

Turnbridge / Turning Point Institutional Due-Diligence and Public

Review Evidence Memo

UPDATED July 2026 - includes J.E. / D.A. sexual-privacy incident lead, Joseph Moura / 28-day program-length disclosure lead, early-2023 L.M. forced-exposure allegation, early-2023 Dave Murphy sexual-rumor / pronoun-interrogation concern, and 2021 "Scarface Adam" / T.K. sexual-assault legal-proceeding lead, and March 2026 R. / Drew Behr client-autonomy lead

Firsthand Accounts, Staff-Vetting Concerns,
Public-Record Leads, Public Review Evidence,
Client Culture Concerns, Client Property
Concerns, and Records-Preservation Questions

I. Scope and Standard

This memorandum combines institutional due-diligence notes, firsthand recollections, direct disclosures, secondhand or relayed allegations, public-record leads, archived review screenshots, review-platform evidence, staff-conduct concerns, review-integrity concerns, admissions / program-length concerns, and records-preservation questions. The purpose is not to ask readers to accept every account as proven fact. The purpose is to preserve source material, identify recurring categories of concern, distinguish evidence types, and frame due-diligence questions that Turnbridge / Turning Point should be able to answer through records. This memorandum distinguishes:

- firsthand observations;
- firsthand disclosures to staff;
- secondhand / overheard allegations;
- public-review allegations;
- public-record material;
- employee-review context;
- review-integrity concerns;
- observed institutional patterns;
- evidence and records requiring preservation.

Where evidence is not independently verified, this memo says so.

II. Methodological Note

This document uses the following reliability framework. Class A - Public-source materials Publicly accessible materials, including public review pages, public police-log reporting, public licensing records, public news reporting, official Turnbridge materials, and employee-review pages. These sources may change over time and should be preserved through screenshots, PDFs, archive captures, or dated downloads. Class B - Archived review captures and screenshots Archived Google review captures and screenshots preserved as part of the Turnbridge institutional archive. Because Google reviews are dynamic and may change, these materials should be paired where possible with live review URLs, profile captures, screen recordings, or dated archive copies. Class C - Firsthand recollections and archive notes Firsthand recollections, direct disclosures, contemporaneous archive notes, and secondhand or relayed

allegations

preserved for due-diligence purposes. These materials should be treated as allegations or leads unless corroborated by records, witnesses, communications, or official documentation. Terminology rule For positive reviews, this memo uses

language such as:

- review-integrity concern;
- low-probative review;
- relationship-based review;
- clustered positive-review pattern;
- suspicious review pattern warranting due-diligence review.

It avoids describing reviews as fake, fraudulent, or sham as a factual conclusion unless specific proof exists. "Sham"

may appear only as quoted or paraphrased reviewer language or as informal shorthand outside formal public language.

III. Central Due-Diligence Questions

This archive raises recurring questions about Turnbridge / Turning Point's institutional systems:

1. How were client-on-client violence, threats, and coercion documented?

2. What happened after sexual-boundary complaints?

3. Were clients separated after violence, threats, unwanted sexual contact, harassment, outing threats, or coercion?

4. Who reviewed CCTV footage after serious incidents?

5. Could staff replay, discuss, or mock sensitive CCTV footage?

6. Were families notified after safety incidents?

7. What incident reports exist?

8. What staff-vetting procedures were used before staff were placed around vulnerable clients?

9. What public-record, licensing, social-media, employment, and conduct reviews were performed?

10. What happened when staff were accused of violence, boundary problems, misconduct, unsafe judgment, unsafe transportation conduct, or sexual-boundary concerns?

11. Were staff ever disciplined, removed, rehired, or allowed back after client-safety concerns?

12. How were public negative reviews, employee reviews, and review-integrity concerns handled?

13. Can Turnbridge produce records that confirm, refute, or contextualize the accounts preserved here?

14. How were expected length of stay, program duration, contract signing, and admissions representations communicated to clients and families before intake?

15. Did staff know or hear clients state a materially different understanding of

program length before contracts were signed, and if so, what duty existed to correct that understanding before signing?

IV. Firsthand Observations / Events Personally Witnessed or

Experienced

1. Staff replaying CCTV footage of M.J. chasing and spraying C.S. with a fire

extinguisher while attempting to beat him with the extinguisher

Approx. date: February 2022

Program/location: Phase 1 / Turnbridge

Staff involved: Drew Behr, Phase 1 case manager

Clients involved: M.J.; C.S.

