the ECCF MHW cells, correctional staff monitor individuals on "Close Observation" status at irregular 15-minute intervals and continuously monitor those on "Constant Observation." Decisions to remove an individual on MHW's clothing and possessions is made by mental health and security staff on a case-by-case basis. If an individual's clothes are removed, they receive a safety smock and safety blanket.[115]

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[113] *See* 103 CMR 932.
[114] *See* 103 CMR 901; 103 CMR 904.
[115] Essex County House of Correction: Suicide Prevention, 103 ECSD 244.00.

Administrators report that individuals typically stay on MHW for 1 to 4 days. If their time on MHW extends beyond that then they are considered for transfer to BSH. While on MHW, individuals typically do not get out of cell time, and access to family and attorney calls are considered on a case-by-case basis. According to administrators and former BSH PS, the lights in the ECCF MHW cells are kept on 24 hours per day, which former BSH PS describe as "horrible," "like torture," and making it even more difficult for them to sleep than it already is using the thin, foldable mattresses they are issued.

Appendix A: Glossary of Acronyms Used in the Report

BSH	Bridgewater State Hospital
DLC	Disability Law Center
DMH	Department of Mental Health
DPH	Department of Public Health
DOC	Department of Correction
ECCF	Essex County Correctional Facility
EOPSS	Executive Office of Public Safety and Security
ETO	Emergency Treatment Order
ISOU	Intensive Stabilization and Observation Unit in the Bridgewater Annex located at Old Colony Correctional Center
ISU	Intensive Stabilization Unit
MESU	Middlesex Emergency Stabilization Unit
MHOC	Middlesex County House of Correction
OCCC	Old Colony Correctional Center
PS	Person(s) Served
RFR	Request for Response
RH	Restrictive Housing
RTA	Recovery Treatment Assistant
RU	Residential Unit in the Bridgewater Annex located at Old Colony Correctional Center
SST	Strategic Sourcing Team
TST	Therapeutic Safety Technician

Appendix B: Summary of DLC Monitoring Activities During Reporting Period

During this reporting period, DLC conducted monitoring of BSH and continuity of care for PS through a variety of activities, including:

- Weekly onsite BSH visits;
- BSH PS video, phone, and in-person meetings;
- BSH staff in-person meetings;
- Onsite visits to the OCCC BSH Units - ISOU and the RU;
- OCCC BSH Annex Unit PS video, phone, and in-person meetings;
- OCCC BSH Annex Unit staff in-person meetings;
- Meetings and correspondence with BSH administrators and Contracted Provider leadership;
- Meetings and correspondence with DOC administrators and DOC Legal Department;
- BSH PS Governance Meetings;
- Attending BSH Governing Body meetings and Department of Mental Health quarterly meetings;
- Requests for data and documentation to the Contracted Provider and DOC;
- Review of BSH 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 BSH restraint and seclusion orders and documentation;
- Review of individual PS medical records;
- Review and analysis of PS discharge data;
- Onsite visits to DMH hospitals and units: Lemuel Shattuck Hospital, Worcester Recovery Center and Hospital, Tewksbury State Hospital, and Western MA Unit at Mountain View to meet with facility staff and discharged PS;
- Onsite visit to Essex County House of Corrections to tour facility, meet facility staff, and meet with discharged PS
- 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.

Appendix C: Department of Correction Response to Disability Law Center July 2024 Report on Bridgewater State Hospital (January 6, 2025)

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

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

TERRENCE M. REIDY
Secretary

SHAWN P. JENKINS
Commissioner

CHRISTOPHER NICHOLS
MITZI S. PETERSON
THOMAS J. PRESTON
Deputy Commissioners

January 6, 2025

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

Re: Disability Law Center Public Report dated July 2024 on Bridgewater State Hospital

Dear Director L'Italien,

The Department of Correction is in receipt of DLC's July 2024 report on Bridgewater State Hospital (BSH). As in your prior report, DLC calls for the transfer of the Commonwealth's strict security hospital from the Department of Correction (DOC) to the Department of Mental Health (DMH). As we have noted in the past, this recommendation is beyond the scope of DOC's ability to respond.

While not under the purview of DMH, persons served at BSH are protected by robust rules and regulations in the same manner that patients in a DMH facility are protected. Moreover, BSH, as a Department of Public Health-licensed hospital and Joint Commission-accredited behavioral health hospital, has extensive facility policies and practices related to health safety and quality of care for persons served.

BSH persons served are provided with trauma-informed, person-centered mental health treatment from Recovery Solutions.

Strict Security Definition

DLC's report claims an inconsistent definition of strict security within the Commonwealth's courts, county correctional facilities, DOC and DMH. Though DOC cannot speak to how a Court or county correctional facility would define or consider the need for strict security, forensic evaluators at BSH utilize evaluation factors to ensure a comprehensive and consistent assessment of security needs, prioritizing safety. These factors include, but are not limited, to:

- Frequency and severity of violence;
- Prior aggression in less secure settings;
- Risk of elopement;
- Risk of engaging in sexually problematic behaviors;
- Risk related to increased access to substances;
- Risk related to increased access to weapons and fire-starting materials; and
- Risk related to increased access to technology.

Seclusion and Restraint

As you know, the BSH Seclusion and Restraint Policy and Involuntary Medication Policy were shared with DLC prior to their finalization. Suggested additions and edits by DLC were incorporated into both policies. Each policy is fully compliant with the Massachusetts General Laws and has been approved by DOC. Recovery Solutions is required to follow and does follow these policies strictly. Recently, BSH underwent a survey by the Joint Commission with detailed chart audits, persons served interviews and a review of all policies. BSH was reaccredited by the Joint Commission, reaffirming that the policies are appropriate and fully consistent with the standard of care.

With regard to the issues brought forth about the BSH Medication Restraint form, the form has been reviewed by multiple agencies, including DMH and the Joint Commission, to ensure that it meets all legal standards. The form contains person-centered criteria of assessment, intervention and discontinuation tailored to reflect the individual need and clinical presentations of individuals. The form is designed to view person served care as a continuum of events, incorporating person served preferences and trauma history into the de-escalation plan. The impact of interventions is assessed during person served debriefing following any incident of seclusion or restraint. While data on race, ethnicity and language are not included on the form to eradicate any potential misidentification errors, the data is collected and analyzed internally to ensure accuracy. This approach aims to provide a comprehensive and sensitive framework for managing seclusion and restraint, prioritizing the dignity and safety of persons served as well as legal compliance.

Consistent and ongoing training about trauma informed practices and seclusion and restraint continue for all staff at BSH.

Protective Gear

The use of protective gear is governed by Recovery Solutions policy PC300-12 Serious Clinical Episode, Use of Protective Gear. Recovery Solutions approaches the use of protective gear with a multidisciplinary decision making and trauma informed lens, with the goal of achieving the safest possible outcome for the person served and staff members. The use of protective gear is tracked with qualitative data to identify trends impacting serious clinical episodes and to mitigate issues.

