



Disability Law Center

Massachusetts Protection and Advocacy

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



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

A report to the President of the Senate, Speaker of the House of Representatives, Chairs of the Joint Committee on Mental Health Substance Use and Recovery, Joint Committee on the Judiciary, Senate Ways and Means Committee, and House Ways and Means Committee, submitted pursuant to the FY 2022 Budget (Line Item #8900-0001).

January 2022

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Introduction and Overview

This report covers Disability Law Center (DLC) monitoring of Bridgewater State Hospital (BSH), including the Bridgewater Units at Old Colony Correctional Center (OCCC Units), known as the Intensive Stabilization and Observation Unit (ISOU) and the Residential Unit (RU), pursuant to expanded authority granted by Line Item #8900-0001,¹ for the period from July 2021 to December 2021. DLC's ongoing extensive monitoring would not be possible without our expanded authority granted by Line Item #8900-0001.

DLC provided a private version of this report, issued on January 31, 2022, to the President of the Senate; the Speaker of the House of Representatives; the Joint Committee on Mental Health, Substance Use and Recovery; the Joint Committee on the Judiciary; the House Committee on Ways and Means; the Senate Committee on Ways and Means; and the Commissioner of the Department of Correction (DOC). After allowing time for review and redacting photographs taken during an onsite inspection of BSH, DLC made its findings and recommendations public on February 9, 2022.²

During this reporting period, DLC utilized our expanded authority granted by Line Item #8900-0001 to include oversight of a plethora of issues ranging from BSH physical plant mold to continuity of care in mental health services at county jails. Specifically, DLC conducted monitoring of Wellpath LLC's (Wellpath) delivery of services at BSH, incorporating assessment of continuity of care for Person Served (PS) upon discharge, through a variety of activities, including:

- Onsite BSH visits;
- Consultation with expert mycologist;
- Onsite BSH mold testing with expert mycologist;
- BSH PS video, phone, and in person meetings;
- BSH staff video, phone, and in person meetings;

¹ FY22 Budget: “[P]rovided further, that not less than \$125,000 shall be expended for the Disability Law Center, Inc. to monitor the efficacy of service delivery reforms at Bridgewater state hospital, including units at the Old Colony correctional center and the treatment center; provided further, that the Disability Law Center, Inc. may investigate the physical environment of those facilities, including infrastructure issues, and may use methods including, but not limited to, testing and sampling the physical and environmental conditions, whether or not they are utilized by patients or inmates; provided further, that the Disability Law Center, Inc. may monitor the continuity of care for Bridgewater state hospital persons served who are discharged to county correctional facilities or department of mental health facilities, including assessment of the efficacy of admission, discharge and transfer planning procedures and coordination between the department of correction, Wellpath LLC, the department of mental health and county correctional facilities; provided further, that not less than once every 6 months, the Disability Law Center, Inc. shall report on the impact of these reforms on those served at Bridgewater state hospital to the joint committee on mental health, substance use and recovery, the joint committee on the judiciary, the house and senate committees on ways and means, the senate president and the speaker of the house of representatives”.

² Redactions appear in pages 8 through 13 of the public report.

- Participation in BSH Governing Body meetings and Department of Mental Health (DMH) quarterly meetings;
- Review of Wellpath 24 Hour Nursing Reports;
- Review of DOC Incident Reports;
- Review of BSH restraint and seclusion data;
- Review of BSH restraint and seclusion orders and documentation;
- Requests for documentation to Wellpath and DOC;
- Review of voluminous PS medical records;
- Review and analysis of PS discharge data;
- Virtual and in person meetings and correspondence with administration from county Sheriff's Departments;
- Onsite county correctional facility visit to tour Regional Mental Health Stabilization Unit;
- Onsite visit to Lemuel Shattuck Hospital to meet facility staff and meet with discharged PS;
- Phone interviews with discharged PS at Vibra Hospital, Worcester Recovery Center and Hospital, Lemuel Shattuck Hospital, and in the community;
- Distribution of surveys to PS discharged to county correctional facilities;
- Distribution and posting of online survey for former PS and their loved ones;
- Meetings with BSH friends and family group;
- Weekly internal staff meetings; and
- Hiring a new DLC Disability Rights Advocate to engage in BSH monitoring activities.

DLC now has almost eight (8) years of continuous daily oversight at BSH. While progress has been made, it is abundantly clear that there is significant work to be done to protect the rights of PS confined in BSH and the OCCC Units. Our monitoring confirms that, while certain specifics may have shifted over the years, many of the pillars of BSH's inadequacy remain. Concerns about the economic toll and health and safety risks resulting from physical plant conditions; providers' failure to comply with legal requirements concerning administration and documentation of PS restraint and seclusion; the prevailing culture of intimidation; and the lack of immediate and robust programming upon admission are all reminiscent of the deficiencies that gave rise to DLC's initial investigation and settlement agreement in 2014. The Commonwealth must

recognize that improving the efficacy of treatment, continuity of care, and outcomes following evaluation and treatment at BSH benefits the community at large, not just PS.³

In the discussion below, DLC focuses on six (6) broad areas of concern during the period from July 2021 to December 2021:

- 1. Physical Plant Health and Safety Risks – Pervasive Mold and Potential Asbestos Exposure;**
- 2. Illegal and Unreported Use of Restraint and Seclusion;**
- 3. Limitations on Persons Served Access to Medical Care;**
- 4. COVID-19 Response and Program Reopening;**
- 5. Persons Served Continuity of Care; and**
- 6. Additional Issues Requiring Continued Monitoring.**

Sections 1 through 5 include DLC's recommendations to improve the safety and treatment of PS. The complete recommendations are compiled at the Conclusion of the report. Section 6 lists issues that DLC intends to monitor further and, depending on our findings, include in DLC's next report.

³ As stated in our July 2021 report, the expansive plans set forth in the Executive Office of Health and Human Services' *Roadmap for Behavioral Health Reform: Ensuring the right treatment when and where people need it*, unfortunately, do prioritize access to mental health care for people inside DOC or county correctional facilities or preparing for and supporting their transition to the community. See Executive Office of Health and Human Services, *Roadmap for Behavioral Health Reform*, <https://www.mass.gov/service-details/roadmap-for-behavioral-health-reform>.

1. Physical Plant Health and Safety Risks – Pervasive Mold and Potential Asbestos Exposure

During this reporting period, updates from DOC, DLC’s observations, and the expert findings of Gordon Mycology Laboratory, Inc. (“Gordon Mycology”) demonstrate that economic inefficiency and continuing risks to health and safety remain constants in the operation of BSH. Every report DLC has issued since May 2018, each entitled *A Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital*,⁴ has made clear that the state of the physical plant and infrastructure at BSH warrant the facility’s closure.

For years, individuals receiving and providing treatment at BSH have reported symptoms consistent with exposure to poor air quality. DLC has exhaustively raised concerns about physical plant deficiencies that impact PS safety, including repeated leaks and mold. After DOC refused to conduct comprehensive mold sample swab testing throughout the facility, DLC, after securing enhanced legislative authority, retained and conducted mold testing at BSH with Gordon Mycology in December 2019. Both observations and sample testing in 2019 revealed the presence of mold in almost every single area swabbed by the expert, including HVAC systems and vents. Gordon Mycology issued extensive recommendations for DOC to follow in order to remediate the pervasive mold, as set forth in DLC’s March 2020 report.⁵ Thereafter, DOC reported completing repairs and mold removal in the areas identified. DOC did not, however, provide evidence that its remediation efforts were performed in keeping with the expert recommendations or with industry standards.

Due to the lack of clarity concerning DOC’s attempts at mold remediation and continuing reports from inside BSH, DLC and Gordon Mycology returned in an announced visit on December 6, 2021 to visually inspect and collect surface swab samples from the areas tested two years earlier. Again, this DLC inspection was possible due to DLC’s expanded authority granted in Line Item #8900-0001. Gordon Mycology’s detailed Mold Inspection Report and the AccuScience Laboratory Results are attached hereto as **Appendix B**.

Both Gordon Mycology’s firsthand observations and lab results from the swabs substantiated DLC’s concerns that remediation efforts at BSH were insufficient to protect the health and safety of PS and staff alike. Per the Report, “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).”⁶ Moreover, the continuing presence of mold growth in BSH buildings and HVAC systems on the same sources identified in 2019 “indicates that the necessary mold remediation,

⁴ DLC’s past reports concerning BSH are available at: <https://www.dlc-ma.org/monitouing-investigations-reports/>.

⁵DLC, *A Public Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital (March 2020)*, <https://www.dlc-ma.org/wp-content/uploads/2020/07/BSH-Combined-Report.pdf>.

⁶ App. B at 1.

cleaning, and maintenance actions have not been performed (or kept up with as regularly as they need to be).⁷

HVAC systems observed during the inspection were in horrible condition, some with air handlers in wet and flooded basements with rampant mold growth. The black dust/debris inside HVAC system air handlers and supply diffusers remained, seemingly untouched, along with unacceptable levels of mold growth; the air coming through these systems is what persons served and staff in the buildings must breathe day in and day out. Mold growth has been unacceptably painted over on walls and ceilings (mold feeds on wet paint, making the problem worse). Indeed, during this inspection, a staff member told [Gordon Mycology] that he was going to have a ceiling covered with mold growth painted in order to address the problem (without removing the mold first). 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 recommendations were largely ignored. This inaction has caused the mold problems to become worse in certain areas observed and potentially more harmful to those who work and live in the facility.⁸

In addition to recording visual observations in each BSH building inspected confirming excessive moisture/standing water, visible mold, and HVAC contaminants, Gordon Mycology identified deteriorating pipe and duct wrap in several mechanical rooms that house HVAC units. According to DOC personnel present during the inspection, some of the pipe wrap – the wrap marked with orange paint – had already been identified as containing asbestos; based on years of experience, Gordon Mycology believed that other unmarked wrap may also contain asbestos. Of course, deteriorating asbestos wrapping and insulation may give rise to dangerous airborne asbestos fibers. When necessary to address other repairs in recent years, DOC has acknowledged the need for asbestos abatement in the mechanical room of the Medical Building basement (water pipe insulation)⁹ and reportedly completed asbestos abatement in the mechanical rooms of the Buildings A, B, and C.¹⁰ Information available to DLC over the course of our monitoring does not indicate that DOC's Department of Resource Management has done or hired an asbestos expert to complete an evaluation of the entire facility.

To make plain the level of concern these issues warrant, DLC highlights below a sampling of Gordon Mycology's inspection observations, along with illustrative photographs taken by the expert. During the visit, DOC personnel took duplicate photographs in real time to recreate each of the over 200 photos taken by Gordon Mycology for DOC's records.

⁷ App. B at 11.

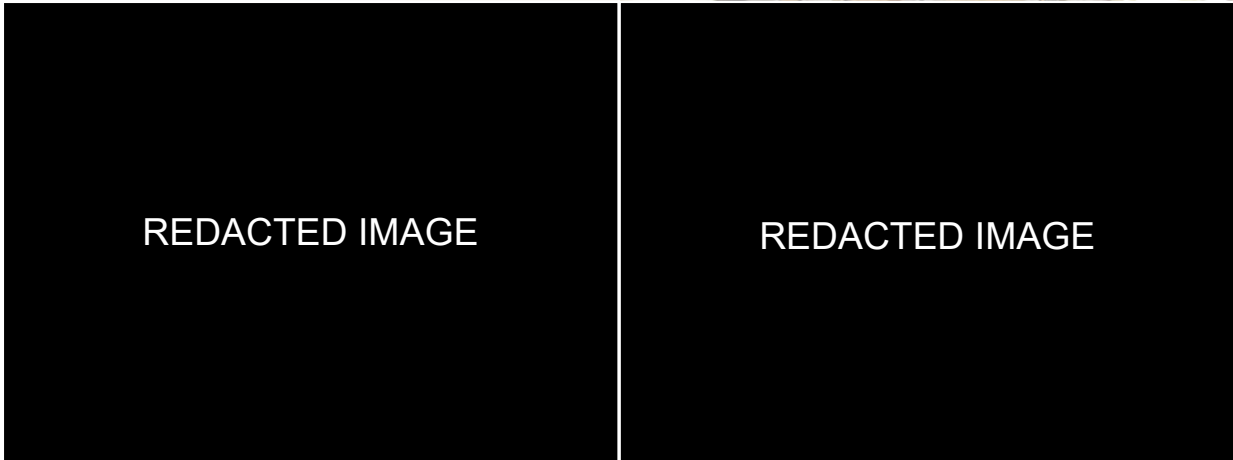
⁸ App. B at 11.

⁹ Feb 2019 report, Attachment 1 – 1/14/19 letter to DLC from DOC

¹⁰ DOC, *Governing Body Meeting June 11, 2020 2pm: Physical Plaintiff Update*.

Administration Building Basement - The administration building holds the entryway to BSH and security screening area, offices for Wellpath and DOC administrators and staff, the visiting areas for attorneys and loved ones, and the onsite courtroom, among other things.

- “Visible growth on wall framing, plywood partition wall, ventilation system vents, painted concrete walls, ceilings, and baseboards.”¹¹
- “HVAC system ceiling diffusers had been painted over but rust and a significant amount of accumulated black dust/debris remained inside the diffusers; this condition remained unchanged from the 2019 inspection.”¹²
- “Mechanical Room...
 - Wet areas and standing water on the floor
 - Large, deep wastewater sump was full of standing water (raw sewerage)...the sump’s cover was open allowing hazardous bacteria and other contaminants to migrate into the mechanical room air....
 - Large sections of asbestos pipe wrap remained, some of which were jagged/ripped potentially resulting in hazardous, airborne asbestos fibers
 - Visible mold growth on wall materials, both porous and painted concrete....”¹³
- “Administration building first floor HVAC system supply diffusers were filthy with black dust; this condition was unchanged from the 2019 inspection.”¹⁴



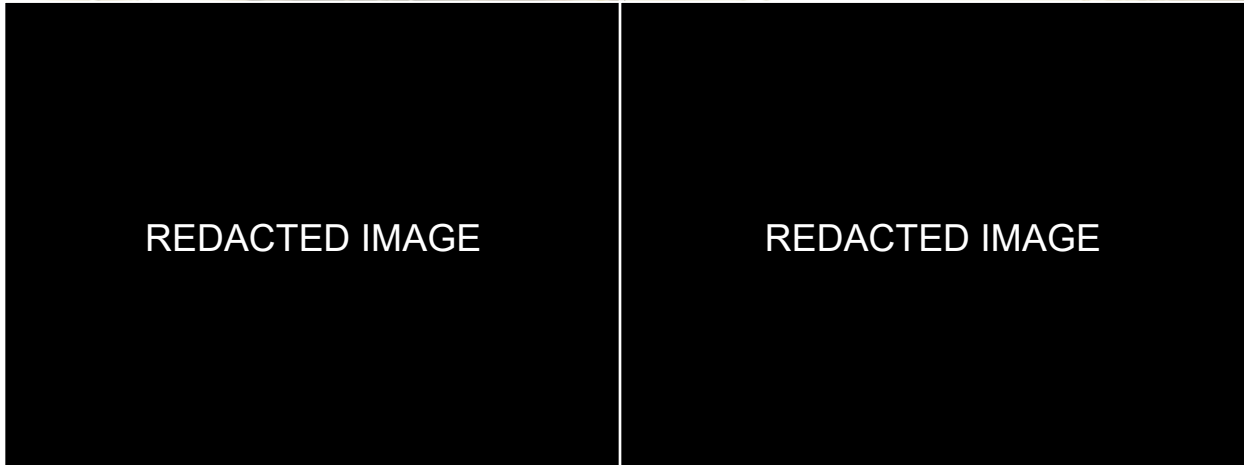
Photos by Gordon Mycology Laboratory, Inc

¹¹ App. B at 2.

¹² App. B at 2 (emphasis in original).

¹³ App. B at 2-3 (emphasis added). Note: Gordon Mycology was informed that the orange markings on pipes in this mechanical room signify they have already been identified as having asbestos pipe wrap.

¹⁴ App. B at 3 (emphasis in original).



Photos by Gordon Mycology Laboratory, Inc.

