THE LEGACY OF MOLD/HEALTH CLAIMS: EXPENSIVE REMEDIATION

The Mitigating Role of the Health Professional

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After the flurry of mold/ health claims following the 2000 Ballard[i] decision, mold/health litigation appears to be changing and, perhaps, decreasing. This is so because these claims have not been very successful in the Courts, and for good reason. Many of these claims are not scientifically supportable. For example, numerous health claims of mycotoxicity are inconsistent with basic toxicological principles. They have also come under intense medical/scientific scrutiny with numerous critical review articles and consensus papers. It's not that mold never has a health impact; rather, the personal injury claims' explosion far exceeded the provable illnesses.

Property evaluations and remediation following water events, by contrast, remain a robust and expensive legacy of mold and health. Moreover, although these activities are presumably guided by health concerns, they are often chaotic and unfocused. Today, facilities damaged by water are probed, prodded, tested, examined, explored and remediated in ways determined by whoever is hired rather than by what is needed.

This leaves an important question. Why, if the health issues drive evaluation, testing and remediation costs, are there not more health criteria standardization and consistency? Why do these associated costs continue to rise when health claims are declining? Facility management has taken on a new intensity with its own life, its own standard-of-care, with few questions asked, such as: Why are we doing these things? Why are we doing as much as we are? Why is remediation so expensive? The unspoken assumption is that "why," whichever the "why" is – depending upon the provider - is needed to protect occupant health. The cost of a "why" is driven as much by fear as by health-based realities.

Much of the testing, probing, prodding, examining and remediating costs are, from the health standpoint, unfocused at best, unnecessary at worst, and costly in either case. As health professionals, we may agree with evaluation and remediation plans, but the chances, in a given situation absent our involvement with the plan development, are purely random.

Even more problematic and more risky are the regular remediation activities which take place behind plastic, but in plain view of employees and other occupants. Employees, who yesterday were working in the very spot where people are today donned in respirators and Tyvek suits, are invariably distressed. "Why do the workers need this protection when I had no protection: what health risks threaten me?" are their normal concerns. Thus, health-based risk communication emerges as one of the first and most essential requirements. Someone with health expertise, environmental (i.e. mold)

knowledge, communication skills, and believability *must* be an integral part of a remediation team, if one hopes to prevent panic, sick-building symptoms, illnesses and workers' compensation claims. Answers for these worried employees are available– "Remediators are constantly exposed: exposure levels are far higher during tear outs: precautions in their cases are warranted." But, to be believable, and to answer medical questions like, "Why was I coughing last week?" that risk communication must come from a medical doctor, not from facility management, maintenance staff, building engineers, industrial hygienists, or other testing companies.

A number of other issues are driven by health, at least in part, even if not expressly. Do people need to be removed from the space? How much remediation is required? When can they return? What levels are safe? Do furnishings, equipment and other belongings pose a health risk, or can they be cleaned? The full scope of these answers cannot be covered here as individual circumstances vary in every situation. A few case studies will follow.

Case Study 1

A child developed bronchopulmonary aspergillosis (a serious mold-induced lung disorder) and the school was found to have some *Aspergillus* contamination, the parents and faculty were panicked, certain that the school was the source and a pervasive threat. The community demanded the school be closed immediately. Several physicians concurred with closing the school, fueling the panic. A more in-depth evaluation of the child and his medical records by the medical doctor revealed two critical facts: first, this child had cystic fibrosis, making him susceptible to this fungal disease; second, he had been playing in a mulch pile all summer, providing the near certain source of his infection. Effective medical communication with the school and its occupants explained these facts and why the school was not causal in this case. The actual threat to others was minimal. The school was permitted to reopen following limited, focused remediation.

Case Study 2

An atopic (one with multiple environmental allergies) instructor reported asthma-like symptoms when working at the office. He complained of "Toxic Mold" in his classroom and formaldehyde off-gassing from furniture as the cause of his problems. Others in the building were also concerned. A comprehensive health evaluation was performed. A visual inspection revealed signs of an old water leak with no obvious evidence of mold amplification. The furniture was also inspected. There was on going renovation of this old building occurring in nearby offices. A pathway with enough air pressure differential was also found to be exposing this instructor to allergens probably carried on the construction dust/ debris. The occupants were so advised and the instructor was temporarily transferred to an existing trailer classroom for the duration of the renovation. Dust control modifications were recommended to the construction team to prevent widespread distribution. The instructor returned to his classroom after the renovation without a medical incident. Health-based management of the situation by trained health professionals identified the root cause of the problem, addressed the fears of the occupants through effective risk communication, mitigating potential problems.

Case Study 3
Following the flooding of an assisted-living facility, significant mold growth, *Stachybotrys* included, resulted. Decisions had to be made about the occupants, their accommodations and their possessions with respect to the extent of remediation required. Several town meetings with physician communicators revealed that the residents were more fearful of being forced to vacate their rooms than they were of the potential health risks associated with the mold. Although ambient levels of mold were higher than customary, the medical doctors concluded that the health risks were minimal. It was concluded that the health-based remediation plan could take place with no resident relocations. The remediation plan was communicated to the residents. Remediation went forward with medical oversight and the occupants remained in place with minimal inconvenience. The cost was reasonable and everyone remained healthy.

These assisted living residents were quite immune to mold fears. This raises a key element–psychology. The misperceptions of mold hazards are often more important solution drivers than the risks themselves. These fears can very expensive and may lead to evacuations, building material deterioration, property damage, breaking of leases and lawsuits or workers' compensation claims. They can also be, and often are, exacerbated by thoughtless or unknowledgeable "professionals." Witness the scientifically inaccurate statement often used by testing groups, building engineers, remediators, and even some health professionals. "We just don't know about mold-health risks." That common, but erroneous, refrain alone is a major cost driver.

Active participation by the right environmental health medical experts can make a dramatic difference in the risks and costs of water damage or mold-related evaluations and remediation. Health issues do drive much of today's remediation costs following water damage and mold growth. But they do so erratically and with little health input or oversight. The result is an unfocused, misdirected system, wasteful of resources and contributing to unnecessary remediation costs, personal fears and claims risks. The goal should be medically driven investigation appropriately addressing and resolving the health risks, as illustrated by the examples above.

A blend of the right medical - scientific knowledge and practical experience will help ensure that mold related health risks and building health risk cost drivers are properly addressed. The result: fewer personal injury and workers' compensation claims; less worker downtime; lessened physical and psychological health risks, and reduced remediation costs.

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[i] *Ballard v. Fire Insurance Exchange,* 2001 WL 883550 (Tex. Dist.)(Unpublished opinion).