The DOC supports Recovery Solutions' current review of protective gear utilized in other behavioral health settings. DOC welcomes DLC's assistance in surveying other high acuity involuntary psychiatric hospitals where protective equipment for staff is utilized.

Environmental Concerns Reported by DLC

The DOC continues in its efforts to provide the best environment for our patients. Conditioned air units, consistent access to the outdoors and cooling stations in the form of misting tents were enlisted to address the high temperatures this summer. Educational materials regarding Heat Related Illnesses were posted on each unit, and nurses were retrained on the signs and symptoms of heat related illnesses.

As you are aware, DOC is currently drafting a Request for Response (RFR) for the upcoming contract for BSH. We have invited DLC to be a stakeholder in this process and provide feedback on the RFR. We look forward to a collaborative process, acknowledging that our statutory obligation remains unchanged. Should you have any follow-up questions, please do not hesitate to contact me. Thank you.

Respectfully,

Shawn P. Jenkins
Commissioner

Appendix D: Gordon Mycology Laboratory, Inc., Mold Inspection Report (January 24, 2025) and Laboratory Results

Gordon Mycology Laboratory, Inc.
P.O. Box 310, Groton, MA 01450
Phone: 978-448-9954 www.moldtestimgma.com

Mold Inspection Report

Bridgewater State Hospital
20 Administration Road
Bridgewater, MA

Project ID: 24-070GML
Inspection Date: November 7, 2024

January 24, 2025

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 November 7, 2024 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, general cleaning, professional 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, 2021, 2022, and 2023. 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 temperature and relative humidity levels.

Culturable surface swab samples were collected using sterile sampling supplies and industry-standardized sampling procedures from HVAC system components and building materials in the Administration, Lighthouse, Lenox, Carter, Attucks, and Adams 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.

Background Information

GML has inspected the buildings of Bridgewater State Hospital yearly since 2019, skipping 2020 due to Covid 19. Since 2019, there have been updates made, professional mold remediation in selected areas, HVAC system cleaning, and some other actions to correct maintenance and plumbing issues, however, problems persist with chronic dampness, visible mold growth, and HVAC systems in poor condition.

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 2023 inspection)
    - Self-contained modular air filtration unit in the ceiling of the Room AD11 was filthy (this condition remained unchanged from the 2023 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
        - Water damage and resulting mold growth from the leak in 2023, and prior leaks, at what appeared to be a vent pipe through the wall was still present
        - A pile of trash/debris on the floor had been moved around but was still present since 2022 (2 years that the same trash/debris has been left on the floor)
        - No cleaning or removal of building materials had taken place; the condition remained the same as in 2022 and 2023
    - 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 2023 inspection)
    - HVAC system supply diffusers were filthy and still contained a significant amount of accumulated black dust/debris; this condition remained unchanged from the 2023 inspection
    - No dehumidifier was present in any basement room; this condition remained unchanged from the 2023 inspection
    - Relative humidity levels averaged 47.2%, which is somewhat elevated during the heating season; no dehumidification system was present
    - The temperature ranged from 74°F – 82.6°F, which is unacceptably high
    - 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 this condition remained unchanged from the 2023 inspection

        - Small patch of water damaged ceiling in an already patched area remained unchanged from the 2023 inspection
        - HVAC filters were being stored on the rusty metal shelf in the Custodian closet; the filters were unwrapped and, therefore unprotected from the mold and humidity in the closet (unchanged since the 2023 inspection)
    - Mechanical room
        - The room was cleaner than in 2023, debris and trash had been removed from the floor
        - Pipe and ductwork insulation was removed and will be replaced
        - Large, open sump with wastewater (tampons and other wastewater components visible in the sump and on the surrounding floor) in 2023 remained unchanged, allowing potentially pathogenic contaminants (fungal, bacterial, viral) to continually get into the basement air; there cannot be any open wastewater sources indoors
        - Less water damage noted during this inspection as some of those materials had been removed since the 2023 inspection
        - Visible mold confirmed in 2023 on wall materials was no longer present
        - Significant amount of rusted surfaces remained and some worsened by the chronic humidity issues
        - Many areas of rusted pipes/fittings this condition remained unchanged from or has worsened since the 2023 inspection
        - Metal door framing was rusted out at its base from floods left unchecked
        - The same yellow bucket with a flexible tube draining into it that contained standing water and mold growth in 2023 was present during this inspection; the bucket still contained standing water and mold growth, this bucket should be discarded, and there should be no containers of standing water
        - Relative humidity was 37.5%
        - The temperature was 85.8°F, which is unacceptably high
        - Adjacent electrical/tech room (condition mostly unchanged from the 2023 inspection)
            - Mold growth on the walls
            - Wood materials housing utilities were moldy
            - Walls were water stained up at least 2 feet from the floor
            - Towels/rags on the floor had been wet and were moldy
            - Large piece of mechanical equipment on the far wall was rusted out at its base; there were black trash bags covering the unit allowing water to run down the plastic into containers on the floor (condition remained unchanged from the 2023 inspection)
- Administration Building Roll Call Room
    - HVAC system supply air diffusers contained heavy black dust/debris as did the ceiling around the diffuser; this condition remained unchanged from the 2023 inspection
    - Modular air filtration unit in the ceiling remained filthy, as it was in 2023
    - Room and surrounding rooms/areas were stuffy and well above acceptable temperatures for occupied spaces
- Lighthouse (Medical) Building Basement
    - Mold odor detected; this condition remained the same as in 2023 and is unacceptable in any occupied building, but particularly a medical building
    - Basement was mostly empty; what was present during this inspection was mostly the same as in 2023 with some newer items having been brought in for storage (vinyl chairs at high risk for growing mold) and some older items having been removed