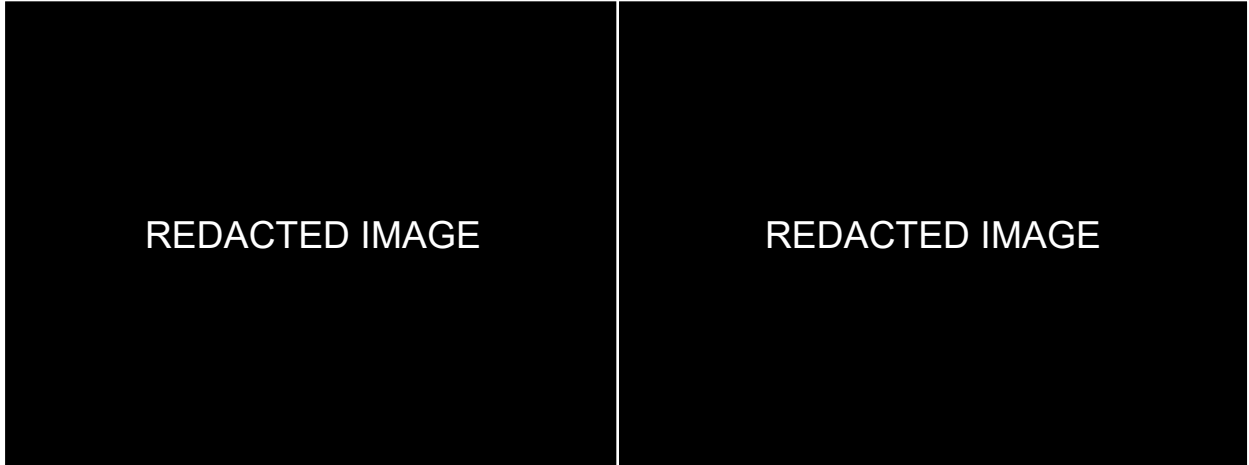
Medical Building (Lighthouse) Basement – This building is the site of the BSH infirmary, dental office, negative pressure chamber, PS property storage, admissions/booking, and the isolation unit known during the COVID-19 pandemic as the Containment Unit.

- “HVAC ductwork had been painted in the past but the paint was peeling and visibly moldy throughout.”¹⁵
- “HVAC vents in the green rooms were filthy, almost blocked with black dust and debris; this condition remained unchanged from the 2019 inspection,”¹⁶
- “Mechanical room
 - Largely, the mold and moisture condition of this room remained the same as during the 2019 inspection...
 - Right wall covered with a fabric-type material was ripped, deteriorated, water stained and covered in mold growth; this condition remained unchanged since 2019...
 - Ceiling was covered with mold growth...
 - Asbestos and fiberglass pipe wrap was water damaged and covered in mold growth; this condition was unchanged from 2019.”¹⁷

¹⁵ App. B at 3.

¹⁶ App. B at 3 (emphasis in original).

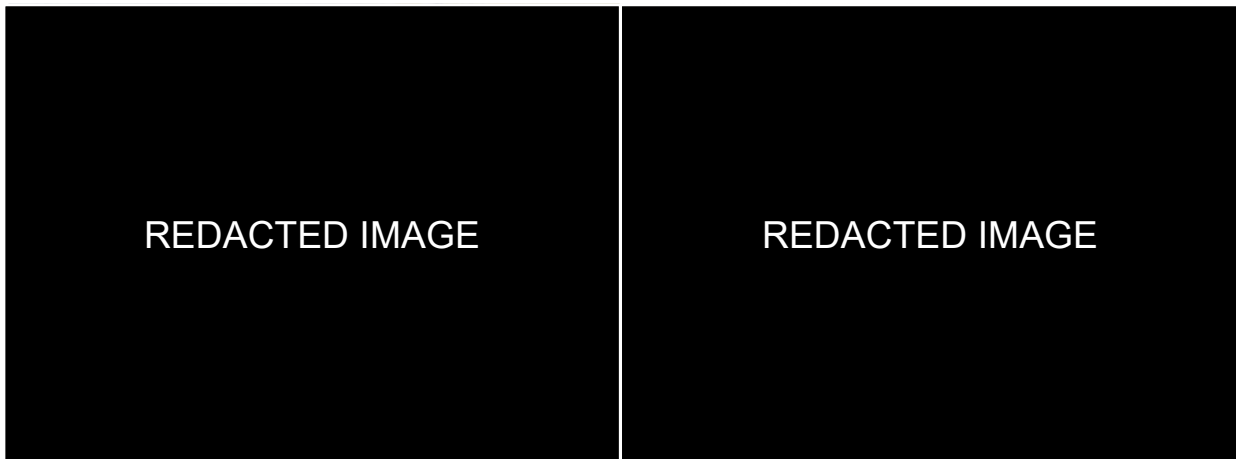
¹⁷ App. B at 4 (emphasis in original).



Photos by Gordon Mycology Laboratory, Inc.

Building A (Adams) - This building is a residential unit for PS.

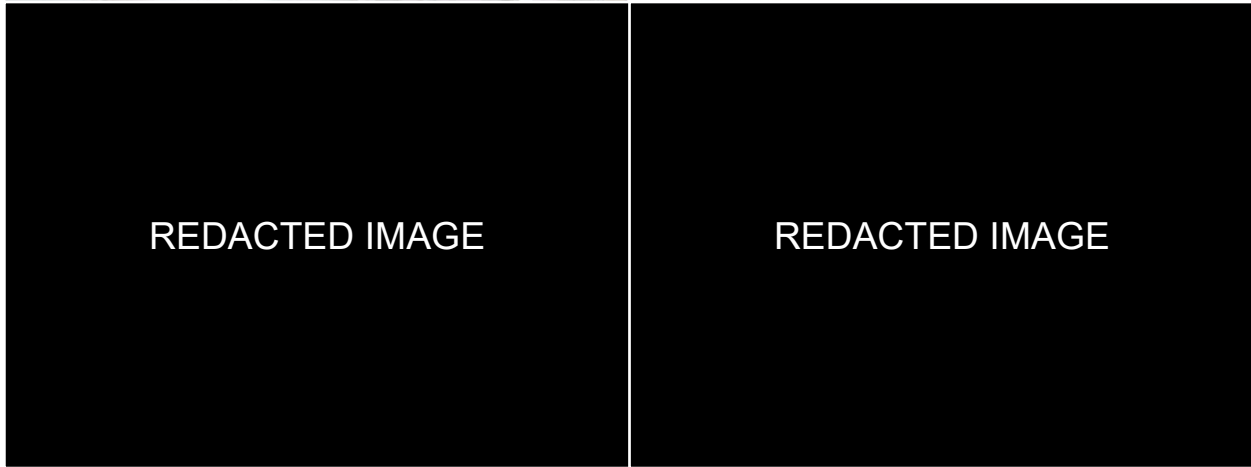
- “Second floor common rooms with filthy HVAC ductwork, unchanged from 2019; exposed surfaces of the diffusers had been painted but the inner surfaces were rusted, filthy, and moldy”¹⁸
- In the basement level, “[a]n HVAC system inspected in 2019 was in a currently flooded basement and could not be inspected (about 6-8 inches of standing water); a pump and PVC pipe had previously been installed to evacuate water when the basement flooded (the cause was reportedly a clogged drain but a basement with an actively used HVAC system for occupied spaces and other mechanical equipment cannot continue to flood.”¹⁹



Photos by Gordon Mycology Laboratory, Inc.

¹⁸ App. B at 4 (emphasis in original).

¹⁹ App. B at 5.



Photos by Gordon Mycology Laboratory, Inc.

Building C (Carter) Basement – Building C is a residential unit for PS.

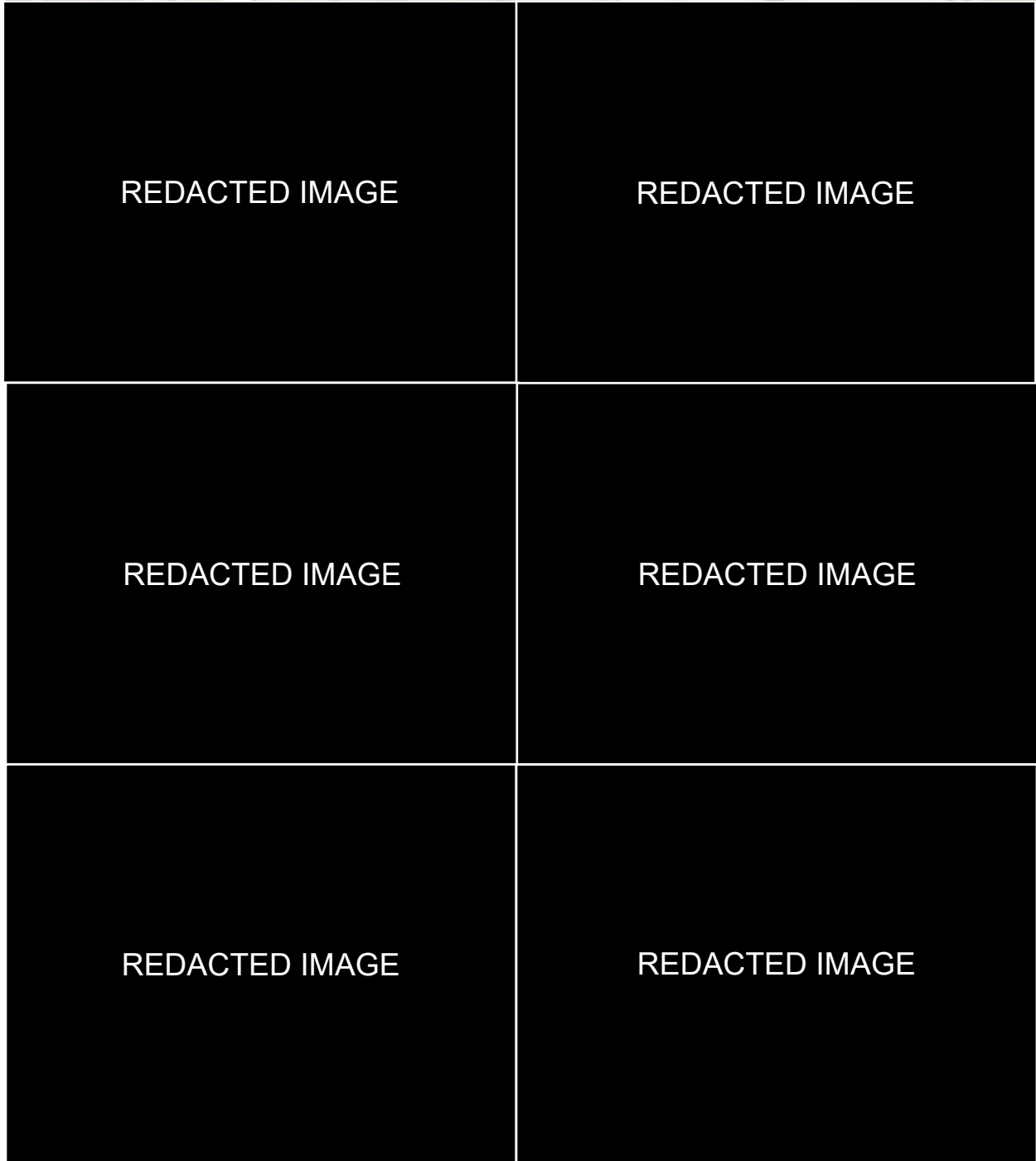
- “There was standing water on the floor in the back of the room....”²⁰
- “All metal surfaces were rusted, some almost completely corroded.”²¹
- “Widespread mold growth, particularly on the external ductwork wrap.”²²
- “HVAC system
 - Air handler was filthy, covered inside and out with accumulated organic debris that was or will be growing mold (leaves, dirt, dead insects, etc.)...
 - Visible mold growth on several components...
 - Filter compartments were open, introducing wet and moldy air into the filthy system; the combination of chronic moisture and organic dirt/debris provides conditions that promote and support unacceptable mold growth inside an active air handling system
 - One inch filters were filthy and black with accumulated dust, debris, and mold growth; cardboard filter frames were wet
 - Pipe and ductwork wrap was ripped, deteriorated, and moldy.”²³

²⁰ App. B at 5.

²¹ App. B at 5.

²² App. B at 5.

²³ App. B at 5.



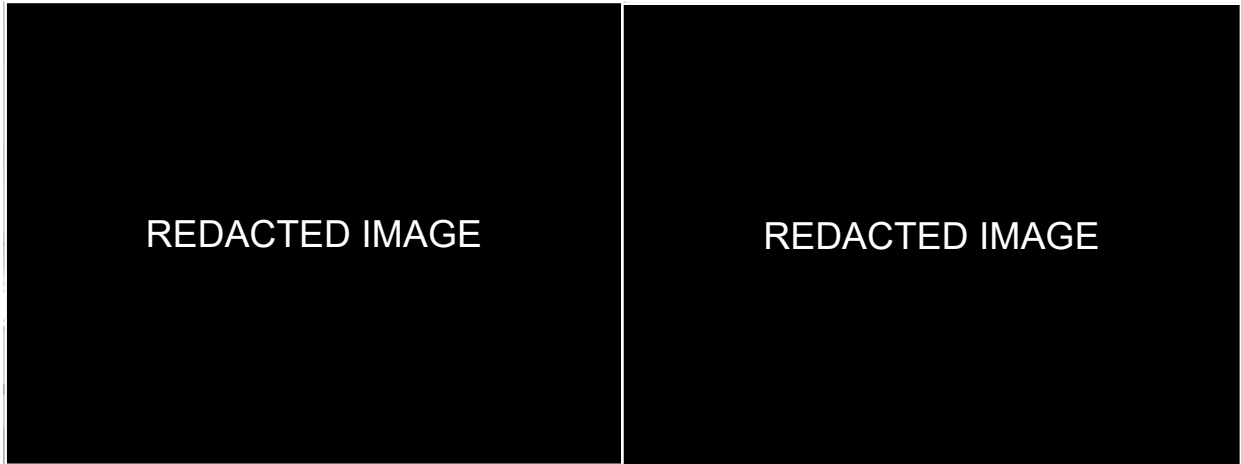
Photos by Gordon Mycology Laboratory, Inc.

Attucks Building – Attucks holds a number of important spaces for PS, including the gymnasium, the library, programming rooms, chapel, classrooms, and the cafeteria (not currently in use due to COVID-19).

- “HVAC vents in all inspected areas were filthy; unchanged from 2019.”²⁴

²⁴ App. B at 5 (emphasis in original).

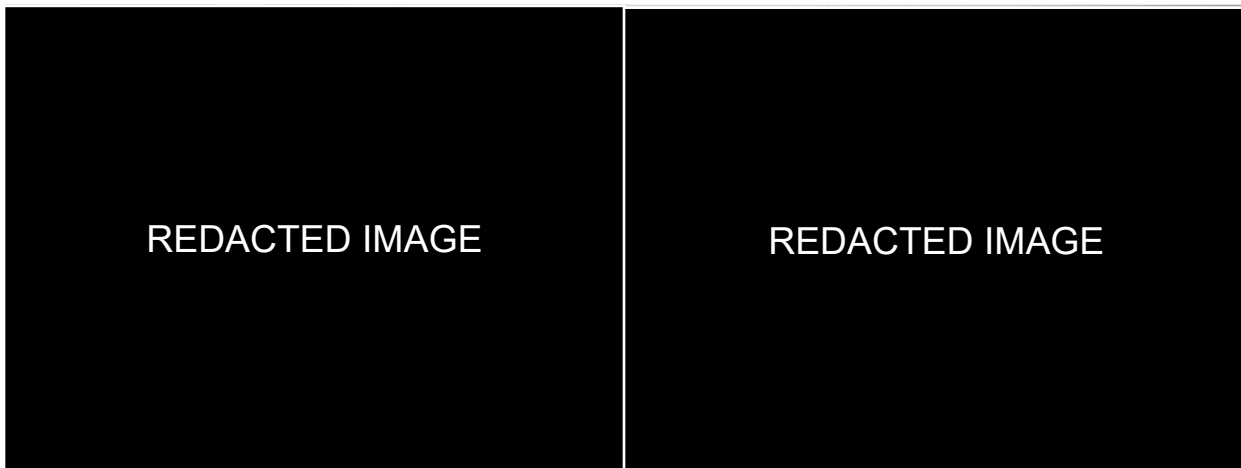
- “Technology/computer room [PS law library] had mold growth on the ceiling.”²⁵
- “Developmental Disabilities room [the area historically used for the Developmental Services Program for PS with intellectual and developmental disabilities]
 - The ceiling was covered with visible mold growth from the continually running air conditioner in December.”²⁶



Photos by Gordon Mycology Laboratory, Inc.

Max 2 Building (Lenox) – This building and Max I (Hadley) are residential units for PS deemed to warrant maximum security, a higher level of security and more on unit time than Buildings A, B, and C.

- “HVAC vents were filthy, unchanged from 2019.”²⁷
- “Shower room with moldy wall panels and flooring (fiberglass) beneath the shower and plumbing.”²⁸



Photos by Gordon Mycology Laboratory, Inc.

²⁵ App. B at 5.

²⁶ App. B at 5.

²⁷ App. B at 6 (emphasis in original).

²⁸ App. B at 6. Notably, DOC conducted renovations in Lenox in 2018, including updates to the shower room, cells, the day room, and offices.