- Shelving unit with the cardboard boxes of files, equipment, tools, etc. remained
- Storage rooms and the main room had been painted prior to the 2023 inspection; some mold growth remained 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 of wet materials found) but could also be due to calcimite ceilings, and there was mold growth above the peeling paint; this condition remained unchanged from the 2023 inspection
- 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 2023 inspection
- Return grilles in the main room ceiling were filthy with accumulated dust/debris
- 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 the 2023 inspection
- HVAC vents in the green rooms were dirty with black dust and debris; this condition remained unchanged from the 2023 inspection
- Pipe and HVAC ductwork insulation had mostly been removed
- Door frames were rusted along the bottom from repeated flooding events
- Door casings with peeling paint and visible mold growth beneath the paint
- The high capacity, commercial grade dehumidifier installed in 2021 was not present/running during this inspection
- Mechanical room
    - The moisture condition of this room remained the same as during the 2019, 2021, 2022 and 2023 inspections
    - The mold condition appeared to have been partially addressed by the removal of most insulation and other porous materials along with cleaning or mold remediation; some moldy surfaces remained however
    - The main room still had some heating system pipe insulation that was water stained and moldy, although it had been painted over (which is not an acceptable practice)
    - Large fan on the floor was being used to temper the heat and humidity in the room which was coming from holes in rusted pipes, fittings, sumps in the floor, and other hot water containing plumbing fixtures
    - The vent (to the outdoors) in the concrete block wall remained open
    - Several wet areas on the floor and dripping pipes; sludgy, wet, moldy material on the floor where leaks have been ongoing
    - Several sections of pipes were significantly corroded/rusted out and at high risk for breaking and leaking/flooding the room; these are a high priority to fix or replace as soon as possible
    - Questionable asbestos containing materials although asbestos abatement had previously been conducted in this room
    - Other metal surfaces were rusted throughout from chronic dampness
    - Evidence of chronic moisture on the walls, particularly at their base
    - Plastic chair was moldy and had evidence of a dried puddle on the seat (something dripping from above)
    - Vertical duct/fan unit showed considerable evidence of dripping; the painted exterior of the duct was visibly moldy, and the paint was bubbled and peeling from chronic exposure to water
    - 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, damp air from the room to be drawn into the system and spread into the rooms/areas supplied by the ductwork (even if the system is not running)
        - Used rags sitting on top of the air handler
    - Electrical/IT room (condition remained unchanged from 2023)
        - 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
        - Drip marks and water stains from ceiling to floor
        - Heavy mold growth on the painted plywood housing electrical panels (exactly as it had been during the 2022 and 2023 inspections)
        - Heavy mold growth on the underside of the same particleboard table that has been in this room for years; the table edge was swollen and delaminated from exposure to moisture
        - Water staining on the painted concrete wall beneath a large black pipe (waste pipe presumably)
    - Relative humidity levels and temperatures during the inspection were about 10% and 10°F higher, respectively, than in 2023:
        - First room on left 47.5% 80.4°F
        - Main room 49.2% 80.4°F
        - Paint storage room 47.5% 81.3°F
        - Vinyl chair storage 48.5% 82.3°F
        - Mechanical room 41.7% 91.6°F
        - Electrical/IT room 44.4% 81.0°F
- Lighthouse (Medical) Building First Floor
    - Supply air diffusers were filthy, containing the same black dust/debris as in all the inspected years; this condition remained unchanged from 2023
    - Supply air diffusers with condensation drip marks
    - Supply air diffusers had been painted but the filth and rust could be seen on surfaces that were missed by the paint; painting over rusty, dirty diffusers is not an acceptable practice
    - Relative humidity and temperature in the hallways was 41.8% at 76.5°F, which is to warm
    - HVAC room
        - The room had been cleaned since the 2023 inspection but there were still areas for improvement
        - The painted concrete walls were dirty with mold growth remaining at their base
        - Mold growth and water staining on remaining fabric-type duct-covering
        - The room was too humid and too hot with 57.2% relative humidity at 76.1°F
        - HVAC system (similar or worse condition as in 2023)
            - Two-inch filters were filthy, clogged with dirt and debris; this condition was worse than in 2023
            - Air handler with handfuls of accumulated organic debris sitting in its base; debris was on both sides of the filters (supply and return)
            - Internal components were rusted
            - Beneath the accumulated debris, there was a thick layer of stuck on dust/debris because it has gotten wet, which matted it down

- This unit has not been cleaned in a very long time and is overdue for specialized cleaning and component replacement/upgrade as needed
- This is a medical building with sick, and some chronically ill, people who need to be breathing clean air; this HVAC system is not providing that quality of clean air

- 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, 2021, 2022, and the 2023 inspections
  - Supply air diffusers had been painted but the filth and rust could be seen on surfaces that were missed by the paint; painting over rusty, dirty diffusers is unacceptable
  - Shower room was in much better condition compared with the 2023 inspection; the room was cleaner, shower heads were not leaking, and there was no visible mold or notable mold odor
  - Shower room relative humidity was 50.1% at 74.7°F
  - Basement
    - Large grate over the access opening, as with the other basements; it was unclear why these basements containing HVAC systems and other mechanical equipment were open to the elements, but it is strongly not recommended
    - Floor was mostly dry although there were some damp areas and large, dried puddles from previous floods/leaks
    - Water was actively leaking out of a long crack in a pipe and was raining down on pieces of randomly (and inappropriately) stored wood on top of the filter compartment; the wood was moldy
    - Pipe insulation and HVAC system fabric covering had been removed but there were two pipes with ripped material that may be asbestos containing
    - All metal surfaces were rusted, some completely corroded
    - Several sections of pipes/fittings were almost rusted through; numerous areas of corroded/oxidized pipes
    - Water seeping out of large sumps in the floor
    - Dirty, wet, moldy rags sitting on surfaces
    - Large pipe exiting through the foundation had a large gap around it that was filled with organic debris, rodent nesting materials, etc.
    - Relative humidity was 38.9% at 81.3°F
    - HVAC system (similar or worse condition as in 2023)
      - Air handler was 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 rusted
      - Filter compartment and a section of ductwork (with an ill-fitted piece of sheet metal) was open to the basement, which has been allowing the damp, moldy air to enter the system; return air from the building will also bypass the filters
      - Two-inch filters, that had been changed only a month ago, were filthy and black with accumulated dust, debris
      - A discarded filter lay on the floor of the air handler, absorbing moisture and growing mold
      - Copper pipes were oxidized from chronic moisture exposure

- Attucks Building
    - Areas of water damaged ceilings from chronic roof leaks; it was reported that the leaks had been repaired
    - The dining hall HVAC vents that were rusty, filthy with black dust/debris, and visibly moldy for the last five years were painted over; surfaces inside the vents were visibly still filthy with the black dust/debris
    - The dining hall ceiling was still water damaged in several areas, but had been painted over
    - The dining hall floor was filthy, although reportedly cleaned often
    - 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, 2021, 2022, and 2023
    - Library had several water stains in the ceiling from roof leaks; some of the stains were present in 2023 but others were new since that inspection
    - The technology room no longer had visible mold on the ceiling, although the water damage remained but was painted
    - Library relative humidity was 37.9% at 79.9°F, which is unacceptably high
    - The ceiling around an HVAC supply vent above the Librarian's desk had what appeared to be visible mold growth (tested for confirmation); the mold was beneath a layer of chipped paint, which again, painting over mold growth is an unacceptable practice
    - A rectangular rust stain on the VCT floor tiles was noted where a metal bookcase had once been; this confirms that there was water on the floor from a roof leak or moisture seeping up through the floor tiles, if this area was on a concrete slab
- Carter Building
    - Filthy HVAC system ductwork, unchanged from 2019, 2021, 2022, and 2023; exposed surfaces of the diffusers had been painted but the inner surfaces remained rusted, filthy the black dust and debris, and moldy
    - Return grille and ductwork in the hallway still contained a thick layer of accumulated debris
    - Common room self-contained modular air filtration unit remained and was filthy; these units throughout the buildings are no longer used and should be removed entirely as they remain a source of airborne contaminants
    - More black dust/debris on ceilings around HVAC vents than in 2023
    - Large section of the hallway ceiling was water damaged and patched/painted
    - Communal bathroom
        - Water damage with potential mold growth was noted by a Disability Law Center representative in the ceiling the week prior to this inspection
        - Staff reported to GML that the day before the inspection, the damaged ceiling area had been removed
        - The hole had been closed with a piece of sheet metal and the edges sealed with plaster joint compound
        - Remaining ceiling materials looked free from residual water damage or mold growth
        - Materials in the cavity above or the top of the remaining ceiling drywall could not be evaluated due to the recent work
        - The bathroom was in poor condition overall, with rusted metal panels on sink cabinets, peeling, filthy, and moldy paint on sink cabinet concrete, a filthy and stained floor from chronic water exposure, filthy and moldy painted concrete partitions between toilets
    - Relative humidity was 39.0% at 78.9°F, which is unacceptably high

- Basement
  - Open access grate allowing organic debris and trash to fall into the wet basement
  - Large amount of standing water on the floor, same condition as in 2023
  - Numerous leaks were occurring, hot water was dripping at a fast rate from several fittings and pipes onto the floor and other plumbing components – same condition as in 2023 (possibly different leaks)
  - Most pipe and ductwork insulation had been removed, although sloppily because ripped remnants remained
  - At least two elbows of suspected and ripped (loose fibers hanging) asbestos pipe wrap remained; these were also visibly growing mold (outer wrap)
  - All metal surfaces were rusted, some completely corroded
  - A lot of trash and other debris on the floor, most of which was moldy
  - Relative humidity was 38.2% at 86.9°F, which is unacceptably high and due to the hot water pipe/plumbing leaks and steam releases
  - HVAC systems (similar or worse condition as in 2023)
    - 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 actively used air handling systems providing the only air to the occupied building
    - Two-inch filters (changed recently in October) in the bottom unit were filthy and brown with accumulated dust, debris, and mold growth
    - Copper pipes were oxidized from chronic moisture exposure

- Adams Building
  - Common rooms with filthy HVAC system ductwork, <u>unchanged from 2019, 2021, 2022, and 2023</u>; 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, as in all other inspected buildings
  - Relative humidity in the day room on the first floor was 32.4% at 81.0°F, which is unacceptably high
  - Trash and water heater room with a water damaged section of the ceiling
  - Basement (mostly unchanged condition from 2023)
    - Open access grate, causing the same issues as the other basements
    - Deep, standing water on the floor
    - Leaks were occurring from some fittings/pipes onto the floor and other plumbing components
    - Most pipe and ductwork insulation had been removed
    - 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, which reached the ceiling and were condensing
    - Metal supports for heating system and other mechanical equipment were rusted out at their base
    - All metal surfaces were rusted, some completely corroded

- Cardboard or paper-covered narrow cylinder lying on the floor was covered in black mold growth
- Debris/trash on the floor, most of which was moldy; clumps of removed insulation also present, which is a sign that the removal was not professional
- Brown plastic chair sitting in a puddle and had a dried puddle on the seat from water leaking from pipes above
- Relative humidity was 37.3% at 83.4°F, which is unacceptably high
- HVAC systems (similar or worse condition as in 2023)
    - 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 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
    - Ripped fiberglass insulation along the edges of the open filter compartment, which would introduce harmful fiberglass particles into the airstream being sent into the occupied space above
    - Filters were filthy, but having only been changed in October
    - Copper pipes were oxidized from chronic moisture exposure
    - A discarded/"fallen-in" filter was noted on the base of the air hander cabinet; the filter has absorbed moisture, collected debris and dirt, and is growing mold

Laboratory Results

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

Surface swab results are reported as colony forming units per square inch (CFU/in^2), 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/in^2, 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 levels and/or unacceptable types** of active (living) mold on the following tested materials:

- Administration Building basement room AD-11 – HVAC system supply air diffuser
- Administration Building basement room AD-11 – HVAC system return air grille
- Administration Building Roll Call Room – HVAC system supply air diffuser
- Lighthouse basement main room – HVAC system return air grille
- Lighthouse basement main room – visible mold on painted HVAC duct seam
- Lighthouse Building first floor HVAC room – HVAC system, return side of filter
- Lighthouse Building first floor HVAC room – HVAC system, supply side of air handler
- Lighthouse Building first floor – HVAC supply air diffuser outside Nurse's Station
- Lighthouse Building first floor – HVAC system supply air diffuser in hallway H169
- Lenox – supply air diffuser in shower hallway

- Lenox basement – HVAC system, return side of filter
- Attucks dining hall – HVAC system supply air diffuser, at water damaged ceiling
- Attucks library – HVAC system supply air diffuser
- Carter Building – HVAC system supply air diffuser in day room (game room)
- Carter Building hallway – HVAC system return air grille
- Adams Building – HVAC system supply air diffuser in day room
- Adams Building basement – visible mold on cardboard/paper-covered cylinder on floor
- Adams Building basement – lower HVAC system filter, supply side

Mold levels defined by culture analysis on these surfaces far exceed those expected on the same materials if they had not been exposed to chronic moisture from multiple sources that have not been resolved since the last inspection. Some of these surfaces have been professionally 'remediated' or cleaned (HVAC systems), however, if visible mold growth remains on the surface, it is automatically concluded that remediation and cleaning have failed. These samples, and the visual inspection, confirm that mold is still alive and actively growing year after year even with the cleaning or remediation efforts that have been performed.

The visual inspection confirmed **abnormal and unacceptable mold growth** as well as large amounts of black debris (HVAC diffusers/vents) on the following surfaces, which included some that had been professionally remediated or cleaned in the last year:

- Administration Building basement mechanical room– visible mold on HVAC duct seam
- Lighthouse basement boiler room – visible mold on painted duct column with fan
- Lighthouse basement IT room – visible mold on electrical panel plywood
- Lighthouse basement IT room – water stained painted concrete wall beneath ceiling pipe
- Attucks library – suspected mold growth on ceiling around HVAC supply air diffuser

These samples did not result in high levels of culturable molds (mold was confirmed visually during the inspection), which is an indication that the remediation company soaked/heavily sprayed surfaces with a sanitizer or the mold has died on its own (not typical, though). 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. 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 and laboratory results failed all remediation efforts again this year.

Mold types identified growing on the tested surfaces included *Alternaria, Aspergillus niger, Aspergillus flavus, Aspergillus fumigatus, Aspergillus ochraceus, Aspergillus sydowii, Aspergillus versicolor, Aureobasidium, Chaetomium, Cladosporium, Epicoccum, Penicillium, Pithomyces, Rhizopus* 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 and ongoing 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. Many of these surfaces were visually inspected and tested in previous inspections with similar results, concluding that either remediation and cleaning efforts have failed, or no work was done, leaving the mold growth on surfaces, year after year.