The laboratory results from Gordon Mycology’s mold swabs identified various mold types growing on the surfaces swabbed, such as “*Aspergillus fumigatus*, *Aspergillus niger*, *Aspergillus ochraceus*, *Aspergillus sydowii*, *Aspergillus versicolor*, *Aspergillus sydowii*, *Aureobasidium*, *Chaetomium*, *Cladosporium*, *Fusarium*, *Mucor*, *Penicillium*, *Phoma*, and *Trichoderma* along with environmental yeasts and non-sporulating fungi (unable to mature on culture plates for identification but require similar growth conditions as molds).”²⁹ The presence in numerous samples of *Aureobasidium*, *Chaetomium*, and *Fusarium*...confirm[s] chronically wet materials or materials that get wet on repeated occasions and are not cleaned so the dust/debris and mold continue to increase each time the surfaces are wetted.”³⁰ Gordon Mycology also reports that *Aspergillus* and *Fusarium*, both “confirmed on many tested surfaces in the buildings, including HVAC systems,” can give rise to serious health issues:

Aspergillus can cause chronic lung and sinus infections, produces mycotoxins, and is a common allergenic mold. *Fusarium* is known as an opportunistic pathogen and can cause respiratory diseases such as pneumonia, chronic sinusitis, and hard to treat skin infections. Chronic mold 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 go away, chronic sinus infections, persistent coughing, itchy and runny eyes, sore throats, exhaustion, lethargy, mental foggiess, etc. People with underlying health conditions and weaker immune systems are most affected by chronic mold exposure. The 2019 inspection confirmed mold contamination sources that remained as of this inspection, confirming that there is chronic mold exposure potential for staff members and persons served.³¹

Gordon Mycology’s findings, therefore, reveal that DOC has failed to diligently execute mold remediation recommendations issued by Gordon Mycology following the 2019 inspection, leaving PS and staff exposed to mold. In addition, expert observations in conjunction with DOC’s disclosures indicate that further attention must be paid to the presence of asbestos in all areas of BSH to ensure that PS and staff are not being exposed to this deadly substance as well – through the HVAC systems or while performing maintenance duties in the mechanical rooms. With respect to any individuals doing maintenance, whether staff, contractors, or PS/prisoner workers, in mechanical rooms or in any area where mold or asbestos may be present, DLC is highly concerned that DOC is not providing them with all appropriate warnings, training, and protective equipment, in keeping with industry standards.

At the same time, neither DOC nor Wellpath ensure that PS receive regular, targeted medical evaluations to determine whether they are suffering respiratory or other health

²⁹ App. B at 7.

³⁰ App. B at 7.

³¹ App. B at 7.

effects related to mold exposure and potential exposure to asbestos. This is unacceptable.

In the face of overwhelming evidence of persistent health and safety risks to PS, DOC, the Executive Office of Public Safety and Security, and the Commonwealth must act immediately. BSH – a prison – does not and has never offered a suitable therapeutic environment to meet the needs of the individuals with acute behavioral health needs forced to reside there. Once again, evaluation by DLC’s retained expert shows that the aged physical plant has deteriorated to the point that spending time inside BSH is not safe for anyone.

Recommendations:

DOC must immediately remediate mold and assess for other environmental toxins existing in the physical plant at BSH in accordance with expert recommendations and industry standards.

DOC and Wellpath BSH must provide regular health screenings for symptoms of mold and environmental toxin exposure to all PS and staff, provided by a contracted health professional with expertise in the area. Without a plan for systematic detection, to support appropriate prevention and treatment, BSH faces untold numbers of sick PS and staff due to the documented presence of mold and asbestos that have existed for years throughout the physical plant.

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

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

2. Illegal and Unreported Restraint and Seclusion

In 2014, Disability Law Center opened an investigation into the excessive and illegal restraint and seclusion of individuals with mental illness at BSH pursuant to our federal authority as Massachusetts' designated Protection and Advocacy agency. Faced with the findings of DLC's investigation and pending litigation, DOC agreed to implement changes to policies and practices to reduce incidence and duration of restraint and seclusion of PS. As raised repeatedly in prior DLC reports, this progress, however, did not extend to the use of forced psychotropic medication at BSH and the OCCC Units.³²

During this reporting period, DLC's in depth review of daily nursing notes, restraint & seclusion packets, and clinical records of multiple persons served revealed that Wellpath is now subjecting PS to all forms of restraint and seclusion in unsanctioned circumstances, particularly the use of manual holds, seclusion, and chemical restraint. DLC also found that there is significant underreporting of restraint and seclusion, with Wellpath failing to report at least 80 instances of restraint and seclusion to the BSH Superintendent and the DOC Commissioner, as required.³³

A. Legal Standards for Restraint and Seclusion

Massachusetts law strictly limits the use of restraint and seclusion. Per G.L. c. 123, §21, restraint and seclusion of a person with mental illness in DMH facilities or BSH "may only be used in cases of emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide," with strict requirements regarding examinations and who may provide written authorizations for the restraint. The Supreme Judicial Court has made clear that "[n]either doctors nor courts have the power to expand the circumstances in which a patient may be restrained."³⁴ All uses of restraint and seclusion must be tracked in individual medical records, and "[c]opies of all restraint forms and attachments shall be sent to the commissioner of mental health, or with respect to Bridgewater state hospital to the commissioner of correction, who shall review and sign them within thirty days, and statistical records shall be kept thereof for each facility including Bridgewater state hospital, and each designated physician."³⁵

Use of chemical restraint, in particular, requires a determination upon examination "that such chemical restraint is the least restrictive, most appropriate alternative available; provided, however, that the medication so ordered has been previously authorized as part of the individual's current treatment plan."³⁶ Indeed, under Massachusetts law, there are only two distinct exceptions to the general rule that mental health medication should be administered involuntarily only pursuant to a court order – commonly referred

³² DLC discussed these concerns in our reports to the Legislature issued in May 2018, February 2019, July 2020, March 2020, October 2020, July 2021.

³³ DLC discovered several instances of restraint and seclusion that are well documented in PS clinical records but are missing from both daily nursing notes and the restrain packets prepared for the DOC Commissioner. It is highly likely that a review of all PS clinical records would reveal a significantly higher number of unreported incidents.

³⁴ *O'Sullivan v. Sec'y of Hum. Servs.*, 402 Mass. 190, 194 (1988), citing *Rogers*, 390 Mass. at 510.

³⁵ G.L. c. 123, §21.

³⁶ G.L. c. 123, §21.

to as a *Rogers* order – applying a substituted judgment standard and a specific finding that the patient would accept treatment the medication treatment plan if they were competent.³⁷ First, there is the use of chemical restraint to prevent an imminent threat of harm to oneself or others under the state’s police power.³⁸ The second exception is the exercise of the state’s *parens patriae* powers, which permits the state 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.’”³⁹ Repeated use of this exception, requiring that, when someone is medicated in order to avoid said deterioration “and the doctors determine that the antipsychotic medication should continue and the patient objects, the doctors must seek an adjudication of incompetence.”⁴⁰

B. *BSH Involuntary Medication Practices*

DLC’s July 2021 report laid out in detail how Wellpath’s policy governing *Use of Involuntary Psychotropic Medication*⁴¹ applicable to BSH and the OCCC Units runs afoul of the legal requirements for restraint in Massachusetts.⁴² In short, the policy excludes clear applications of chemical restraint from its definition of “Medication Restraint” and permits chemical restraint absent emergency circumstances. Wellpath’s so-called Medication Restraint is confined to the use of involuntary medication when a PS “volitionally engages in dangerous behaviors (i.e. [,] *not related to mental illness*) which places self or others at imminent risk of harm, and less restrictive interventions are unsuccessful in deterring these behaviors.”⁴³ For obvious reasons, it is quite rare for dangerous behaviors of PS to be deemed unrelated to mental illness. “Emergency Treatment Orders” (ETO), by contrast, permit involuntary medication when a PS “presents in a psychiatric emergency such that leaving him untreated would result in *potential* harm to self or others, or an intolerable level of distress” and must only be documented in a progress note.⁴⁴ One of the examples of such behavior cited in the policy, “escalating aggression that cannot be verbally deescalated,” is so broad that one would expect ETOs to be widely used to control PS behavior relating to mental illness without imminent threat of harm.⁴⁵

³⁷ See G.L. c. 123, § 8B; *Rogers v. Comm’r of the Dep’t of Mental Health*, 390 Mass. 489, 504-511 (1983).

³⁸ *Rogers*, 390 Mass. at 510-511. Per the Supreme Judicial Court, “[n]o other State interest is sufficiently compelling to warrant the extremely intrusive measures necessary for forcible medication with antipsychotic drugs.” *Id.* at 511,

³⁹ *Id.* at 511-512.

⁴⁰ *Id.* at 512.

⁴¹ Bridgewater State Hospital Policy and Procedure Manual – *Use of Involuntary Psychotropic Medication*, 5.1 (effective 1/24/2020).

⁴² See DLC, *A Report on the Efficacy of Service Delivery Reforms at Bridgewater State Hospital (BSH) and Continuity of Care for BSH Persons Served* (July 2021) at 9-14, <https://www.dlc-ma.org/wp-content/uploads/2021/07/BSH-Report-7.27.2021.pdf>.

⁴³ Bridgewater State Hospital Policy and Procedure Manual – *Use of Involuntary Psychotropic Medication*, 5.1 (effective 1/24/2020) (emphasis added).

⁴⁴ *Id.* at 5.2.1, 5.2.7.

⁴⁵ *Id.* at 5.2.4.

The permissive BSH policy is in stark contrast to DMH regulations, 104 CMR 27.12, which lawfully define medications given “to control the patient’s behavior or restrict the patient’s freedom of movement and which is not the standard treatment or dosage prescribed for the patient’s condition”⁴⁶ as medication restraint subject to usage requirements of other restraints. Medication restraint may be used only in an emergency, such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide. 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. A “substantial risk includes only the serious, imminent threat of bodily harm, where there is the present ability to effect such harm.”⁴⁷ DMH regulations likewise make clear that “[s]eclusion and restraint, as defined in these regulations, may not be used for behavior management, but may only be used in accordance with 104 CMR 27.12.”⁴⁸

DLC’s review of restraint and seclusion orders produced by DOC – the same documentation that the DOC Commissioner reviews and signs pursuant to G.L. c. 123, § 21 – demonstrates that not a single Medication Restraint was ordered in the period from June 26, 2021 through November 25, 2021. While this, by law, should establish that no PS were subjected to chemical restraint, restraint and seclusion orders show that a staggering 370 ETOs were administered in conjunction with manual holds, mechanical restraints, or during seclusion.⁴⁹

ETOs Noted in Restraint and Seclusion Orders Provided to DLC During Current Reporting Period		
Month	Number of Days	Number of ETOs
June (26 – 30)	5	13
July (1 – 31)	31	79
August (1 – 31)	31	84
September (1 – 30)	30	80
October (1 – 31)	31	58
November (1 – 25)	25	56
Total	153	370

This 370, of course, does not account for the significant number of ETOs recorded in PS medical records that occurred either without manual holds or with manual holds and other restraints that were omitted from restraint packets provided to the DOC

⁴⁶ 104 CMR 27.12(8)(3)(a).

⁴⁷ 104 CMR 27.12(8)(b).

⁴⁸ 104 CMR 27.10(6)(b).

⁴⁹ Restraint and seclusion orders ask whether ETO was administered during, before, or after the restraint or seclusion. The orders indicate whether ETO was administered, though not whether it occurred during, before, or after restraint or seclusion. Manual holds or mechanical restraint may be stated to be carried out for the purpose of administering the ETO.

Commissioner.⁵⁰ In sum, nursing notes, restraint and seclusion orders, and clinical records demonstrate that ETOs were widely used to control behaviors that do not justify chemical restraint, i.e., where no imminent threat of serious harm to self or others existed.

We emphasize that DLC gathered this information about ETOs from various types of documentation and records; neither Wellpath nor DOC track, report, or compile this information. DMH-run and -licensed facilities, conversely, do so pursuant to DMH regulations, which appropriately define medication restraint and adhere to reporting obligations under G.L. c. 123, § 21.⁵¹ Until tracking and reporting requirements are enforced, Wellpath and DOC fail to act in accordance with the law and all interested parties lack the ability to oversee this widespread *modus operandi* staff use to control PS behaviors and, possibly, to inflict punishment upon them for engaging in disruptive, unhygienic, and otherwise unwanted behaviors. Staff convenience cannot legally justify nonconsensual invasion of PS' bodily integrity. Additionally, these medications are generally administered intramuscularly (IM), with the added restraint of manual hold – an equally unjustified restraint when no imminent threat is present.

Examples of Wellpath staff administering ETOs when there was no recorded imminent threat of serious harm, or when it appeared that the reported threat of harm could have been mitigated using a less restrictive intervention, include:

- PS was “uncooperative and agitated” (unspecified). PS “[r]equired manual hold to safely administer IM ETO medications.”
- PS was “uncooperative and verbally aggressive” (unspecified) with staff. PS required manual hold to safely administer IM ETO medications.
- PS banged on his door, demanding food. Staff told PS there was not any food available at that moment. PS continued banging loudly, disrupting the unit, and couldn't be redirected. MD was notified and ETO meds were administered using a manual hold.
- PS was yelling, banging on his door and kicking the wall late at night for about 45 minutes. Therapeutic communications and oral medication were offered but PS

⁵⁰ Wellpath defines manual holds as restraint. Bridgewater State Hospital Policy and Procedure Manual, Title PC 400-08 – *Use of Seclusion and Restraint*, 7.1 (effective 1/24/2020). However, DOC policy entitled *Use of Seclusion and Restraint for Bridgewater State Hospital* improperly excludes certain manual holds from its definition of restraint, limiting a PS freedom of movement, including the physical holding of a person served by a staff member for purposes of placing a person served in seclusion or restraint. 103 DOC 651.01. To Wellpath's credit, it still considers manual holds to be restraints for which orders are required, counts them as restraints, and includes the restraints in the packets for Commissioner's review. In many instances, however, the orders were not done as required.

⁵¹ DMH regulations require that at the end of each month, DMH facilities submit to the Department copies of all restraint and seclusion forms with attachments and an aggregate report for each facility unit containing statistical data on the episodes of restraint and seclusion for the month. The Commissioner or designee reviews such aggregate reports and a sample of restraint and seclusion forms, and maintains statistical records of all uses of restraint or seclusion, organized by facility and unit. 104 CMR 27.12(8)(i).

continued to be disruptive. An IM ETO of Benadryl, Ativan and Haldol was administered using a manual hold.

- PS “was causing a climate issue while on the phone, yelling, and not receptive to staff’s verbal redirection.” The yelling was causing others in the unit distress. PS secluded and ETO administered.
- PS was placed in a manual hold for safe IM ETO of Zyprexa and Benadryl “due to exhibiting bizarre behaviors:” covering camera, screaming uncontrollably, tearful, and banging on door. PS refused oral medication and could not be redirected.
- PS was “on hunger strike, attempting to assess and patient jumping up and posturing at staff. ETO IM administered.”
- PS was pacing inside his room, “throwing breakfast to one of the staff members,” smearing the rest of his breakfast on his windows and floor, and refusing to give back the Styrofoam trays. PS refused oral medications, and staff placed PS in a manual hold to escort PS to another room to administer the ETO.
- PS made unspecified “verbally threatening” statements to Unit Director, was offensively swearing loudly, and threw food against the wall and floor. Staff were unable to redirect his behavior, so PS placed in seclusion and ETO administered.
- PS was hiding under his bed surrounded by a blanket and mattress. Staff could not determine whether PS was safe, and tried to persuade him to reveal himself. When staff called a code green, PS “began begging and yelling profanities” at staff. PS refused medication, and the on call-psychiatrist ordered IM ETO of Haldol and Ativan. The ETO was administered with a manual hold.
- PS became anxious during recreation time in the yard and began crying, and told staff his penis had fallen off and not to take it away, and that he needed to be taken to a hospital right away. PS was fixated in this belief despite staff explaining no one was trying to take his private parts. PS refused to return to his room after his rec time was up. Staff escorted PS to his room using a manual hold; IM ETO medications Zyprexa and Benadryl were ordered and administered.
- PS urinated outside in the yard during rec time, exposing his genitals. When staff asked why he peed in the yard, PS stated, “It’s for convenience.” PS refused to lock into his room after rec time, and instead went into the TV room. PS was secluded in the TV room “to ensure PS safety” and staff administered ETO IM medications.
- PS threw food at staff when he was being handed a food tray. PS seemed agitated and refused oral medication. “Prior to this occurrence, PS had been banging on his door, spilling water from his toilet to the floor.” Staff manually held PS for an IM ETO of Thorazine.

- PS refused to transfer from one unit to another (reason for transfer unspecified) and “started with verbal aggression and threat to staff (unspecified). After PS refused oral medication and continued “verbal aggression,” PS “required a manual hold” and placed in mechanical restraints to administer ETO IM medication.
- PS covered his door and camera, and smeared feces on the walls of his room despite redirection from staff. Staff placed PS in mechanical restraints (handcuffs) for transport to seclusion room where he was placed in 4-point restraints and IM EMO of Ativan and Thorazine was administered. PS was placed again in 4-point restraints the following two days for smearing feces and threatening to destroy things in his cell. On those two days, he did not receive ETOs.

In many instances, ETOs were administered long after emergency circumstances subsided. Reports set forth incidents in which PS receive ETOs after calmly being escorted to their rooms or in upwards of 40 minutes after seclusion was initiated with no observations in the interim recorded that provide justification for the delayed ETO. For example:

- At 9:55 AM, PS became agitated in the BSH clinic, jumped out of his chair and attempted to assault staff. Staff restrained PS with a manual hold, followed by handcuffs, and escorted PS to his room. The mechanical restraint order then described PS as calm following the escort, and staff were able to remove handcuffs. Fifty minutes later, the psychiatrist ordered an oral ETO based on the PS’ behavior in the clinic. PS refused to take it, saying, “I’m not taking no fucking Thorazine.” Despite the lack of further emergent behaviors, the psychiatrist ordered the medications to be administered IM. Staff performed a manual hold restraint for the IM ETO.
- PS assaulted another PS in the day room, in retaliation for an assault two days earlier. According to staff notes in the PS’ clinical records, the video showed that he grabbed his peer and repeatedly struck him. Staff restrained PS with a manual hold and escorted to his room, where he was secluded at 11:10 AM. During seclusion PS was observed pacing, and said to staff, “They better not try to medicate me. I’m not taking medications but they can try.” PS asked to take a shower because he had blood on his arm.

The psychiatrist assessed PS, who said he could not recall what had happened, but if given ETO he will fight. The psychiatrist’s mental status exam found PS to be alert and oriented to person, time and place; making normal eye contact; and noted PS was pacing in room but with no other psychomotor agitation. The psychiatrist explained to PS that given the nature & severity of the assault, he would need to give him medication and keep him secluded.

Seclusion checks show that PS was calm in seclusion for an extended period of time before meeting with the psychiatrist: the first four ten-minute checks observe

him to be calm, at the next check, he is washing his hands, and then four more ten-minute checks describe PS as calm. However, just before PS was medicated – most likely at the time he was told it would be ordered – PS became angry, and was medicated with an ETO of Thorazine, Ativan & Benadryl IM with a manual hold.

- According to clinical records, PS came out for rec time at noon, asked to take a shower, and threw his soap at the Therapeutic Safety Technician (TST). PS was loud and argumentative with staff. After his shower PS was screaming that he needs to “speak with the ethics committee,” and he “knows what is going on here;” PS continued to be “paranoid about staff.” After some discussion with TST, he told the TST would be able to go back to his room without violence, but he continued to be “verbally aggressive.” PS returned to room without incident. He was secluded for a half hour, and an ETO for Haldol, Ativan and Benadryl were ordered just before seclusion ended when PS was calm.

DLC interviewed multiple PS who had been subjected to and observed repeated ETOs, providing details and points of view not contained in the records created by Wellpath staff. PS describe ETOs as happening often to them and others, which may entail TST’s entering with their rooms wearing black tactical gear and helmets and carrying a large shield intending to forcibly impose their will on PS: “If PS act out in any way, they will inject meds.” Some PSs describe accepting oral medication under duress – a group of staff outfitted in tactical gear threaten to use force to hold the PS down for an injection if the PS refuses to take the medications orally.

C. *Improper Physical Restraint & Seclusion Practices*

DLC also found through our intensive review of practices during this reporting period that Wellpath is subjecting PS to improper physical restraint – in the form of manual holds – and seclusion. As with chemical restraint, records indicate that Wellpath staff imposed restraints on PS in the absence of any stated imminent, serious threat to self or others. Indeed, in many instances, Wellpath orders and clinical notes describe incidents in such vague or broad terms that it is difficult to understand what justified the forced intervention. Vague terms such as “threats,” “threatening,” “posturing,” “aggressive” are frequently used, instead of specific descriptions of the PS’ actions, statements, and condition. Finally, the forms Wellpath utilizes to track orders do not require staff to describe the less intrusive or restrictive alternatives, or to record de-escalation efforts.

Listed below are examples of physical restraint and seclusion imposed on PS, despite lack of any recorded imminent threat of serious harm to self or others. The descriptions

are derived from the section of the BSH “Nurse Initiation of Seclusion/Mechanical Restraint” form created for describing the “behavioral emergency”.⁵²

- PS was placed in a manual hold and then 40 minutes of seclusion after throwing a cup of water at a TST.
- PS secluded for one hour after “refusing to follow directives from unit staff” (unspecified), screaming and yelling vulgarities; PS is described as dysregulated.
- PS was placed in manual hold then four-point restraint due to severely disorganized behavior, attempting to flood cell and throwing water under the door, blocking doorway with mattress, refusing all treatment. PS is described as “aggressive.” PS was restrained while staff prepared alternative housing placement.
- PS “postured at door” prior to coming out for recreation time, and could not be assessed due to self-dialogue. PS stated, “I hate you.” PS has history of unprovoked assaults on staff and other PS. PS secluded for one hour.
- PS appeared agitated, refused to stay in day room during rec time, paced the hallway, not willing to follow staff redirection or take PRN medication. PS was placed on seclusion for one hour “due to non-compliant behavior.”
- Fifty minutes of seclusion was imposed for PS to “deescalate and cool off” after PS was punched in the back of the head by another PS.
- PS was secluded *for six hours* after walking with a cup of urine toward another PS with whom he had had a verbal altercation. TST removed the cup and escorted him to his room and secluded PS because he was at imminent risk of being assaulted by other unit patients in the dayroom and on the unit because of hypersexual activity and history of urinating in cups and throwing at other PS. Seclusion was extended twice because PS remained uncommunicative regarding his impulsive behavior.
- PS described as “agitated,” and naked in his room. PS “has not made any threats to others or of self-harm at this point. However, given his current condition, walking around unit unclothed would put him at risk of injury from other patients who may find this behavior inappropriate.” Seclusion checks note seclusion “for a climate issue.” The first twenty minutes of seclusion checks noted that PS is agitated and yelling. Then, each ten-minute check described PS as sitting on his bed or standing at the door, until seclusion was discharged when he was “clothed

⁵² The section of the form directs staff to: “Describe the observed behavior(s) and/or elements of the Person Served’s presentation and mental status and explain how they signify, for this individual, that he currently presents a behavioral emergency such as THE OCCURRENCE or SERIOUS THREAT OF EXTREME VIOLENCE, PERSONAL INJURY, or ATTEMPTED SUICIDE.”

and in behavioral control.” After initially yelling in his cell, PS was calm for 1 hour and 45 minutes before seclusion was discontinued.

Routinely, seclusion was ordered following conflicts between PS, with no discussion of whether the PS remained aggressive, or of less restrictive alternatives, such as a voluntary timeout, if the PS remained upset or agitated. Some of the seclusion orders describe the PS complying with staff directives and walking to their rooms without needing a manual hold for escort, but still being secluded and often chemically restrained via ETO.

D. Systemic Deficiencies in Reporting Restraint and Seclusion

Based upon DLC’s review during this reporting period, the systemic deficiencies in the utilization and reporting of PS restraint and seclusion are overwhelming. While Wellpath must act within the confines of Massachusetts law when providing care and treatment for PS, DOC bears absolute responsibility for ensuring that its contractor is meeting both contractual and legal requirements. Both Wellpath and DOC must prioritize meeting their respective obligations and protecting the rights and health of PS, all of whom are currently at risk of being subjected to the types of improper restraint and seclusion discussed above. To do so, a complete audit of Wellpath reporting and record keeping is necessary.

DLC highlights for further investigation the following points pertaining to restraint and seclusion reporting as well as DOC’s and Wellpath’s execution of their respective duties:

- Regardless of the dictates of BSH policy, all ETOs ordered in emergency circumstances constitute chemical restraint and must be recorded and reported as such to the DOC Commissioner. In this reporting period alone, hundreds of PS chemical restraints were not reported as required by G.L. c. 123, § 21.
- BSH significantly undercounts its usages of physical restraint and seclusion. Reviewing of daily nursing reports, DLC discovered at least 76 instances of restraint and seclusion (not including ETOs) between June 25, 2021 and November 25, 2021 that were not appropriately recorded or reported to the Commissioner. In addition, the clinical records reviewed demonstrated that even more restraints and seclusions occurred absent requisite orders and documentation.
- Every order of restraint or seclusion issued absent requisite emergency conditions violate the dictates of G.L.c. 123, § 21. Wellpath staff either do not understand or refuse to comply with the legal requirements of this statute. DLC’s review of restraint and seclusion forms completed by Wellpath, compiled by BSH administrators, and submitted to and endorsed by the DOC Commissioner reveals repeated failure to provide sufficient written justification for uses of seclusion and of manual and mechanical restraints on PS. DLC also notes many instances in which additional important details are included in the daily nursing

notes or clinical records which were omitted from the restraint or seclusion orders. While DOC Health Services Division used to conduct in depth records audits to ensure that documentation was sufficient to justify the initial and continuing orders of restraint and seclusion, DLC is not aware of DOC performing such audits in recent history.

- BSH policy requires that the BSH Hospital Administrator provide an aggregated report of each individual use of seclusion and restraint to the BSH Superintendent and the DOC Commissioner on a bi-monthly basis. The report must include the complete medical record documentation of every individual event of seclusion or restraint in the bi-monthly period. DLC found that no such records accompanied the orders.

Relying on DOC alone to conduct an examination of the points listed is insufficient. Lest there be any confusion, however, DOC cannot claim ignorance as to Wellpath's restraint and seclusion activities. DOC approves all BSH policies, including the policy governing the *Use of Involuntary Psychotropic Medication* that explicitly sanctions Wellpath imposing chemical restraint on PS without meeting legal requirements.⁵³ In addition, DOC administrators review and compile the restraint and seclusion documentation and the DOC Commissioner reviews and signs off on it. Accordingly, the Commonwealth must engage DMH or another external party to investigate.

E. *Addressing a Culture of Intimidation – Training, Individualized PS Plans, Debriefs, Peer Support, and Emphasis on Least Restrictive Alternatives*

From the perspective of many PS DLC interviewed, current BSH culture deems use of force to be an acceptable form of treatment, without regard to PS rights, human dignity, or legal requirements. Even PS who simply express frustration, anger, or distress are likely to face TSTs outfitted in tactical gear prepared to force them into submission through the use of ETOs, manual holds, mechanical restraint, and seclusion. One PS reported that Wellpath staff would “supply the disturbance” or in order to give PS chemical restraint, make PS upset with triggering comments or instigating conflict between PS. All of these observations suggest a return to the correctional model of BSH that Wellpath was supposed to dismantle.

Whether based in reality or PS perception, such a culture foreseeably enflames tensions among PS and staff and heightens fear and anxiety, which can exacerbate mental health, in a population already experiencing significant behavioral health issues and the stress of being denied their liberty and held in a correctional facility.

A culture of intimidation is also a gross contradiction of the values of recovery and trauma-informed, person-centered treatment that are supposed to inform the provision of mental health treatment in this Commonwealth. The “Department of Mental Health Seclusion and Restraint Philosophy Statement” expresses a goal of eliminating the use

⁵³ Bridgewater State Hospital Policy and Procedure Manual – *Use of Involuntary Psychotropic Medication*, 5.1 (effective 1/24/2020).

of restraint or seclusion – a goal that “is consistent with a mental health system that treats people with dignity, respect and mutuality, protects their rights, provides the best care possible, and supports them in their recovery.”⁵⁴ DMH further recognizes these truths that Wellpath would do well to remember:

Any intervention that recreates aspects of previous traumatic experiences or that uses power to punish is harmful to the individuals involved. In addition, using power to control an individual’s behavior or to resolve arguments can lead to escalation of conflict and can ultimately result in serious injury or even death.⁵⁵

Current BSH culture and its overreliance on restraint and seclusion suggest grave failures in supervision and training. Wellpath staff, and the Wellpath and DOC administrators charged with running BSH and the OCCC Units, must be appropriately trained regarding the dictates of G.L.c. 123, § 21, to prevent restraint and seclusion whenever possible, and to appreciate:

1. the harmful emotional and physical effects of restraint and seclusion on patients and staff;
2. the impact of trauma, including sexual and physical abuse and witnessing of violence, on individuals;
3. the impact of restraint or seclusion on individuals with a history of trauma, including the potential for retraumatization;
4. crisis prevention approaches and de-escalation strategies;
5. the use of the individual crisis prevention plan.⁵⁶

To reduce reliance on restraint and seclusion, Wellpath must fully implement the Personal Safety Plans (PSP) required under its Restraint and Seclusion policy,⁵⁷ and bring its review and implementation of such plans up to the level of Individual Crisis Prevention Plans, which are an essential part of DMH facilities’ strategic plans for reducing, and, wherever possible, eliminating the use of restraint and seclusion.⁵⁸ At BSH, a PSP is supposed to be started at the onset of the hospital admission, documenting PS preferences and recommendations for intervention if a situation arises that could lead to seclusion and restraint. Appropriately implemented under BSH policy, the plans would reduce the instances of restraint and seclusion by identifying a) techniques and methods that would help the PS to control his behavior; b) triggers that are upsetting or evoke distress for the PS; and c) any history of sexual or physical abuse that could place the PS at greater psychological risk during seclusion or restraint.

⁵⁴ Department of Mental Health Seclusion and Restraint Philosophy Statement (September 18, 2007), <https://www.mass.gov/lists/department-of-mental-health-seclusion-and-restraint-philosophy-statement>.

⁵⁵ *Id.*

⁵⁶ 104 CMR 27.12(2). These DMH regulation require that all DMH licensed facilities to ensure that all “staff who may be involved in restraint and seclusion receive training in the prevention and minimal use of restraint and seclusion” and that, at a minimum, such training include those five listed topics.

⁵⁷ Bridgewater State Hospital Policy and Procedure Manual, Title PC 400-08 – Use of Seclusion and Restraint, 5.1 (effective 1/24/2020).

⁵⁸ 104 CMR 27.12(2)(h), 27.12(4).

Staff are to collaborate with the PS to identify factors that may contribute to escalating dangerous behavior, as well as steps that would be helpful for reducing such behavior. The PSP is to be reviewed and updated after each seclusion and restraint event, and as otherwise needed.

DLC did not find one completed PSP – called “De-Escalation Preference Interview/Personal Safety Plan” – in seven clinical records reviewed. Two attempts were made close to the time of admission, generally when PS was clinically unstable; social work staff noted that PS was not cooperating or engaging in clinical contact and made no further attempts to complete the plan. Each of the PS was subsequently restrained and secluded multiple times.

By contrast, staff in DMH hospitals are required to develop a plan even if the patient cannot cooperate initially, using available information, and must make continuing efforts to encourage the patient to participate in reviewing and revising the plan.⁵⁹ Relevant clinical data and trauma history is likely available for PS who have been to BSH previously; when appropriate, family members can be consulted.⁶⁰ Finally, once the plan is developed, it should be updated to reflect any changes in triggers and strategies, as well as following any restraint or seclusion episode.⁶¹ A copy should be given to the PS and staff on all shifts should be aware of and have access to the plan.⁶² DOC and Wellpath must revise BSH policy to include these requirements and ensure that staff are trained and fully implement the policy.

Wellpath and DOC must make every effort to ensure that staff employ least restrictive alternatives; for example, and that quiet rooms are available for voluntary timeout and de-escalation prior to imposing seclusion. While it was reported during the September 2021 Governing Body Meeting that several Comfort Rooms are open, DLC did not observe that during on-site monitoring or in conversations with PS or staff.

Wellpath staff must prioritize meeting with PS to debrief all instances of seclusion and restraint. DLC review found that debriefing was not completed following some episodes of restraint and seclusion. In DMH facilities, the regular use of debriefing activities for both patients and staff is an essential component of reducing episodes of seclusion and restraint.⁶³ Debriefing can also mitigate the potentially traumatizing effects of a restraint and seclusion event.⁶⁴ The current BSH debriefing policy requires identifying with PS what factors led to the seclusion or restraint, and what steps could potentially have avoided the episode; PS perception of his well-being, both physical and psychological, during the event; discussion of possible modification to the PS treatment plan and PSP; and any counseling needed.⁶⁵ BSH must add to its policy the requirement that the

⁵⁹ 104 CMR 27.12(4)(b).

⁶⁰ *Id.*

⁶¹ 104 CMR 27.12(4)(c).

⁶² 104 CMR 27.12(4)(d).

⁶³ 104 CMR 27.12(4)(j).

⁶⁴ See National Association of State Mental Health Program Directors (NASMHPD), *Six Core Strategies for Reducing Seclusion and Restraint Use* (2006).