Aspergillus is one of the most clinically important mold groups that is commonly found indoors when conditions are favorable for its growth; *Aspergillus* growth confirmed on most of the tested surfaces in the buildings, including HVAC system components. *Aspergillus*, and particularly *A. fumigatus* found on several surfaces this year, 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 fogginess, etc. People with underlying health conditions and weaker immune systems are most affected by chronic mold exposure. The 2019, 2021, 2022, 2023 inspections confirmed many mold contamination sources, and particularly inside HVAC systems serving occupied spaces, that remained as of this 2024 inspection. Yearly visual inspections (2020 omitted due to Covid) and laboratory results confirm that there has been, and still is, chronic mold exposure for staff members and persons served.

In 2023, particulate analysis was performed on the black dust/debris from inside HVAC system supply and return ductwork/vents. The analysis confirmed the presence of irritating and dangerous particles. The black dust and debris remained in all systems inspected and tested during this inspection. Deteriorated fiberglass linings inside the air handlers and ductwork have not been removed even after repeated recommendations; the professional HVAC system cleaning that has reportedly been performed since GML began inspecting the buildings has not addressed any of the global problems with the systems. Loose/rough-edged fiberglass should not be inside air handling systems as the particles that are released get into the airstream and then into peoples' lungs, eyes, and sinuses. Fiberglass particles are irritating, exacerbate asthmatic conditions, cause irritation in the mucous membranes, and can cause other health problems according to the current medical literature. Organic debris that has been, and continues to be, spread through the air handlers and ductwork is unacceptable. The systems were filthy and full of trash and debris, including dirt, leaves, old, unretrieved filters, mold growth, etc. Supply diffusers should be delivering clean air that is free from all of these particle types to the occupied spaces.

Current Industry Guidelines

According to the ANSI/IICRC Document S520: Standard and Reference Guide for Professional Mold Remediation (2015) the following Conditions for indoor mold have been defined:

Condition 1: An indoor environment that may have settled spores, fungal fragments, or traces of actual growth whose identity, location, and quantity are reflective of a normal fungal ecology for a similar environment.

Condition 2: An indoor environment primarily contaminated with settled spores dispersed directly or indirectly from a Condition 3 area, and which may have traces of actual growth.

Condition 3: An indoor environment contaminated with the presence of actual mold growth and associated spores. Actual growth includes growth that is active or dormant, visible or hidden.

Based on the current and pervasive mold condition in all inspected buildings (HVAC systems, basements, occupied spaces), the inspected buildings of the Bridgewater State Hospital are, again this year, collectively characterized as a Condition 3 Environment, as defined by the Document S520. A Condition 3 Environment warrants the work of a specialized mold remediation company to remove and clean moldy building materials and a NADCA certified HVAC system cleaning company to clean the HVAC systems according to current mold remediation and NADCA guidelines. It is not recommended for people to be working or living in the buildings until the current mold contamination sources have been appropriately remediated by qualified, specialized companies; the buildings are not currently providing healthy living or work environments due to the mold contamination sources in basements, occupied areas, and HVAC systems serving the occupied areas of the buildings. The mold condition, and environmental conditions that have caused and supported continued mold contamination in the buildings, has stayed the same or gotten worse in the five years of GML inspections. The remediation, cleaning, and maintenance work done to date has been largely ineffective at resolving these ongoing problems.

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 in some areas there were still suspect materials in several areas 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 and accumulating in the basements and other areas of the buildings year after year is unacceptable. Pipes were leaking, basements were flooding with rain and ground water, sumps were open including one with raw sewerage components and one with steaming water coming from boiler pipes, mechanical equipment draining into open buckets, unconditioned outdoor air allowed to come in where it was causing condensation problems, the absence of dehumidification in all basement level spaces, etc. These moisture sources are the direct cause for abnormal and unacceptable mold growth and cannot be allowed to continue. Most of these same moisture sources were documented in 2019, 2021, 2022, 2023, and 2024.

A specialized mold remediation company is needed to remove mold growth sources and remediate remaining materials/surfaces in basements of the Administration, Lighthouse, Adams, Carter, and Lenox buildings; isolated areas in several other buildings also need to be professionally remediated (water damaged ceilings that need removal). 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 previous 4 reports, but because successful, corrective actions have not yet been taken, 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.

Remediation Protocol: Administration Building Basement

- Seal all sumps but particularly the one with hazardous, raw sewerage components exposed
- Remove all residual pipe insulation
- Remove all residual HVAC system ductwork insulation and tape at seams (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 (just outside the mechanical room door); 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 exposed wood in the Men's shower where the vents/pipes had leaked; remove the tiled wall beneath that has been exposed to the leaking pipe for years
- Discard all trash and debris on all floors
- Discard extraneous, porous building materials as they have been exposed to chronically elevated relative humidity levels and are either growing mold or at high risk for doing so
- 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 as the mold will continue to grow on 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

Remediation Protocol: Medical (Lighthouse) Building

- Remove boxes of files (discard cardboard, put contents in alternative containers)
- 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
- Discard 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
- 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 remaining external coverings, tape, paper, insulation, and peeling paint from HVAC system ductwork and units (if not asbestos containing)
- Once removed materials have been 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

Remediation Protocol: Basements of the Adams, Lenox, and Carter Buildings

- 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
- Any residual HVAC system ductwork insulation/wrap/tape/paper materials must be removed (unless they are asbestos containing)
- Any residual pipe insulation/wrap must be removed (unless it is asbestos containing)
- Once removed materials have been 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

Remediation Protocol: Attucks Building

- The mold remediation company should remove and discard the moldy window air conditioner in the storage/break 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
- Water damaged sections of the Technology/computer room and library ceilings 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 have been 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

Remediation Protocol: Carter Building

- The mold remediation company should remove the water damaged section of the communal bathroom and hallway, with removal extending at least 2 feet in all possible directions past visual evidence of water or mold damage
- Communal bathroom sink cabinets should be removed; concrete sections can remain, but the water damaged and moldy paint must be scraped off and the surfaces sanitized
- Once removed materials have been 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 wall, ceiling, and floor materials in the Lenox shower regularly based on the amount of shower usage
- Remove and replace any water stained ceiling tiles
- Appropriately label rooms/closets 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 all bathroom and shower surfaces; 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 basements from outdoor air; all basements should be as water and air-tight as possible and dehumidified or mold growth will recur (if make-up air is needed for the heating systems, it can be brought in through direct-ducted systems)
- Sumps with access to wastewater overflows cannot be left open or hazardous and pathogenic bacteria will enter the basements, and air handling systems; all sumps should have sealed but removable covers to prevent evaporation into the basements which must be dehumidified
- Repair and replace all leaking pipes, fittings, valves, and equipment; accumulating water from pipe leaks, steam releases, open sumps, etc. will increase the relative humidity and be counterproductive to the dehumidification systems as well as cause mold growth on surfaces that get wet
- Clean HVAC rooms and basements regularly to remove trash or other debris on floors; these areas have a long history of water problems, and this debris supports mold growth

HVAC Cleaning Protocol (All Buildings)

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; the company currently used should be replaced as the condition of systems is unacceptable. 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 damp 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

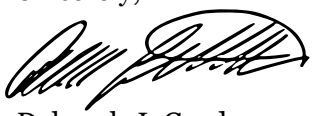
Many of the sources of mold growth identified during the 2019, 2021, 2022, and 2023 inspections of the Bridgewater State Hospital buildings and HVAC systems were confirmed to still be present (visually and with laboratory data) during the 2024 inspection. This indicates that the necessary mold remediation, cleaning, and maintenance actions have not been fully 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 mold growth and some remaining asbestos. 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 sections of HVAC systems that had been professionally cleaned were confirmed to be filthy and riddled with active mold growth after the cleaning.