⁶⁵ Bridgewater State Hospital Policy and Procedure Manual, Title PC 400-08 – Use of Seclusion and Restraint, 6.2 (effective 1/24/2020).

debrief include discussion of the adequacy of the PS' PSP.⁶⁶ BSH should also increase the time for required debriefing from 24 to 48 hours, in keeping with DMH regulations,⁶⁷ to allow for further time and reflection on the episode, and if needed, to make more than one attempt to meet with the PS. BSH should also require that staff who are not involved in the restraint be the ones to debrief the PS; that staff document all patient responses to the episode, even if the PS does not complete the form; that PS shall have opportunity to provide comments following the debriefing period, and that staff shall continue to make efforts to engage the patient who has refused to participate in debriefing as clinically appropriate.⁶⁸ Finally, the debriefing forms should be included as attachments to the restraint seclusion forms and provided for the Commissioner's review, as they are in DMH facilities.⁶⁹

Finally, DLC recommends that BSH integrate peer support specialists in efforts to reduce restraint and seclusion by increasing peer involvement and support for PS who experience high rates of restraint (including ETOs) and seclusion and soliciting recommendations from peer support specialists for additional methods for reducing restraint and seclusion. Peer supports are an essential component of DMH facility efforts to reduce restraint and seclusion.⁷⁰

Recommendations:

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

The Commonwealth must demand that DOC and Wellpath accurately document and report all uses of chemical restraint, physical restraint, and seclusion in keeping with applicable law and engage DMH or another external party to conduct an in-depth investigation into BSH practices. Without accurate documentation and data concerning restraint and seclusion, the care and treatment PS receive at BSH and in the OCCC Units cannot be measured against the data and standards in DMH facilities.

Both Wellpath and DOC must prioritize meeting their respective legal obligations and protecting the rights and health of PS, all of whom are currently at risk of being subjected to the types of improper restraint and

⁶⁶ DMH regulations require review of Individual Crisis Prevention Plans in debriefing with patients. 104 CMR 27.12(5)(b)(1)(b).

⁶⁷ 104 CMR 27.12(5)(b)(1).

⁶⁸ 104 CMR 27.12(5)(b)(2) & (3).

⁶⁹ Unlike DMH regulations, BSH's restraint and seclusion policy does not require that debriefing forms be attached to the restraint and seclusion orders, and does not require that attachments to orders be included in the packets sent to the DOC Commissioner and BSH Superintendent. 104 CMR 27.12(5)(b)(4), 27.12(8)(i).

⁷⁰ See 104 CMR 27.12(2)(e); NASMHPD, *Six Core Strategies for Reducing Seclusion and Restraint Use* (2006).

seclusion discussed above. To do so, both DOC must resume regular audits of Wellpath restraint and seclusion reporting and record keeping.

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

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

To reduce reliance on restraint and seclusion, Wellpath must properly implement Personal Safety Plans (PSP) requirements.

Wellpath should integrate peer support specialists in efforts to reduce restraint and seclusion by increasing peer involvement and support for PS who experience high rates of involuntary medication, chemical and physical restraint, and seclusion.

3. Limitations on Persons Served Access to Medical Care

In this reporting period, DLC has observed through data and reports from PS concerning limitations on PS access to medical care due to processes in place at BSH. Unlike prisoners in other DOC facilities and county correctional facilities, because of processes in place at BSH, PS lack sufficient mechanisms for making direct requests and inquiries to medical staff regarding their medical issues.

DOC prisoners are able to file written sick call slips with medical staff, making a record of their medical issues and requests for medical attention. Through these slips, prisoners get appointments with providers or written responses. If a DOC prisoner is aggrieved by the care or written response received, they may file a medical grievance that is handled by the facility Health Services Administrator, who provides a written response indicating that some action will be taken or that the requested relief is denied.

While not the ideal system by any means, the processes available to BSH PS are much more opaque. Especially during the pandemic, PS are siloed to their assigned units at BSH; PS do not have the opportunity to walk into the medical building to speak with medical staff without an appointment or staff escort. There is no policy, procedure, or form for PS to directly notify medical staff in writing about their medical issues or their requests for treatment thereof. PS are left with two uncertain options.

First, PS can rely on TSTs, mental health staff, nursing staff, and Wellpath personnel who they happen to interact with to pass on their medical concerns and requests to medical staff. The likelihood that a PS attempt to engage busy BSH staff about issues outside of their purview will be successful and that said staff will remember to pass on – or credit as legitimate – the medical concerns of a PS to facility medical staff is low. One PS described repeatedly seeking help with a serious medical issue to no avail over the course of an eight-month commitment – his caseworker told the PS it wasn't his job to help with medical issues and the staff on his unit, the forensic evaluator, the nurse, and the PS Advocate all directed him to speak with someone else. This PS did not receive the care he needed until after he was discharged from BSH.

The second option is to submit a formal written grievance to the Person Served Advocate, who is not a member of medical staff. The Person Served Advocate is charged with processing a very high volume of grievances covering a broad range of topics and few result in any action. From July through November 2021, PS filed 485 grievances against Wellpath with the Person Served Advocate. The most grieved issues were medical (71/485), staff (75/485), and clinical treatment (64/485). Of these 485 grievances, 258 were determined non-grievable and only 30 were supported with corrective action taken. None of the resolutions reported pertain to medical grievances.⁷¹ Grievances deemed non-grievable are referred back to treatment teams,

⁷¹ DLC commends PS Advocate resolution of grievances including training staff on protocols for handling legal mail, replacing rusty nail clippers, placing clocks in traps where PS can see them, scheduling yard access, providing PS with menus, resolving dietary issues for food allergies, and resolving property issues.

which may be the root of the grievance or, in the case of seeking medical treatment, return the PS to the first option of playing a dicey game of telephone.

The lack of any process to provide PS with direct, definite access to medical staff and the high incidence of medical grievances (15%) is extremely concerning for a number of reasons, including:

- The confirmed widespread presence of mold poses health risks to PS for which they are not being screened;
- Wellpath's practice of subjecting PS to chemical restraint and other forms of involuntary medication, which may cause extensive side-effects and other medical issues requiring assessment;
- The world is still in the throes of the COVID-19 pandemic and many PS have comorbidities that place them at higher risk of complications; and
- Wellpath has acknowledged a deficiency in medical 1:1s and has made that the focus of their 2021 Failure Mode and Effects Analysis (FMEA).⁷²

As a general matter, DLC notes that the role of Person Served Advocate is not appropriately utilized by Wellpath. PS cannot call the Person Served Advocate and may only submit written grievances, so there is no informal process of requesting support from any advocate. Handling all grievances leaves the Person Served Advocate with little time or opportunity to provide meaningful advocacy and support for PS. Peer Support Specialists at BSH are not on treatment teams, not involved in intake/admissions, and are not advocates. This paradigm contrasts sharply with Peer Support Specialists and Human Rights Officers in licensed Department of Mental Health facilities.

Recommendations:

DOC and Wellpath must adopt a process that allows PS to submit written requests for evaluation and treatment of medical issues that will be reviewed and responded to promptly by a member of medical staff.

DLC strongly recommends that PS be permitted to call the Person Served Advocate and submit grievances over the phone, in person, as well as in a written format, to ensure that those with different communication abilities are able to access the grievance process.

⁷² See Joint Commission Update 2021 FMEA, Governing Body Meetings September 9, 2021 and December 9, 2021. From July to September 2021, Wellpath sent out PS on almost 250 emergency medical trips and 44 medical hospital admissions.

DLC recommend engaging Peer Support Specialists along with the Person Served Advocate in the grievance process to promote timely review of grievances.

BSH must expand the role of Peer Support Specialists by integrating them into treatment teams and the intake/admission process, while also having them function as advocates through the handling of grievances along with the Person Served Advocate.

4. COVID-Response and Program Reopening

Wellpath began relaxing COVID protocols at BSH, including discontinuing use of cohorts in Hadley and Lenox, over the summer of 2021. The Containment Unit was used intermittently to quarantine PS and closed on September 21, 2021 through the remainder of the reporting period. PS report that use of the Containment Unit, formerly known as the Intensive Treatment Unit (ITU), has had a re-traumatizing and destabilizing effect on PS who had been held in the ITU during previous BSH stays. Before its closure in April 2017, PS experienced excessive restraint and seclusion on the ITU, as recognized through multiple lawsuits and settlement agreements. Since the Containment Unit closed, Bradford remains the most restricted COVID unit.

During the summer 2021, while remote court hearings continued at BSH, Section 18(a)s admitted to BSH from county Sheriffs' Departments nearly tripled (22 to 60). At the same time, there was a significant drop in state prisoner Section 18(a)s admitted to OCCC (42 to 24). This downward trend in state prisoner 18(a)'s continued in Fall 2021 (24 to 10). By the fall of 2021, PS were able to attend court hearings in person.

During Phase I of reopening, in effect during the summer and early fall of this reporting period, all new admissions were quarantined for 5 days, regardless of vaccination or testing status, only to come out of cells for scheduled recreation, showers or calls. On October 26, 2021, BSH updated its COVID-19 quarantine protocol. Fully vaccinated PS who tested negative upon admission were immediately cleared from quarantine, and unvaccinated/partially vaccinated PS were still quarantined for 5 days then, if negative, cleared from quarantine. DLC's main concern continues to be the lack of clinically appropriate treatment and activities for PS quarantined upon admission at a time when they are likely to be in a psychiatrically unstable condition and particularly vulnerable to isolation.

While BSH was still in Phase I of reopening, OCCC BSH Units were running on a pre-pandemic programming schedule. BSH has maintained that, over the reporting period, programming was slowly expanded from off unit programming on a weekly basis to pre-COVID-19 comparable levels off units. Wellpath reopened Recovery Place for programming in mid-September, a full eighteen (18) months after the programming treatment hub of the facility for committed PS was shut down. Three units cohorted together at Recovery Place. As Recovery Place is also where programming for the Developmental Services Program (DSP) is centralized, the closure stunted specialized group treatment for some of the most vulnerable at BSH. Wellpath reports that the DSP is now back to full engagement and has a new Coordinator who is looking to individualize the program more.⁷³ Wellpath has been reporting since it took over the DSP program that it would individualize this programming and improve the quality of treatment for this particularly vulnerable and complex group of men.

⁷³ Rehabilitation Report, Governing Body Meeting, at 2 (December 9, 2001).

Although BSH maintains that by the end of September 2021, BSH reopened treatment milieus and programming to all PS, with the exception of those on the quarantine units, and that programming is also conducted on the units, it does not appear to DLC that programming is up to pre-pandemic levels. During monitoring visits conducted in September, October, and December DLC observed that many PS were in their cells or in the day room not participating in activities, more so than prior to March 2020.

Wellpath maintained video visits while restarting in-person visits. Visitors must be COVID-tested at Talbot House prior to entering any facility, with some exceptions, and mask mandates are still in effect. All PS were still eating meals in their cells, and there are still cohorts on Bradford I and the Lighthouse, as needed.

Three note-worthy initiatives include Family Therapy Sessions for PS and their families, the Culture of Recovery to promote trauma focused services for PS and a “supportive and compassionate work environment” for staff, and piloting of Voyce, a real-time HIPAA compliant video language interpretation service for PS.⁷⁴ While these are improvements, DLC is still concerned with the lack of programming for PS who are at BSH but not yet committed. Recovery Place is only for committed, which means that PS must wait over a month to begin to engage in therapeutic programming. Moreover, Recovery Place is not available to PS who are screened out for security.

Recommendations:

Wellpath must permanently close the former ITU unit and never allow another PS to experience the trauma of isolation in that space, whether for quarantine, seclusion, or any other justification.

Upon admission to BSH, Wellpath must begin assessing PS and offering programming to PS and cease delaying access to meaningful treatment until after determining that the PS will be committed.

DOC and Wellpath must commit to providing appropriate and accessible mental health care to PS with intellectual and/or developmental disabilities. This necessarily includes reviewing best practices for treatment modalities and interventions for individuals with co-morbid mental health and intellectual and/or developmental disabilities; maintaining a robust DSP; and engaging with both DMH and DDS in treatment and discharge planning for PS.

Comfort rooms must be made available to all PS at BSH and in the OCCC Units without further delay.

⁷⁴ Clinical Services Report, Governing Body Meeting (December 9, 2021).

5. Persons Served Continuity of Care

During this second reporting period with DLC's expanded role under Line Item #8900-001, DLC dug deeper into continuity of care issues for PS. DLC explored discharge from BSH and the transfer of individuals to DOC facilities, county correctional facilities, and DMH facilities, gaining perspectives from current and former PS, BSH staff, Sheriff's Department staff and administrators, and family and friends of PS.⁷⁵

DLC has targeted four county Sheriff's Departments for information-gathering through correspondence, documentation requests, and meetings with staff and administrators. Among the four are the Hampden County Sheriff's Department and the Middlesex Sheriff's office, which run the two designated Regional Mental Health Stabilization Units in the Commonwealth. In addition, DLC was able to conduct onsite visits and interviews at BSH, OCCC, Lemuel Shattuck Hospital, and the Hampden County Correctional Center. We also spoke via telephone and videoconference with current PS at BSH and in the OCCC Units, and with former PS at Worcester Recovery Center and Hospital, Vibra Hospital of Western Massachusetts, Lemuel Shattuck Hospital, and in the community. DLC also distributed print surveys to approximately 50 PS discharged to county correctional facilities and an online survey for former PS and PS loved ones.

A. Regional Mental Health Stabilization Centers

DLC explored both of the Regional Mental Health Stabilization Units in examining continuity of care issues. These Units, located in the Hampden Correctional Center and the Middlesex County House of Correction and Jail, are provided funding from the Legislature to operate as a "regional behavioral evaluation and stabilization unit to provide forensic mental health services within existing physical facilities for incarcerated persons in the care of correctional facilities."⁷⁶ Further, among the information that the Centers are required to report on to the House and Senate Committees on Ways and Means is "alleviation of caseload at Bridgewater state hospital associated with fewer incarcerated persons in the care of counties being attended to at the hospital."⁷⁷

Hampden County Sheriff's Department Regional Mental Health Stabilization Unit is intended "to serve the needs of incarcerated persons in the care of Berkshire, Franklin, Hampden, Hampshire and Worcester."⁷⁸ Hampden's Unit, called the Emergency Stabilization Unit (HESU), which has 31 maximum security inpatient beds. All prisoners coming to Hampden from DMH hospitals, private psychiatric hospitals, or BSH go directly to the HESU. For those who are transitioning between BSH and another county

⁷⁵ DLC also experienced turnover in the full-time Advocate position hired in the last reporting period to work on BSH matters. After going through the hiring process again, DLC now has a new highly qualified Disability Rights Advocate.

⁷⁶ Massachusetts FY 2022 Budget, Line Item #8910-1010, *Hampden Sheriff's Regional Mental Health Stabilization Unit*; Massachusetts FY 2022 Budget, Line Item #8910-1101, *Middlesex Sheriff's Mental Health Stabilization Unit*.

⁷⁷ *Id.*

⁷⁸ Massachusetts FY 2022 Budget, Line Item #8910-1010, *Hampden Sheriff's Regional Mental Health Stabilization Unit*.

Sheriff's Department, HESU staff focus on achieving a smooth transition, including preparing for medication issues upon transfer. For Hampden prisoners, the focus is on stabilization and transition either to the less secure Mental Health Unit or a general population unit. Prisoners in HESU beds are held up to two weeks for stabilization; they are under 24-hours observation and are seen by their treatment team at least two times per week. Hampden's mental health team utilizes a team model of collaboration between mental health and security staff and supervisors. If staff are unable to help the prisoner stabilize, they will pursue a Section 18(a). Notably, staff reported that the local court clinician tries to find beds in area hospitals for evaluation before the prisoner is sent to BSH to ensure that they go to the least restrictive setting possible, unless the prisoner's charges or individualized security issues require the strict security of BSH.

The Regional Mental Health Stabilization Unit run by the Middlesex Sheriff's Office is intended to cover the eastern counties of Barnstable, Bristol, Dukes County, Essex, Nantucket, Middlesex, Norfolk, Plymouth, and Suffolk.⁷⁹ Middlesex's Emergency Stabilization Unit (MESU) operates within its Health Services Unit, which has a total of 22 beds. As a result of this fixed limited space, there is a shortage of beds that may give rise to delays in accepting transfers from other counties, but the MESU never declines. The MESU does operate as a stopover for some people before going to BSH for evaluation. BSH determines whether PS from other county Sheriff's Departments go to their home counties or the MESU upon discharge. In the Health Services Unit, the MESU has 24-hour nursing coverage, daily clinician rounds, access to clinicians based via sick call slips or in response to crises. Multidisciplinary meetings are held daily to discuss the needs of MESU, participation in treatment and programming, and programming to foster transition to the general population.

Both Regional Mental Health Units receive oversight and an annual quality review from DMH. Based on the information gathered during this reporting period, the degree of regular coordination between DMH and the HESU and MESU regarding care of prisoners in those units appears dependent on whether the prisoner is already a DMH client. HESU also reported making weekly contact with the DMH Forensic Services Division to advocate for their prisoners to be admitted to DMH hospitals upon release from the correctional facility.

Based on the information DLC gathered from the Sheriff's Departments, the Regional Mental Health Stabilization Units are underutilized by other county correctional facilities and under-resourced. As borne out by BSH admission and discharge data, many counties send individuals directly to and receive PS from BSH, rather than utilizing the resources at Hampden and Middlesex to promote stabilization and reduction of commitments for evaluation. Indeed, a medical administrator at one eastern Massachusetts county informed DLC that they were not aware of the MESU or that they could send their prisoners there for stabilization services. At the same time, some Sheriff's Department staff who are aware of the Units may nevertheless be reticent to take the time to coordinate with the regional units instead of moving immediately for a

⁷⁹ Massachusetts FY 2022 Budget, Line Item #8910-1101, *Middlesex Sheriff's Mental Health Stabilization Unit*.

Section 18(a) because their onsite mental health services are not sufficient to provide necessary mental health services to the individual in crisis, even briefly. This reticence may be bolstered by delay caused by inadequate space and resources, particularly in the MESU. Of course, increased utilization of the Units by other counties would lead to further strain on the resources of Hampden and Middlesex.

The underutilization of the Regional Mental Health Stabilization Units is certainly not due to lack of demand. In speaking with administrators and staff from the four targeted Sheriff's Departments and other county correctional facilities over the course of this reporting period, all report an overwhelming number of individuals entering their facilities in need of mental health care. Correctional facility administrators and mental health staff from various counties expressed that the current Wellpath model at BSH emphasizing competency restoration and the change in mission has increased strain on county correctional facility mental health and security staff, especially in counties without the additional resources that come with housing a Regional Mental Health Stabilization Unit and other earmarked funding. Prisoners sent to BSH return faster than in the past, especially those who have significant behavioral issues that give rise to repeated disciplinary action. The days are gone when county correctional facilities were able to send a prisoner to BSH for respite, serving the mental health needs of the prisoner and providing county correctional facility staff much-needed time to regroup.

B. Major Failings with PS Discharge from BSH to County Correctional Facilities and DMH Facilities

While DMH and Sheriff's Department administrators and staff report a gradual improvement of information sharing when a BSH PS is being discharged to their facilities, there are still occasions when they receive short notice of a PS's pending arrival. Conversely, current and former PS report being provided no opportunity to participate in any discharge planning or even being made aware of the plan decided upon prior to discharge. For example, one individual discharged from BSH to a DMH hospital reported that he had no idea he was being discharged from BSH or why up until he was leaving the facility. In most circumstances, according to PS and BSH staff, PS get notice less than two hours prior to discharge/transfer to reduce incidents at BSH. Former PS with whom DLC spoke invariably report that they did not receive a copy of their discharge plan from BSH. Understandably, former PS indicate that performing discharges in this way induces stress and does not promote a stable transition to their new placement. Once they arrive, the receiving facility and the discharged PS are left to deal with the aftermath.

Formulary inconsistencies also rank among the drivers of difficult transition between BSH and county correctional facilities. DLC has discussed with Sheriff's Department staff and administrators, as well as current and former PS, having to transition from medication that helped to stabilize the PS at BSH to different medications on the more limited formularies of the receiving county correctional facility. Obviously, these transitions can be difficult and it is DLC's position that discharged PS should not be subjected to this trying, countertherapeutic, and potentially dangerous process. Still, not even the Regional Mental Health Stabilization Units offer the same formulary as BSH.

Strikingly, one administrator from a county correctional facility noted that BSH and the county Sheriff's Department all utilize the State Office of Pharmacy Services – meaning, all of the same medications are available – but that each Sheriff's Department is able to decide which medications will be on their correctional facilities' formulary and under what circumstances prisoners will be approved for non-formulary medications. This system is designed to fail.

D. DMH Engagement with County Correctional Facilities

It is abundantly clear that increased support from DMH is needed to support continuity of care for PS transitioning to county correctional facilities, DMH and community hospitals, and the community. Sheriff's Departments report that, despite the high demand for mental health services among prisoners, many of the individuals entering custody are not current DMH clients and DMH has minimal involvement in their mental health care. And, even when prisoners are DMH clients, DMH is not involved until the prisoner is nearing reentry and may receive transition planning from DMH's Forensic Services Division.

To improve PS continuity of care, foster positive outcomes, and reduce recidivism of PS and other prisoners with behavioral health conditions, DMH should be charged with providing more oversight of county correctional facilities and direct support for people in their custody. DMH is the best-situated and most qualified agency to fill the gaps.

At present, the Commonwealth's county correctional system is fragmented in terms of the mental health treatment each facility provides, depending on space, staffing levels, funding, formulary, staff training and culture, and other variables. The Commonwealth needs more robust guidelines for all corrections facilities to ensure that placement in a particular facility does not impact whether someone has access to appropriate mental health care. While every Sheriff's Department should be offering meaningful, individualized mental health services to individuals within their facilities, that is not often the case. DMH needs to become more engaged in evaluating mental health treatment in all county correctional facilities, enforcing minimum standards, promoting best practices, and creating working groups to ensure a collaborative approach to care and responsiveness to the needs of this population.

Moreover, DMH should be more engaged in the care and treatment of individuals with significant behavioral health needs in county correctional facilities, especially with respect to BSH PS transitioning to county correctional facilities. To bolster continuity of care for these PS, DMH should employ clinicians and case managers to provide support to the PS and facility mental health staff, and make peer specialists accessible to provide advocacy and support to the PS within the correctional facility. In addition, upon identification of need by county correctional facilities or self-identification by prisoners, DMH should expeditiously identify whether prisoners qualify for DMH services. Assessment by DMH and approval for services can be a lengthy process. DMH must eliminate red tape to ensure that individuals receive appropriate care within correctional facilities and that that care continues without disruption upon reintegration to the community.

As people of color are overrepresented within the population of the Massachusetts correctional system and BSH, they bear the brunt of this lack of appropriate mental health care. These issues must be addressed immediately.

Recommendations:

DLC recommends that the Commonwealth, through the State Office of Pharmacy Services or otherwise, implement standardized formularies for BSH and county correctional facilities or, at the least, require that special consideration be given to non-formulary mental health medication requests from individuals who have transitioned from the BSH to a county correctional facility.

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

DMH should devote resources to ensuring that PS transitioned to county correctional facilities can access appropriate mental health services and supports while incarcerated and promptly upon release.

6. Additional Issues Requiring Continued Monitoring

- Continuity of Care for OCCC Unit PS returning to DOC facilities
- Unequal treatment of PS in OCCC Units
- OCCC ISOU installation of remote monitoring station for 1:1
- BSH admission processes, including strip searches and ETOs
- TST Training and Interactions with PS amounting to use of force
- Discharge planning for long term PS
- Staff Vacancies and Turnover (DOC Deputy Commissioner and Assistant Deputy Commissioner; Wellpath Assistant Hospital Administrator, Risk Manager, Director of Social Services, Director of Rehabilitation, DSP Coordinator, Unit Directors and many front line staff positions)
- Expansion of use of Zyprexa Relprevv, given concerns regarding administration and reporting of medication, and such use is not standard within DMH
- Persistent advocacy from former Psychiatry Faculty Member to the Massachusetts Psychiatry Society regarding delays related to the adjudication of Court Authorized Treatment Plans focused on skirting due process for PS, rather than participation in person-centered individualized treatment
- Joint Commission Accreditation for Behavioral Health Care and Human Services, not as a Psychiatric Hospital

Conclusion

To ensure the safety and treatment of persons served at BSH and in the OCCC Units, DLC calls upon DOC, Wellpath, and the Commonwealth to follow the recommendations discussed above in Sections 1 through 6 and restated below:

DISABILITY LAW CENTER RECOMMENDATIONS:

1. Physical Plant Health and Safety Risks – Pervasive Mold and Potential Asbestos Exposure:

DOC must immediately remediate mold and assess for other environmental toxins existing in the physical plant at BSH in accordance with expert recommendations and industry standards.

DOC and Wellpath BSH must provide regular health screenings for symptoms of mold and environmental toxin exposure to all PS and staff, provided by a contracted health professional with expertise in the area. Without a plan for systematic detection, to support appropriate prevention and treatment, BSH faces untold numbers of sick PS and staff due to the documented presence of mold and asbestos that have existed for years throughout the physical plant.

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

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

2. Illegal and Unreported Use of Restraint and Seclusion:

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

The Commonwealth must demand that DOC and Wellpath accurately document and report all uses of chemical restraint, physical restraint, and seclusion in keeping with applicable law and engage DMH or another external party to conduct an in-depth investigation into BSH practices. Without accurate documentation and data concerning restraint and seclusion, the care and treatment PS receive at BSH and in the OCCC Units cannot be measured against the data and standards in DMH facilities.

Both Wellpath and DOC must prioritize meeting their respective legal obligations and protecting the rights and health of PS, all of whom are currently at risk of being subjected to the types of improper restraint and seclusion discussed above. To do so, both DOC must resume regular audits of Wellpath restraint and seclusion reporting and record keeping.

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

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

To reduce reliance on restraint and seclusion, Wellpath must properly implement Personal Safety Plans (PSP) requirements.

Wellpath should integrate peer support specialists in efforts to reduce restraint and seclusion by increasing peer involvement and support for PS who experience high rates of involuntary medication, chemical and physical restraint, and seclusion.

3. Limitations on Persons Served Access to Medical Care:

DOC and Wellpath must adopt a process that allows PS to submit written requests for evaluation and treatment of medical issues that will be reviewed and responded to promptly by a member of medical staff.

DLC strongly recommends that PS be permitted to call the Person Served Advocate and submit grievances over the phone, in person, as well as in a written format, to ensure that those with different communication abilities are able to access the grievance process.

DLC recommend engaging Peer Support Specialists along with the Person Served Advocate in the grievance process to promote timely review of grievances.

BSH must expand the role of Peer Support Specialists by integrating them into treatment teams and the intake/admission process, while also having them function as advocates through the handling of grievances along with the Person Served Advocate.

4. COVID-19 Response and Program Reopening:

Wellpath must permanently close the former ITU unit and never allow another PS to experience the trauma of isolation in that space, whether for quarantine, seclusion, or any other justification.

Upon admission to BSH, Wellpath must begin assessing PS and offering programming to PS and cease delaying access to meaningful treatment until after determining that the PS will be committed.

DOC and Wellpath must commit to providing appropriate and accessible mental health care to PS with intellectual and/or developmental disabilities. This necessarily includes reviewing best practices for treatment modalities and interventions for individuals with co-morbid mental health and intellectual and/or developmental disabilities; maintaining a robust DSP; and engaging with both DMH and DDS in treatment and discharge planning for PS.

Comfort rooms must be made available to all PS at BSH and in the OCCC Units without further delay.

5. Persons Served Continuity of Care:

DLC recommends that the Commonwealth, through the State Office of Pharmacy Services or otherwise, implement standardized formularies for BSH and county correctional facilities or, at the least, require that special consideration be given to non-formulary mental health medication requests from individuals who have transitioned from the BSH to a county correctional facility.

DMH resources should be committed to further DMH engagement with all county correctional facilities regarding mental health treatment. Such engagement should include enforcing minimum standards, promoting best practices, and creating working groups to ensure a collaborative approach to care and responsiveness to the needs of this population.

DMH should devote resources to ensuring that PS transitioned to county correctional facilities can access appropriate mental health services and supports while incarcerated and promptly upon release.

Appendix A: Glossary of Acronyms Used in the Report

BSH	Bridgewater State Hospital
DDS	Department of Developmental Services
DLC	Disability Law Center
DMH	Department of Mental Health
DOC	Department of Correction
DSP	Developmental Services Program
ETO	Emergency Treatment Order
HESU	Hampden Emergency Stabilization Unit
IDO	Irreversible Deterioration Order
IM	Intramuscular
ITU	Intensive Treatment Unit
ISOU	Intensive Stabilization and Observation Unit in the Bridgewater Annex located at Old Colony Correctional Center
MESU	Middlesex Emergency Stabilization Unit
OCCC	Old Colony Correctional Center
PS	Person(s) Served
PSP	Persons Safety Plan
RU	Residential Unit in the Bridgewater Annex located at Old Colony Correctional Center
TST	Therapeutic Safety Technician

**Appendix B: Gordon Mycology Laboratory, Inc. Mold Inspection
Report & AccuScience Laboratory Results**



P.O. Box 310, Groton, MA 01450
Phone: 978-448-9954 Fax: 978-448-9152

Mold Inspection Report

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

Project ID: 21-100GML
Inspection Date: December 6, 2021

January 7, 2022

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

Dear Ms. Pritchard:

The following report details observations, laboratory results, and recommendations from a mold inspection performed by Gordon Mycology Laboratory, Inc. ('GML') on December 6, 2021 in several buildings of Bridgewater State Hospital located at 20 Administration Road in Bridgewater, MA. The goal of the inspection was to evaluate areas in which mold remediation, cleaning, and upgrades were performed two years ago as well as several other buildings/areas that had been previously inspected for potential mold growth sources. Appropriate recommendations for any confirmed problems are provided in this report.

Inspection and Laboratory Procedures

GML initially inspected and tested several areas of the property in December 2019. Most of the same areas inspected in 2019 were re-inspected visually and with testing during this inspection. Photographs were taken in all inspected areas.

Culturable surface swab samples were collected using sterile sampling supplies and industry-standardized sampling procedures from building materials in the basements of the Medical and Administration Buildings, HVAC system components in several buildings, and suspect building materials in other inspected areas 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 potential mold growth sources that may be remaining or may have recurred since the last GML inspection.

Background Information

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

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 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
 - Many surfaces had been painted but it was noted that in some areas, rust and mold growth had been painted over
 - Self-contained modular air filtration unit in the ceiling of the old IPS Record Room remained filthy, as it was two years ago; this unit is not in operation any longer (it had been used to help remove cigarette smoke when smoking was allowed in the building), but based on its condition, it should be removed
 - Visible mold growth on wall framing, plywood partition wall, ventilation system vents, painted concrete walls, ceilings, and baseboards
 - Men's and women's bathrooms, both reportedly not in use currently, were clean and free from visible mold growth; rust was noted on metal surfaces from chronically elevated relative humidity levels presumably from when the showers were used and compounded by the historic steam release event a few years ago
 - Women's bathroom had some remaining wood door framing and baseboard trim that was water damaged and moldy; the door and baseboard trim should be replaced with metal and tile, respectively
 - HVAC system ceiling diffusers had been painted over but rust and a significant amount of accumulated black dust/debris remained inside the diffusers; this condition remained unchanged from the 2019 inspection
 - Hallway by the mechanical room and custodian's closet
 - Metal doors rusted at their base
 - Wood doors water damaged, delaminated, and moldy at their base
 - A small patch of the ceiling in an already patched area was water damaged and wet on the inspection; the leak should be identified and repaired immediately
 - Custodian closet with moldy, cotton mop and old stored files that were reportedly being discarded at some point
 - Mechanical room
 - Significant amount of rusted surfaces
 - Wet areas and standing water on the floor
 - Large, deep wastewater sump was full of standing water (raw sewerage), used tampon applicators, and other wastewater debris; the sump's cover

- was open allowing hazardous bacteria and other contaminants to migrate into the mechanical room air
 - Many areas of badly rusted pipes/fittings, some of which were corroded to the point of needing replacement; one of these corroded connections was actively dripping water onto the floor during the inspection
 - Water damage on many surfaces, including pipe insulation wrap
 - Large sections of asbestos pipe wrap remained, some of which were jagged/ripped potentially resulting in hazardous, airborne asbestos fibers
 - Visible mold growth on the asbestos and fiberglass pipe wrap outer covering (organic, fabric/paper-type material)
 - Visible mold growth on wall materials, both porous and painted concrete
 - Metal door framing was rusted out at its base
 - Bucket of standing water with a moldy, flexible tube draining into it
 - No dehumidifier was present in the basement
 - Administration building first floor HVAC system supply diffusers were filthy with black dust; this condition was unchanged from the 2019 inspection
- Medical Building Basement
 - Mold odor detected but was considerably less than during the 2019 inspection
 - Basement was divided in several rooms once used for storage, a large main room, a mechanical room, and an electrical/technology room
 - Basement was mostly empty; rusty, moldy file cabinets with files, building supplies on wood pallets and metal shelves, equipment and tools, etc. remained
 - A hole in one storage room ceiling that had been covered with plastic and tape as of the 2019 inspection remained in the same condition
 - Water marks ran from the ceiling to the floor in the first storage room (with file cabinets)
 - Storage rooms and the main room had been painted; some mold growth was noted beneath the paint and on surfaces where the paint had not fully covered
 - Bubbling and peeling ceiling paint in the green storage rooms appeared to be from water although no other evidence of water was found; this condition remained unchanged from the 2019 inspection (mold growth was noted in some areas above the peeling paint, indicating that the mold was painted over in 2019- as was noted during the 2019 inspection as well)
 - HVAC ductwork had been painted in the past but the paint was peeling and visibly moldy throughout
 - Considerable evidence of accumulated/chronic moisture was noted by rusted metal surfaces, rust staining on floors where metal items had been stored, water damaged building materials, peeling foundation paint, and visible mold growth; many of these conditions remained unchanged from 2019
 - HVAC vents in the green rooms were filthy, almost blocked with black dust and debris; this condition remained unchanged from the 2019 inspection
 - Remaining pipe insulation was visibly moldy in the main room; much of the pipe insulation had been replaced since 2019
 - Door frames were rusted along the bottom few inches and the back exit door was almost rusted out; a new door had been ordered
 - Door casings with peeling paint and visible mold growth beneath the paint
 - A high capacity, commercial grade dehumidifier was installed in the doorway to one of the green storage rooms; the dehumidifier would work for the green rooms and main room but would not be able to effectively dry the mechanical room or the electrical/technology room
 - Electrical/technology room
 - This room was not inspected in 2019
 - The room had older paint on the walls, it was not painted in 2019