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 (unfiltered and unconditioned outdoor air coming directly into the systems, open filter compartments, 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 long-term neglect of critical building systems. Mold remediation performed by an unqualified company who did not follow currently accepted industry standards and procedures was proven to be inadequate, unsuccessful, and deficient. There also are remaining questions regarding the completeness of the asbestos abatement; there appeared to be potentially asbestos-containing materials in the basements that should be investigated by an independent 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, 2021, 2022, and 2023 recommendations were largely ignored as of this 2024 inspection. 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. Based on 5 years of Bridgewater State Hospital inspections by GML, 28 years of professional mold/indoor air quality inspection history and experience, industrial hygiene experience, and industry accepted guidelines for indoor spaces contaminated with mold, GML is concluding that the facility should not be occupied until these problems have been fully resolved and the buildings retested to verify that moisture and mold sources have been resolved and removed, respectively.

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

Sincerely,



Deborah J. Gordon
Microbiologist, Owner
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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. <u>If building materials or belongings are not dried within 48 hours, mold growth begins to develop</u>.

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

<u>Foundation Floors and Walls</u>

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.

<u>Exterior Systems</u>

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 ½ 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.

QLAB, 256 Bridge St, Metuchen, NJ 08840
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AIHA EMPAT Lab ID: 178794

Mycologix™ Culture Media and Methods

Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**
Client: Gordon Mycology Laboratory, Inc.
Groton, MA
Contact: Gordon, Deb
Project ID: 24-070GML BSH-5

QLAB Job No.: ME241108-16
Date Sampled: 11/7/2024
Date Received: 11/8/2024
Date Reported: 11/19/2024

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

Lab Sample No.	ME241108-16(1)			ME241108-16(2)			ME241108-16(3)		
Sample ID	**S1**			**S2**			**S3**		
Sample Location	**Admin. building basement – Rm. AD-11, HVAC supply diffuser**			**Admin. building basement – Rm. AD-11, HVAC return grille**			**Admin. building basement mechanical room – mold on HVAC seam**		
Sample Type / Device	Surface/SpongeSWAB (S)			Surface/SpongeSWAB (S)			Surface/SpongeSWAB (S)		
Media (Temperature: 25°C)	Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	11/19/2024			11/19/2024			11/19/2024		
Amount of Sample Prepared		2 in²			2 in²			2 in²	
Dilution Factor		100			100			100	
Detection Limit (DL)		DL = 50 CFU/in²			DL = 50 CFU/in²			DL = 50 CFU/in²	
Culturable Fungi Conc.*		**1,800 CFU/in²**			**1,100 CFU/in²**			**100 CFU/in²**	
Identification	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**
Major Hydrophilic Fungi*									
Acremonium									
Aureobasidium									
Chaetomium	21	1,100	60				2	100	100
Stachybotrys									
Ulocladium									
Yeast, non-specified									
Rhodotorula (yeast)									
Sporobolomyces (yeast)									
Trichoderma [Spreader]***				1	50	5			
Rhizopus [Spreader]***				1	50	5			
Other Fungi									
Cladosporium	5	250	14	5	250	24			
Penicillium	4	200	11	4	200	19			
Aspergillus versicolor				1	50	5			
Aspergillus sydowii				1	50	5			
Aspergillus ustus									
Aspergillus niger				2	100	10			
Aspergillus fumigatus									
Aspergillus ochraceus									
Aspergillus flavus									
Alternaria									
Epicoccum	2	100	6	4	200	19			
Pithomyces									
Curvularia									
Non-sporulating fungi	3	150	9	1	50	5			
Xerophilic Fungi Screening		***ND***		***1***	***50***	***5***		***ND***	
DG18 (and/or MEA) Dilution Factor:	*100*	*(DL = 50 CFU/in²)*		*100*	*(DL = 50 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

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Client: Gordon Mycology Laboratory, Inc.
Groton, MA
Contact: Gordon, Deb
Project ID: 24-070GML BSH-5

QLAB Job No.: ME241108-16
Date Sampled: 11/7/2024
Date Received: 11/8/2024
Date Reported: 11/19/2024

Lab Sample No.	ME241108-16(4)			ME241108-16(5)			ME241108-16(6)		
Sample ID	**S4**			**S5**			**S6**		
Sample Location	**Admin. building – Roll Call room – supply diffuser**			**Lighthouse basement – main room, return grille**			**Lighthouse basement - main room, mold on painted HVAC duct seam**		
Sample Type / Device	Surface/SpongeSWAB (S)			Surface/SpongeSWAB (S)			Surface/SpongeSWAB (S)		
Media (Temperature: 25°C)	Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	11/19/2024			11/19/2024			11/19/2024		
Amount of Sample Prepared	2 **in²**			2 **in²**			0.5 **in²**		
Dilution Factor	100			100			100		
Detection Limit (DL)	DL = 50 CFU/in²			DL = 50 CFU/in²			DL = 200 CFU/in²		
Culturable Fungi Conc.*	**600** **CFU/in²**			**2,800** **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							3	600	33
Stachybotrys									
Ulocladium									
Yeast, non-specified	3	150	25						
Rhodotorula (yeast)	1	50	8						
Sporobolomyces (yeast)									
Trichoderma [Spreader]***				2	100	4			
Rhizopus [Spreader]***									
Other Fungi									
Cladosporium	2	100	17	41	2,100	73	3	600	33
Penicillium	2	100	17	2	100	4	1	200	11
Aspergillus versicolor	1	50	8	2	100	4			
Aspergillus sydowii									
Aspergillus ustus									
Aspergillus niger				2	100	4			
Aspergillus fumigatus							1	200	11
Aspergillus ochraceus				1	50	2			
Aspergillus flavus	1	50	8						
Alternaria									
Epicoccum									
Pithomyces	2	100	17						
Curvularia									
Non-sporulating fungi				1	50	2	1	200	11
Xerophilic Fungi Screening		***ND***		***5***	***250***	***9***		***ND***	
DG18 (and/or MEA) Dilution Factor:	*100*	*(DL = 50 CFU/in²)*		*100*	*(DL = 50 CFU/in²)*		*100*	*(DL = 200 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

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Client: Gordon Mycology Laboratory, Inc.
Groton, MA
Contact: Gordon, Deb
Project ID: 24-070GML BSH-5

QLAB Job No.: ME241108-16
Date Sampled: 11/7/2024
Date Received: 11/8/2024
Date Reported: 11/19/2024

Lab Sample No.	ME241108-16(7)			ME241108-16(8)			ME241108-16(9)		
Sample ID	**S7**			**S8**			**S9**		
Sample Location	**Lighthouse basement – boiler room, surface of duct column with fan**			**Lighthouse basement – IT room, mold on painted plywood**			**Lighthouse basement – IT room, water stained painted concrete at pipe**		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	11/19/2024			11/19/2024			11/19/2024		
Amount of Sample Prepared	3 in²			0.5 in²			5 in²		
Dilution Factor	100			100			100		
Detection Limit (DL)	DL = 33 CFU/in²			DL = 200 CFU/in²			DL = 20 CFU/in²		
Culturable Fungi Conc.*	**67 CFU/in²**			**200 CFU/in²**			**100 CFU/in²**		
Identification	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**
Major Hydrophilic Fungi*									
Acremonium									
Aureobasidium									
Chaetomium									
Stachybotrys									
Ulocladium									
Yeast, non-specified							2	40	40
Rhodotorula (yeast)									
Sporobolomyces (yeast)									
Trichoderma [Spreader]***							1	20	20
Rhizopus [Spreader]***									
Other Fungi									
Cladosporium	1	33	50				1	20	20
Penicillium									
Aspergillus versicolor									
Aspergillus sydowii									
Aspergillus ustus									
Aspergillus niger									
Aspergillus fumigatus									
Aspergillus ochraceus									
Aspergillus flavus									
Alternaria									
Epicoccum									
Pithomyces									
Curvularia									
Non-sporulating fungi	1	33	50	1	200	100	1	20	20
Xerophilic Fungi Screening		***ND***			***ND***			***ND***	
DG18 (and/or MEA) Dilution Factor:	*100*	*(DL = 33 CFU/in²)*		*100*	*(DL = 200 CFU/in²)*		*100*	*(DL = 20 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

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Client: Gordon Mycology Laboratory, Inc.
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Contact: Gordon, Deb
Project ID: 24-070GML BSH-5

QLAB Job No.: ME241108-16
Date Sampled: 11/7/2024
Date Received: 11/8/2024
Date Reported: 11/19/2024

Lab Sample No.	ME241108-16(10)			ME241108-16(11)			ME241108-16(12)		
Sample ID	**S10**			**S11**			**S12**		
Sample Location	**Lighthouse first floor – HVAC room, return side of HVAC filter**			**Lighthouse first floor – HVAC room, supply side of air handler**			**Lighthouse first floor – supply diffuser outside nurse's station**		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	11/19/2024			11/19/2024			11/19/2024		
Amount of Sample Prepared	3 in²			6 in²			3 in²		
Dilution Factor	10,000			1,000			100		
Detection Limit (DL)	DL = 3300 CFU/in²			DL = 170 CFU/in²			DL = 33 CFU/in²		
Culturable Fungi Conc.*	**220,000 CFU/in²**			**68,000 CFU/in²**			**1,600 CFU/in²**		
Identification	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**
Major Hydrophilic Fungi*									
Acremonium									
Aureobasidium									
Chaetomium							1	33	2
Stachybotrys									
Ulocladium									
Yeast, non-specified									
Rhodotorula (yeast)									
Sporobolomyces (yeast)									
Trichoderma [Spreader]***	0.01	33	< 1						
Rhizopus [Spreader]***							1	33	2
Other Fungi									
Cladosporium	37	120,000	55	33	5,500	8	32	1,100	65
Penicillium	28	93,000	42	15	2,500	4	7	230	14
Aspergillus versicolor							1	33	2
Aspergillus sydowii							1	33	2
Aspergillus ustus									
Aspergillus niger	0.1	330	< 1				1	33	2
Aspergillus fumigatus									
Aspergillus ochraceus							2	67	4
Aspergillus flavus									
Alternaria									
Epicoccum									
Pithomyces	0.1	330	< 1						
Curvularia									
Non-sporulating fungi	2	6,700	3				2	67	4
Xerophilic Fungi Screening		***ND***		***36***	***60,000***	***88***	***1***	***33***	***2***
DG18 (and/or MEA) Dilution Factor:	*100*	*(DL = 33 CFU/in²)*		*10000*	*(DL = 1700 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

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Client: Gordon Mycology Laboratory, Inc.
Groton, MA
Contact: Gordon, Deb
Project ID: 24-070GML BSH-5

QLAB Job No.: ME241108-16
Date Sampled: 11/7/2024
Date Received: 11/8/2024
Date Reported: 11/19/2024

Lab Sample No.	ME241108-16(13)			ME241108-16(14)			ME241108-16(15)		
Sample ID	**S13**			**S14**			**S15**		
Sample Location	**Lighthouse first floor – supply diffuser in H169 hallway**			**Lenox – supply diffuser in hallway outside shower**			**Lenox basement – return side of HVAC filter**		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	11/19/2024			11/19/2024			11/19/2024		
Amount of Sample Prepared	3 in²			3 in²			4 in²		
Dilution Factor	100			100			1,000		
Detection Limit (DL)	DL = 33 CFU/in²			DL = 33 CFU/in²			DL = 250 CFU/in²		
Culturable Fungi Conc.*	**230 CFU/in²**			**2,500 CFU/in²**			**7,000 CFU/in²**		
Identification	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**
Major Hydrophilic Fungi*									
Acremonium									
Aureobasidium									
Chaetomium									
Stachybotrys									
Ulocladium									
Yeast, non-specified									
Rhodotorula (yeast)									
Sporobolomyces (yeast)									
Trichoderma [Spreader]***							1	250	4
Rhizopus [Spreader]***									
Other Fungi									
Cladosporium	3	100	43	61	2,000	80	17	4,300	60
Penicillium				2	67	3	2	500	7
Aspergillus versicolor									
Aspergillus sydowii									
Aspergillus ustus									
Aspergillus niger	1	33	14	1	33	1	0.1	25	< 1
Aspergillus fumigatus	1	33	14						
Aspergillus ochraceus									
Aspergillus flavus									
Alternaria				1	33	1			
Epicoccum	1	33	14	8	270	11	5	1,300	18
Pithomyces				3	100	4			
Curvularia									
Non-sporulating fungi	1	33	14				3	750	11
Xerophilic Fungi Screening		***ND***			***ND***			***ND***	
DG18 (and/or MEA) Dilution Factor:	*100*	*(DL = 33 CFU/in²)*		*100*	*(DL = 33 CFU/in²)*		*100*	*(DL = 25 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