- Considerable evidence of chronically elevated relative humidity levels was noted by rusted metal surfaces, water damaged building materials, peeling foundation paint, and visible mold growth
 - Heavy mold growth on the painted plywood housing electrical panels
 - Mechanical room
 - Largely, the mold and moisture condition of this room remained the same as during the 2019 inspection
 - Large, partially open sump with standing water and water rushing in through a pipe
 - Right wall covered with a fabric-type material was ripped, deteriorated, water stained and covered in mold growth; this condition remained unchanged since 2019
 - Ceiling was covered with mold growth
 - Pipe insulation was water stained and covered in mold growth; several areas of iron pipes were missing insulation and were badly rusted
 - The floor, walls to the right of the HVAC system air handler, and top of the air handler were saturated and dripping with condensation; it is suspected that the still and unnecessarily open outdoor air intake for the unused air handler has been bringing in air of widely varying temperatures and humidity, causing excessive amounts of condensation resulting in significant mold growth
 - HVAC system located in this room
 - Reportedly out of service
 - Outdoor air was blowing through the unit still, causing the blower wheel to turn
 - Ductwork remained and vents were open causing moldy air from the room (and potential asbestos fibers from loose/ripped sections of pipe wrap) to be drawn into the system and spread into the rooms/areas supplied by the ductwork
 - Large opening in the ductwork partially and ineffectively covered with a piece of cardboard has been allowing moldy, damp air into the system and, subsequently into the occupied spaces above
 - Significantly moldy ductwork wrap, which also was ripped and falling off in places
 - Large piece of moldy cardboard sitting on top of the air handler
 - Surfaces were rusted throughout, from floor to ceiling
 - Asbestos and fiberglass pipe wrap was water damaged and covered in mold growth; this condition was unchanged from 2019
 - Standing water and other damp areas on the floor
 - Evidence of chronic moisture on the walls, particularly at their base
 - Accumulated trash and debris strewn about on the floor, some of which was moldy
- Building A (Adams)
 - Second floor common rooms with filthy HVAC ductwork, unchanged from 2019; exposed surfaces of the diffusers had been painted but the inner surfaces were rusted, filthy, and moldy
 - Several patient rooms were visually inspected; rust stains on the floors, radiators, base of metal wall panels behind toilets, and metal legs of furniture, but no visual signs of mold growth
 - Recreation room with a water cooler that was dripping onto the floor causing a puddle to form; the cooler should be replaced immediately (this was pointed out during the inspection)
 - Self-contained modular air filtration unit remained and was filthy

- An HVAC system inspected in 2019 was in a currently flooded basement and could not be inspected (about 6-8 inches of standing water); a pump and PVC pipe had previously been installed to evacuate water when the basement flooded (the cause was reportedly a clogged drain but a basement with an actively used HVAC system for occupied spaces and other mechanical equipment cannot continue to flood—the pump and pipe are only a temporary resolution)
- A second basement was accessible for inspection
 - Large grate over the access opening; it was unclear why these basements containing air handling systems and other mechanical equipment were open to the elements
 - There was standing water on the floor in the back of the room and the relative humidity was exceptionally elevated for this time of year
 - All metal surfaces were rusted, some almost completely corroded
 - Widespread mold growth, particularly on the external ductwork wrap
 - A lot of trash and other debris on the floor, some of which was moldy
 - HVAC system
 - Air handler was filthy, covered inside and out with accumulated organic debris that was or will be growing mold (leaves, dirt, dead insects, etc.)
 - Water was noted inside the unit
 - Visible mold growth on several components
 - Internal components were badly rusted
 - Filter compartments were open, introducing wet and moldy air into the filthy system; the combination of chronic moisture and organic dirt/debris provides conditions that promote and support unacceptable mold growth inside an active air handling system
 - One inch filters were filthy and black with accumulated dust, debris, and mold growth; cardboard filter frames were wet
 - Copper pipes were oxidized from chronic moisture exposure
 - Pipe and ductwork wrap was ripped, deteriorated, and moldy
 - Several pipes, fittings, and valves were actively dripping either from condensation or leaks
 - Two frogs had become trapped in the basement (released during this inspection) when they fell through the grate at some point, another reason why the basements should not be open to the outdoors
- Attucks Building
 - Areas of water damaged ceilings from chronic roof leaks; reportedly the leaks had been repaired but the water damaged/stained ceiling materials remained
 - The dining hall has not been used in a long time due to Covid, the HVAC vents were rusty, filthy with black dust/debris, and were visibly moldy
 - Self-contained modular air filtration units remained in the ceiling and were filthy
 - HVAC vents in all inspected areas were filthy, unchanged from 2019
 - Technology/computer room had mold growth on the ceiling
 - Developmental Disabilities room
 - A window air conditioning unit that was set on 60° was running; the unit was condensing and full of mold growth
 - The room had an elevated relative humidity level for the wintertime of 56.0% vs. 49.4% in the adjacent library; the air conditioner is causing a moisture and mold problem in the room
 - The ceiling was covered with visible mold growth from the continually running air conditioner in December
 - Peeling/bubbled calcimite ceiling from a fairly large roof leak that was reportedly repaired; ceiling materials were dry during the inspection

- Max 2 Building
 - HVAC vents were filthy, unchanged from 2019
 - Shower room with moldy wall panels and flooring (fiberglass) beneath the shower plumbing; the showers were being run even though no one was in them reportedly because the hot water takes some time to get to the showers
 - Rotted/rusted out door framing in the shower area and adjacent hallway
- Recovery Place
 - Modular building built in the 1980's; GML was told in 2019 that it was near the end of its life
 - The building had a foul/stale odor
 - Roof top HVAC units, vents within the building were filthy
 - Carpeting had been removed, a GML recommendation in 2019
 - VCT tile floors remained the same from 2019 or were worse with lifting and broken tiles in numerous areas and swollen/heaved sub-flooring (from moisture)

Laboratory Results

Please refer to the AccuScience report for detailed laboratory results

Surface Mold Samples

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

Swab sampling and/or the visual inspection (in cases where visible mold may not have grown on the culture plates) defined elevated mold levels or unacceptable mold types to have in occupied spaces (*Chaetomium*, *Aspergillus fumigatus*, *Fusarium*) on the following tested materials:

- Administration Building Basement Room AD11 – supply air diffuser
- Administration Building mechanical room – mold on fabric-type material under electrical panel
- Administration Building electrical room – mold on painted concrete wall
- Administration Building roll call room – supply air diffuser
- Medical Building basement – main room, mold on painted HVAC system ductwork seams
- Medical Building basement – mold on electrical/technology room painted plywood
- Medical Building basement – mold on electrical room painted concrete block wall
- Medical Building basement – mold on fabric-type wrap of unused HVAC system
- Medical Building basement – mold on 'wall' behind unused HVAC system
- Medical Building basement – mold on cardboard on top around unused HVAC duct
- Medical Building basement – mold on remaining/original pipe wrap, main room
- Medical Building booking corridor – HVAC system supply air diffuser
- Attucks – lobby HVAC system supply air diffuser
- Attucks – dining hall HVAC system supply air diffuser
- Attucks Developmental Disabilities Room – mold on ceiling
- Attucks Developmental Disabilities Room – mold inside window air conditioner unit
- Attucks library – HVAC supply air diffuser
- Max 2 Building – hallway shower, mold on base of plumbing wall
- Max 2 Building – hallway HVAC system supply air diffuser
- Building C mechanical room basement – HVAC system return side of filter

Mold levels defined by culture analysis on many of the tested surfaces far exceed those expected on the same materials if they had not been exposed to chronic moisture. Mold types identified growing on the tested surfaces included *Aspergillus fumigatus*, *Aspergillus niger*, *Aspergillus ochraceus*, *Aspergillus sydowii*, *Aspergillus versicolor*, *Aspergillus sydowii*, *Aureobasidium*, *Chaetomium*, *Cladosporium*, *Fusarium*, *Mucor*, *Penicillium*, *Phoma*, and *Trichoderma* along with environmental yeasts and non-sporulating fungi (unable to mature on culture plates for identification but require similar growth conditions as molds).

Numerous samples contained the molds *Aureobasidium*, *Chaetomium*, and *Fusarium*. These molds have higher moisture requirements than the other molds identified growing on the tested building materials and when present, confirm chronically wet materials or materials that get wet on repeated occasions and are not cleaned so the dust/debris and mold continue to increase each time the surfaces are wetted. The considerable amount of rust, evidence of chronic moisture, and visible mold growth throughout the inspected areas as well as on HVAC system components confirm chronic/long term moisture that was able to support the growth of these and many other molds.

Aspergillus and *Fusarium* are two of the most clinically important molds that are commonly found indoors when conditions are favorable for their growth; these molds were confirmed on many tested surfaces in the buildings, including HVAC systems. *Aspergillus* can cause chronic lung and sinus infections, produces mycotoxins, and is a common allergenic mold. *Fusarium* is known as an opportunistic pathogen and can cause respiratory diseases such as pneumonia, chronic sinusitis, and hard to treat skin infections. Chronic mold 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 go away, chronic sinus infections, persistent coughing, itchy and runny eyes, sore throats, exhaustion, lethargy, mental foggiess, etc. People with underlying health conditions and weaker immune systems are most affected by chronic mold exposure. The 2019 inspection confirmed mold contamination sources that remained as of this inspection, confirming that there is chronic mold exposure potential for staff members and persons served.

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 based on the age of the building and already confirmed asbestos containing materials, a detailed asbestos inspection and appropriate abatement by a licensed asbestos abatement company will be needed before building materials are disturbed during the mold remediation process. Some asbestos abatement companies also specialize in mold remediation because the removal and cleaning procedures are very similar. Asbestos materials in several areas of the basements were in very poor condition with ripped edges and hanging, loose fibers making the areas hazardous, particularly for anyone moving/disturbing surrounding materials or working on mechanical equipment. When 'insulation removal' is recommended in the mold remediation procedures below, GML is referring to non-asbestos containing insulation as the recommendations are written for a mold remediation company only.

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

A specialized mold remediation company is needed to remove mold growth sources and remediate remaining materials/surfaces in the basements of the Administration and Medical Buildings as well as all basements of the Adams Building and the Attucks Developmental Disabilities and Technology/Computer room. 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 appropriate 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.

Administration Building Basement Remediation Protocol

- Seal all sumps but particularly the wastewater sump with hazardous raw sewerage
- Remove all exposed, water damaged, fiberglass pipe insulation (new and all of the original)
- Remove all HVAC system ductwork insulation and tape at seams
- Remove all fabric-type wall coverings (unless they are asbestos containing)
- VCT floor tiles should be removed as they showed evidence of water damage; moisture was able to get beneath the tiles resulting in mold growth on the underside of the tiles as well as the installation adhesive
- Wood baseboard and door trim in the Women's 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 moldy in a water event
- Open the water damaged/wet section of the mechanical room hallway ceiling; continue removing materials 2 feet in all possible directions beyond evidence of moisture or mold
- Discard moldy cotton mop heads
- 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
- 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
- Abandoned/unused HVAC system equipment or air movers should be removed along with the ductwork; cleaning the ductwork of an abandoned system is not cost effective, although an alternative option is to have the ductwork sealed

- 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, including concrete floor and walls and all materials in 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
- Unfortunately, there is no effective method other than sand 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
- HEPA filtered air scrubbers should run for at least 48 hours after the work is completed

Medical Building Remediation Protocol

- Seal all open sumps
- Remove all pipe insulation
- Remove all fabric/absorbent/porous wall materials
- Remove all rotted/rusted out building materials
- Remove all wood pallets or other absorbent, organic materials on the floors
- Abandoned/unused HVAC equipment or air movers should be removed along with the ductwork (and outdoor air intakes permanently sealed); cleaning ductwork of an abandoned system is not cost effective, but an alternative is to have the ductwork sealed
- Discard all trash and debris on the mechanical room and other floors
- Discard extraneous, porous building materials
- Scrape off any/all loose paint on surfaces
- Remove, if possible, the mechanical room ceiling as it was covered with mold growth and removal may be more cost effective than cleaning
- Discard file cabinets
- Discard/remove moldy plywood in the electrical/technology room
- Remove all external coverings, tape, and peeling paint from HVAC system ductwork and units
- Discard all cardboard in the basement and around/inside the HVAC system
- Once removed materials are discarded, all remaining building materials from floor to ceiling, including concrete floor and walls and all materials in 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
- Painted concrete walls will need to be scrubbed/wire brushed to remove the moldy paint in the rooms that had not been recently painted; the green paint will still need to be scrubbed
- Damp wipe and HEPA vacuum all other surfaces in the basement to remove settled mold spores and demolition dust
- HEPA filtered air scrubbers should run for at least 48 hours after the work is completed

Adams Building Basements

- Mold remediation should take place in all of the basements of this and other buildings with similarly wet environments
- All dirt, trash, and debris must be removed from the floors
- All HVAC system ductwork insulation/wrap must be removed
- All pipe insulation/wrap must be removed

- Remove porous, absorbent ceiling materials (unless they are all concrete)
- Once removed materials are discarded, all remaining building materials from floor to ceiling, including concrete floor and walls and all materials in 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

Attucks Building Remediation

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

General Building Recommendations

- Scrub and sanitize moldy wall and floor materials in the Max 2 shower
- Remove and replace any water stained ceiling tiles in the buildings
- Appropriately label rooms with chemicals; the words “Toxic Closet” are not appropriate and can be dangerous if there is a fire (fire fighters need to know what types of chemicals are stored)
- Replace flooring in the modular building; the sub-flooring should also be replaced as it has become swollen from moisture through the years and will not be able to accommodate new floor tiles
- Regularly clean and sanitize bathrooms and showers; do not run shower water excessively, particularly if no one is showering
- Avoid mopping floors so they become so wet as to rust metal surfaces at the floor level; many rooms/areas did not have reported water events but had had considerable rusted surfaces at the floor because of frequent mopping with too much water
- Water pipes must be fully insulated, including around joints and fittings; if there are gaps in insulation, condensation will occur leading to rust and mold growth
- It is strongly advised to close off the Medical Building basements from the elements; all basements should be as water and air tight as possible and dehumidified or mold growth will recur
- Wastewater sumps cannot be left open or hazardous and pathogenic bacteria will enter the basements; all sumps should have sealed but removable covers to prevent evaporation into the basements which are being dehumidified
- Repair all leaking pipes, fittings, valves, and equipment; any accumulating water will increase the relative humidity and be counterproductive to the dehumidification systems

HVAC Cleaning Protocol

All in-use HVAC systems in all buildings need to be professionally cleaned by a NADCA certified air handling system cleaning specialist. Cleaning the systems will include all components of the air-handlers (unless they are being discarded or replaced), which will need to be disassembled to access all necessary parts, metal ductwork, diffusers and vents 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. One inch filters are designed to be changed between 1-3 months, depending on their MERV rating. Filter compartments must be sealed with removable covers to ensure that external air, particularly basement air, is not circumventing the filters and getting into the systems. Cleaning HVAC systems as described here is recommended every 5–7 years. Regular inspection of HVAC systems is important for early detection of problems.

Conclusion

Sources of mold growth identified during the 2019 inspection of the Bridgewater State Hospital buildings and HVAC systems were confirmed to still be present during the current inspection. This indicates that the necessary mold remediation, cleaning, and maintenance actions have not been performed (or kept up with as regularly as they need to be). HVAC systems observed during the inspection were in horrible condition, some with air handlers in wet and flooded basements with rampant mold growth. The black dust/debris inside HVAC system air handlers and supply diffusers remained, seemingly untouched, along with unacceptable levels of mold growth; the air coming through these systems is what persons served and staff in the buildings must breathe day in and day out. Mold growth has been unacceptably painted over on walls and ceilings (mold feeds on wet paint, making the problem worse). Indeed, during this inspection, a staff member told GML that he was going to have a ceiling covered with mold growth painted in order to address the problem (without removing the mold first). 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 recommendations were largely ignored. This inaction has caused the mold problems to become worse in certain areas observed and potentially more harmful to those who work and live in the facility.

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

Sincerely,

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

Disclaimer/Limitations:

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

General Mold Information

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

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

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

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

General Basement Recommendations

Foundation Floors and Walls

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

Exterior Systems

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

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

Basement Dehumidification

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

Basement Storage

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

Basement Flooring

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

Basement Wall Materials

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

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



Mycologix™ Hidden Mold Detection (HMD) Technologies

Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**

QLAB Job No.: ME211208-14

Client: Gordon Mycology Laboratory, Inc.
 Groton, MA

Date Sampled: 12/6/2021

Contact: Gordon, Deb

Date Received: 12/8/2021

Project ID: 21-100GML Bridgewater

Date Reported: 12/15/2021

Reviewed by: WT

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

Lab Sample No.	ME211208-14(1)			ME211208-14(2)			ME211208-14(3)		
Sample ID	S1			S2			S3		
Sample Location	Admin Bldg Basement Rm. AD11 - Supply air diffuser			Admin Bldg mechanical room - mold on asbestos under electrical panel			Admin Bldg electrical room - mold on painted concrete wall		
Sample Type / Device	Surface/SpongeSWAB (S)			Surface/SpongeSWAB (S)			Surface/SpongeSWAB (S)		
Media (Temperature: 25°C)	Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar		
Date Analyzed	12/15/2021			12/15/2021			12/15/2021		
Amount of Sample Prepared	10 in ²			4 in ²			6 in ²		
Dilution Factor	100			100			10,000		
Detection Limit (DL)	DL = 10 CFU/in ²			DL = 25 CFU/in ²			DL = 1700 CFU/in ²		
Culturable Fungi Conc.*	460 CFU/in ²			200 CFU/in ²			100,000 CFU/in ²		
Identification	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%
Major Hydrophilic Fungi**									
Acremonium									
Aureobasidium									
Chaetomium	14	140	30						
Stachybotrys									
Ulocladium									
Yeast, non-specified				4	100	50			
Rhodotorula (yeast)									
Fusarium									
Trichoderma [Spreader]***	1	10	2				0.01	17	< 1
Mucor [Spreader]***									
Other Fungi									
Cladosporium							26	43,000	43
Penicillium	1	10	2						
Aspergillus versicolor				1	25	13			
Aspergillus sydowii	27	270	59				34	57,000	56
Aspergillus ustus									
Aspergillus niger	1	10	2	3	75	38	0.1	170	< 1
Aspergillus fumigatus									
Aspergillus ochraceus									
Paecilomyces									
Alternaria									
Phoma									
Pithomyces									
Curvularia									
Non-sporulating fungi	2	20	4				1	1,700	2
Xerophilic Fungi Screening									
DG18 (and/or MEA) Dilution Factor:	100	(DL = 10 CFU/in ²)		100	(DL = 25 CFU/in ²)		100	(DL = 17 CFU/in ²)	
ND			ND			ND			ND
Note									

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



Mycologix™ Hidden Mold Detection (HMD) Technologies

Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**

QLAB Job No.: ME211208-14

Client: Gordon Mycology Laboratory, Inc.
Groton, MA

Date Sampled: 12/6/2021

Contact: Gordon, Deb

Date Received: 12/8/2021

Project ID: 21-100GML Bridgewater

Date Reported: 12/15/2021

Lab Sample No.	ME211208-14(4)			ME211208-14(5)			ME211208-14(6)		
Sample ID	S4			S5			S6		
Sample Location	Admin Bldg roll call room - supply air diffuser			Medial Bldg basement - main room, mold on painted HVAC duct seam			Medical Bldg basement - mold on electrical room plywood		
Sample Type / Device	Surface/SpongeSWAB (S)			Surface/SpongeSWAB (S)			Surface/SpongeSWAB (S)		
Media (Temperature: 25°C)	Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar		
Date Analyzed	12/15/2021			12/15/2021			12/15/2021		
Amount of Sample Prepared	10 in ²			2 in ²			2 in ²		
Dilution Factor	100			100			100		
Detection Limit (DL)	DL = 10 CFU/in ²			DL = 50 CFU/in ²			DL = 50 CFU/in ²		
Culturable Fungi Conc.*	80 CFU/in²			100 CFU/in²			450 CFU/in²		
Identification	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%
Major Hydrophilic Fungi**									
Acremonium									
Aureobasidium									
Chaetomium	1	10	13	1	50	50	1	50	11
Stachybotrys									
Ulocladium									
Yeast, non-specified									
Rhodotorula (yeast)	2	20	25						
Fusarium									
Trichoderma [Spreader]***	1	10	13						
Mucor [Spreader]***	1	10	13						
Other Fungi									
Cladosporium									
Penicillium							2	100	22
Aspergillus versicolor									
Aspergillus sydowii	2	20	25	1	50	50	3	150	33
Aspergillus ustus									
Aspergillus niger							1	50	11
Aspergillus fumigatus									
Aspergillus ochraceus	1	10	13						
Paecilomyces									
Alternaria									
Phoma									
Pithomyces									
Curvularia									
Non-sporulating fungi							2	100	22
Xerophilic Fungi Screening									
DG18 (and/or MEA) Dilution Factor:	100	(DL = 10 CFU/in ²)		100	(DL = 50 CFU/in ²)		100	(DL = 50 CFU/in ²)	
Note									

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

Mycologix™ Hidden Mold Detection (HMD) Technologies
Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**
QLAB Job No.: ME211208-14

Client: Gordon Mycology Laboratory, Inc.
 Groton, MA

Date Sampled: 12/6/2021

Contact: Gordon, Deb

Date Received: 12/8/2021

Project ID: 21-100GML Bridgewater

Date Reported: 12/15/2021

Lab Sample No.	ME211208-14(7)			ME211208-14(8)			ME211208-14(9)		
Sample ID	S7			S8			S9		
Sample Location	Medical Bldg basement - mold on electrical room painted block wall			Medical Bldg basement - mold on asbestos wrap of unused HVAC system			Medical Bldg basement - mold on 'wall' behind unused HVAC system		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar		
Date Analyzed	12/15/2021			12/15/2021			12/15/2021		
Amount of Sample Prepared	6 in ²			4 in ²			4 in ²		
Dilution Factor	100			10,000			1,000		
Detection Limit (DL)	DL = 17 CFU/in ²			DL = 2500 CFU/in ²			DL = 250 CFU/in ²		
Culturable Fungi Conc.*	< DL CFU/in ²			130,000 CFU/in ²			14,000 CFU/in ²		
Identification	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%
Major Hydrophilic Fungi**									
Acremonium									
Aureobasidium									
Chaetomium				48	120,000	92	2	500	4
Stachybotrys									
Ulocladium									
Yeast, non-specified									
Rhodotorula (yeast)									
Fusarium									
Trichoderma [Spreader]***							0.1	25	< 1
Mucor [Spreader]***									
Other Fungi									
Cladosporium							52	13,000	96
Penicillium									
Aspergillus versicolor									
Aspergillus sydowii				3	7,500	6			
Aspergillus ustus									
Aspergillus niger									
Aspergillus fumigatus									
Aspergillus ochraceus									
Paecilomyces									
Alternaria									
Phoma									
Pithomyces									
Curvularia									
Non-sporulating fungi				1	2,500	2			
Xerophilic Fungi Screening									
DG18 (and/or MEA) Dilution Factor:	100	(DL = 17 CFU/in ²)		100	(DL = 25 CFU/in ²)		100	(DL = 25 CFU/in ²)	
Note									

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

Mycologix™ Hidden Mold Detection (HMD) Technologies
Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**
QLAB Job No.: ME211208-14

Client: Gordon Mycology Laboratory, Inc.
 Groton, MA

Date Sampled: 12/6/2021

Contact: Gordon, Deb

Date Received: 12/8/2021

Project ID: 21-100GML Bridgewater

Date Reported: 12/15/2021

Lab Sample No.	ME211208-14(10)			ME211208-14(11)			ME211208-14(12)		
Sample ID	S10			S11			S12		
Sample Location	Medical Bldg basement - mold on cardboard around unused HVAC duct			Medical Bldg basement - mold on remaining pipe wrap, main room			Medical Bldg booking corridor - HVAC supply air diffuser		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar		
Date Analyzed	12/15/2021			12/15/2021			12/15/2021		
Amount of Sample Prepared	4 in ²			2 in ²			10 in ²		
Dilution Factor	10,000			1,000			100		
Detection Limit (DL)	DL = 2500 CFU/in ²			DL = 500 CFU/in ²			DL = 10 CFU/in ²		
Culturable Fungi Conc.*	390,000 CFU/in ²			9,000 CFU/in ²			190 CFU/in ²		
Identification	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%
Major Hydrophilic Fungi**									
Acremonium									
Aureobasidium							3	30	16
Chaetomium	148	370,000	96						
Stachybotrys									
Ulocladium									
Yeast, non-specified							4	40	21
Rhodotorula (yeast)				5	2,500	28	4	40	21
Fusarium									
Trichoderma [Spreader]***									
Mucor [Spreader]***									
Other Fungi									
Cladosporium				12	6,000	67	7	70	37
Penicillium									
Aspergillus versicolor									
Aspergillus sydowii	3	7,500	2	1	500	6			
Aspergillus ustus									
Aspergillus niger	1	2,500	< 1						
Aspergillus fumigatus							1	10	5
Aspergillus ochraceus									
Paecilomyces									
Alternaria									
Phoma									
Pithomyces									
Curvularia									
Non-sporulating fungi	2	5,000	1						
Xerophilic Fungi Screening									
DG18 (and/or MEA) Dilution Factor:	100	(DL = 25 CFU/in ²)		100	(DL = 50 CFU/in ²)		100	(DL = 10 CFU/in ²)	
Note									

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



Mycologix™ Hidden Mold Detection (HMD) Technologies

Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**

QLAB Job No.: ME211208-14

Client: Gordon Mycology Laboratory, Inc.
 Groton, MA

Date Sampled: 12/6/2021

Contact: Gordon, Deb

Date Received: 12/8/2021

Project ID: 21-100GML Bridgewater

Date Reported: 12/15/2021

Lab Sample No.	ME211208-14(13)			ME211208-14(14)			ME211208-14(15)		
Sample ID	S13			S14			S15		
Sample Location	Attucks - lobby HVAC supply air diffuser			Attucks - dining hall HVAC supply air diffuser			Attucks Dev. Disabilities Room - mold on ceiling		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar		
Date Analyzed	12/15/2021			12/15/2021			12/15/2021		
Amount of Sample Prepared	10 in ²			10 in ²			6 in ²		
Dilution Factor	100			1,000			1,000		
Detection Limit (DL)	DL = 10 CFU/in ²			DL = 100 CFU/in ²			DL = 170 CFU/in ²		
Culturable Fungi Conc.*	440 CFU/in ²			8,500 CFU/in ²			2,300 CFU/in ²		
Identification	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%
Major Hydrophilic Fungi**									
Acremonium									
Aureobasidium	34	340	77						
Chaetomium									
Stachybotrys									
Ulocladium				1	100	1			
Yeast, non-specified	7	70	16	3	300	4			
Rhodotorula (yeast)				5	500	6			
Fusarium									
Trichoderma [Spreader]***	1	10	2						
Mucor [Spreader]***									
Other Fungi									
Cladosporium				73	7,300	86	14	2,300	100
Penicillium				1	100	1			
Aspergillus versicolor									
Aspergillus sydowii									
Aspergillus ustus									
Aspergillus niger	1	10	2	1	100	1			
Aspergillus fumigatus				1	100	1			
Aspergillus ochraceus				0.1	10	< 1			
Paecilomyces									
Alternaria									
Phoma									
Pithomyces									
Curvularia									
Non-sporulating fungi	1	10	2						
Xerophilic Fungi Screening									
DG18 (and/or MEA) Dilution Factor:	100	(DL = 10 CFU/in ²)		100	(DL = 10 CFU/in ²)		100	(DL = 17 CFU/in ²)	
Note									

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

Mycologix™ Hidden Mold Detection (HMD) Technologies
Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**
QLAB Job No.: ME211208-14

Client: Gordon Mycology Laboratory, Inc.
 Groton, MA

Date Sampled: 12/6/2021

Contact: Gordon, Deb

Date Received: 12/8/2021

Project ID: 21-100GML Bridgewater

Date Reported: 12/15/2021

Lab Sample No.	ME211208-14(16)			ME211208-14(17)			ME211208-14(18)		
Sample ID	S16			S17			S18		
Sample Location	Attucks Dev. Disabilities Room - mold inside window air conditioner			Attucks library - HVAC supply air diffuser			Max 2 - hallway shower, mold on base of plumbing wall		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar		
Date Analyzed	12/15/2021			12/15/2021			12/15/2021		
Amount of Sample Prepared	4 in ²			10 in ²			2 in ²		
Dilution Factor	100			100			10,000		
Detection Limit (DL)	DL = 25 CFU/in ²			DL = 10 CFU/in ²			DL = 5000 CFU/in ²		
Culturable Fungi Conc.*	900 CFU/in ²			50 CFU/in ²			920,000 CFU/in ²		
Identification	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%
Major Hydrophilic Fungi**									
Acremonium									
Aureobasidium									
Chaetomium				1	10	20			
Stachybotrys									
Ulocladium									
Yeast, non-specified				3	30	60			
Rhodotorula (yeast)									
Fusarium	11	280	31						
Trichoderma [Spreader]***									
Mucor [Spreader]***									
Other Fungi									
Cladosporium	21	530	58	1	10	20			
Penicillium	1	25	3						
Aspergillus versicolor									
Aspergillus sydowii									
Aspergillus ustus									
Aspergillus niger									
Aspergillus fumigatus									
Aspergillus ochraceus									
Paecilomyces									
Alternaria									
Phoma							0.2	1,000	< 1
Pithomyces									
Curvularia									
Non-sporulating fungi	3	75	8				184	920,000	100
Xerophilic Fungi Screening									
DG18 (and/or MEA) Dilution Factor:	100	(DL = 25 CFU/in ²)		100	(DL = 10 CFU/in ²)		100	(DL = 50 CFU/in ²)	
Note									

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

Mycologix™ Hidden Mold Detection (HMD) Technologies

Analysis: Culturable Fungi (FC-12MEA+) - **Surface/Bulk**

QLAB Job No.: ME211208-14

Client: Gordon Mycology Laboratory, Inc.
Groton, MA

Date Sampled: 12/6/2021

Contact: Gordon, Deb

Date Received: 12/8/2021

Project ID: 21-100GML Bridgewater

Date Reported: 12/15/2021

Lab Sample No.	ME211208-14(19)			ME211208-14(20)		
Sample ID	S19			S20		
Sample Location	Max 2 - hallway HVAC supply air diffuser			Building C mechanical room (bsmt) - HVAC system return side of filter		
Sample Type (Device)	Surface (SpongeSWAB (S))			Surface (SpongeSWAB (S))		
Media (Temperature: 25°C)	Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar			Common Media: MEA & DG18 QLAB Mycologix™ Media: HR-MEA, Xero-MEA, RD-PDA and/or Stachybotrys Agar		
Date Analyzed	12/15/2021			12/15/2021		
Amount of Sample Prepared	10 in ²			8 in ²		
Dilution Factor	100			1,000		
Detection Limit (DL)	DL = 10 CFU/in ²			DL = 130 CFU/in ²		
Culturable Fungi Conc.*	720 CFU/in ²			13,000 CFU/in ²		
Identification	Adj. Ct.*	CFU/in ²	%	Adj. Ct.*	CFU/in ²	%
Major Hydrophilic Fungi**						
Acremonium						
Aureobasidium	4	40	6	3	380	3
Chaetomium						
Stachybotrys						
Ulocladium						
Yeast, non-specified	3	30	4	9	1,100	9
Rhodotorula (yeast)	2	20	3	2	250	2
Fusarium						
Trichoderma [Spreader]***						
Mucor [Spreader]***						
Other Fungi						
Cladosporium	54	540	75	87	11,000	84
Penicillium	7	70	10	1	130	< 1
Aspergillus versicolor						
Aspergillus sydowii						
Aspergillus ustus						
Aspergillus niger						
Aspergillus fumigatus						
Aspergillus ochraceus						
Paecilomyces						
Alternaria						
Phoma						
Pithomyces						
Curvularia						
Non-sporulating fungi	2	20	3	2	250	2
Xerophilic Fungi Screening						
DG18 (and/or MEA) Dilution Factor:	100	(DL = 10 CFU/in ²)		100	(DL = 13 CFU/in ²)	
Note						

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