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Client: Gordon Mycology Laboratory, Inc.
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Contact: Gordon, Deb
Project ID: 24-070GML BSH-5

QLAB Job No.: ME241108-16
Date Sampled: 11/7/2024
Date Received: 11/8/2024
Date Reported: 11/19/2024

Lab Sample No.	ME241108-16(16)			ME241108-16(17)			ME241108-16(18)		
Sample ID	**S16**			**S17**			**S18**		
Sample Location	**Attucks dining hall – supply diffuser in water damaged section of ceiling**			**Attucks library – possible mold on ceiling around supply diffuser**			**Attucks library – supply diffuser**		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	11/19/2024			11/19/2024			11/19/2024		
Amount of Sample Prepared	3 in²			0.5 in²			2 in²		
Dilution Factor	1,000			100			100		
Detection Limit (DL)	DL = 330 CFU/in²			DL = 200 CFU/in²			DL = 50 CFU/in²		
Culturable Fungi Conc.*	**7,400 CFU/in²**			**400 CFU/in²**			**1,400 CFU/in²**		
Identification	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**
Major Hydrophilic Fungi*									
Acremonium									
Aureobasidium							2	100	7
Chaetomium							1	50	4
Stachybotrys									
Ulocladium									
Yeast, non-specified							2	100	7
Rhodotorula (yeast)							1	50	4
Sporobolomyces (yeast)									
Trichoderma [Spreader]***	0.1	33	< 1						
Rhizopus [Spreader]***									
Other Fungi									
Cladosporium	9	3,000	40				17	850	63
Penicillium	2	670	9						
Aspergillus versicolor									
Aspergillus sydowii									
Aspergillus ustus									
Aspergillus niger							1	50	4
Aspergillus fumigatus									
Aspergillus ochraceus	0.2	67	< 1						
Aspergillus flavus									
Alternaria	2	670	9						
Epicoccum	4	1,300	18				1	50	4
Pithomyces	2	670	9				1	50	4
Curvularia									
Non-sporulating fungi	3	1,000	13	1	200	50	1	50	4
Xerophilic Fungi Screening		***ND***		***1***	***200***	***50***		***ND***	
DG18 (and/or MEA) Dilution Factor:	*100*	*(DL = 33 CFU/in²)*		*100*	*(DL = 200 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

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AIHA EMPAT Lab ID: 178794

Mycologix™ Culture Media and Methods

Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**
Client: Gordon Mycology Laboratory, Inc.
Groton, MA
Contact: Gordon, Deb
Project ID: 24-070GML BSH-5

QLAB Job No.: ME241108-16
Date Sampled: 11/7/2024
Date Received: 11/8/2024
Date Reported: 11/19/2024

Lab Sample No.	ME241108-16(19)			ME241108-16(20)			ME241108-16(21)		
Sample ID	**S19**			**S20**			**S21**		
Sample Location	**Carter - first floor day room – supply diffuser**			**Carter – first floor hallway – return grille**			**Adams - day room – supply diffuser**		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	11/19/2024			11/19/2024			11/19/2024		
Amount of Sample Prepared	3 in²			1 in²			3 in²		
Dilution Factor	100			100			1,000		
Detection Limit (DL)	DL = 33 CFU/in²			DL = 100 CFU/in²			DL = 330 CFU/in²		
Culturable Fungi Conc.*	**1,800 CFU/in²**			**1,100 CFU/in²**			**10,000 CFU/in²**		
Identification	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**
Major Hydrophilic Fungi*									
Acremonium									
Aureobasidium							3	1,000	10
Chaetomium									
Stachybotrys									
Ulocladium									
Yeast, non-specified									
Rhodotorula (yeast)									
Sporobolomyces (yeast)									
Trichoderma [Spreader]***									
Rhizopus [Spreader]***									
Other Fungi									
Cladosporium	17	570	31	5	500	45	12	4,000	39
Penicillium	3	100	5	3	300	27	4	1,300	13
Aspergillus versicolor									
Aspergillus sydowii									
Aspergillus ustus									
Aspergillus niger				2	200	18			
Aspergillus fumigatus									
Aspergillus ochraceus									
Aspergillus flavus									
Alternaria							2	670	6
Epicoccum	17	570	31				7	2,300	23
Pithomyces	13	430	24						
Curvularia									
Non-sporulating fungi	4	130	7	1	100	9	3	1,000	10
Xerophilic Fungi Screening	***1***	***33***	***2***		***ND***			***ND***	
DG18 (and/or MEA) Dilution Factor:	*100*	*(DL = 33 CFU/in²)*		*100*	*(DL = 100 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

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Mycologix™ Culture Media and Methods

Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**
Client: Gordon Mycology Laboratory, Inc.
Groton, MA
Contact: Gordon, Deb
Project ID: 24-070GML BSH-5

QLAB Job No.: ME241108-16
Date Sampled: 11/7/2024
Date Received: 11/8/2024
Date Reported: 11/19/2024

Lab Sample No.	ME241108-16(22)			ME241108-16(23)		
Sample ID	**S22**			**S23**		
Sample Location	**Adams - basement – mold on cardboard on floor**			**Adams basement – lower HVAC system, filter**		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA			Media: MEA, DG18, and/or Mycologix™ Media: RD-PDA, CA//Stachybotrys (SCUM) Agar, and/or Xero-MEA		
Date Analyzed	11/19/2024			11/19/2024		
Amount of Sample Prepared	1 in²			4 in²		
Dilution Factor	1,000			1,000		
Detection Limit (DL)	DL = 1000 CFU/in²			DL = 250 CFU/in²		
Culturable Fungi Conc.*	**120,000 CFU/in²**			**6,800 CFU/in²**		
Identification	**Adj. Ct.***	**CFU/in²**	**%**	**Adj. Ct.***	**CFU/in²**	**%**
Major Hydrophilic Fungi*						
Acremonium						
Aureobasidium				4	1,000	15
Chaetomium						
Stachybotrys						
Ulocladium						
Yeast, non-specified				1	250	4
Rhodotorula (yeast)						
Sporobolomyces (yeast)						
Trichoderma [Spreader]***						
Rhizopus [Spreader]***						
Other Fungi						
Cladosporium				12	3,000	44
Penicillium				1	250	4
Aspergillus versicolor						
Aspergillus sydowii						
Aspergillus ustus						
Aspergillus niger				0.1	25	< 1
Aspergillus fumigatus				0.2	50	< 1
Aspergillus ochraceus	0.2	200	< 1			
Aspergillus flavus						
Alternaria						
Epicoccum				5	1,300	18
Pithomyces				2	500	7
Curvularia						
Non-sporulating fungi	124	120,000	100	2	500	7
Xerophilic Fungi Screening		***ND***			***ND***	
DG18 (and/or MEA) Dilution Factor:	*100*	*(DL = 100 CFU/in²)*		*100*	*(DL = 25 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