Type: Staff conduct; client safety; misuse of surveillance footage; cruelty / humiliation

In or around February 2022, I personally witnessed Phase 1 case manager Drew Behr replay CCTV footage of a serious

client-on-client incident involving M.J. and C.S. The incident, as I remember it, involved M.J. chasing C.S., spraying C.S.

with a fire extinguisher, and attempting to beat C.S. with the extinguisher. Drew showed the footage to me and

numerous other clients while laughing and calling C.S. a "dumbass." This is included because the underlying incident

involved serious client-on-client violence or threat, including use of a fire extinguisher as an object in the assault or

attempted assault, and because the alleged staff response raises separate questions about surveillance-footage

access, evidence handling, client dignity, staff cruelty, and institutional oversight.

Potential corroboration:

- CCTV footage from the M.J. / C.S. fire-extinguisher incident
- Staff access logs / camera review logs
- Other clients who were shown the footage
- Incident reports, shift notes, or clinical notes
- House rosters or client records confirming M.J. and C.S. were present at the relevant time

Archive classification: Firsthand observation.

2. Reported sexual-boundary incident involving L.M.; Mark David Grasso / Mark

Grasso overheard disclosure but no meaningful action followed Approx. date: Late 2022

Location: 1212 Quinnipiac Avenue, Turnbridge property

Staff involved: Mark David Grasso / Mark Grasso

Clients involved: E.O.; L.M.; myself

Type: Sexual-boundary violation; failure to act; client safety

In late 2022, I told E.O. that L.M. had gotten on top of me, grabbed my penis, and refused to get off during an incident

at the Turnbridge property at 1212 Quinnipiac Avenue. Mark David Grasso / Mark Grasso overheard me relay this to

E.O. He said words to the effect that it sounded crazy and that I should "feel free" to report it to higher-ups if I felt like

it. To my knowledge, no meaningful protective action was taken. I do not recall being formally interviewed, separated

from L.M., or given a clear protective plan. L.M. continued to harass me afterward. The staff identity is based on my

memory of the staff member known as Mark, the screenshot display name "Mark David Grasso," and the public Instagram handle @markdgrassoct22. Official employment records, staff rosters, or shift logs should confirm identity

before stronger public claims are made.

Potential corroboration:

- Employment records confirming Mark David Grasso / Mark Grasso's role / assignment at the time
- House logs / shift notes from 1212 Quinpiac Avenue
- E.O. as witness to my disclosure
- Other clients aware of L.M.'s later harassment
- Any incident reports, if they exist
- Records showing Mark David Grasso / Mark Grasso was present or assigned to the house
- Clinical notes, staff notes, or communications following the disclosure

Archive classification: Firsthand disclosure + staff overhearing + alleged failure to respond.

3. Violent assault by C. using heavy wooden chair; footage later replayed by staff

mockingly Approx. date: Late 2021

Location: 90 Ford Street

Staff involved: Drew Behr

Client involved: C.

Type: Client-on-client violence; surveillance footage; staff cruelty / humiliation

In late 2021, at 90 Ford Street, I was violently assaulted by an older client, C., with a heavy wooden chair. The incident

was on camera. Drew Behr later replayed the footage for me and mocked me for "flinching." This is included both as a

client-safety incident and as a staff-conduct incident. The core institutional questions are whether the assault was

properly documented, whether CCTV footage was preserved and reviewed appropriately, whether staff were permitted

to replay it casually, and whether any meaningful protective action followed.

Potential corroboration:

- CCTV footage from 90 Ford Street
- Incident report / shift notes
- Other clients present at the house
- Medical records or injury documentation, if any
- Staff camera-access records
- House roster for the period
- Staff schedules for Drew Behr and others present
- Records identifying C. and his placement at 90 Ford Street

Archive classification: Firsthand victimization + firsthand staff conduct.

4. Alleged theft / mishandling of \$150 by Phase 1 director John Stewart

Approx. date: Late 2021

Program/location: Phase 1

Staff involved: John Stewart, Phase 1 director

Type: Staff misconduct; alleged theft / mishandling of client money

In late 2021, I personally experienced John Stewart taking \$150 from my hands in three \$50 bills. The money was never

returned. This is included as an allegation involving client money and staff authority. It should be corroborated through

date reconstruction, witness accounts, contemporaneous texts, family disclosures, or records showing staff contact

around the time.

Potential corroboration:

- Late-2021 date/time reconstruction
- Contemporaneous texts to family, therapist, sponsor, or clients
- House/staff logs showing staff contact around the time
- Witnesses, if any
- Internal complaint, note, reimbursement record, or return-of-funds record, if any exists

Archive classification: Firsthand allegation against staff.

4A. Client property / PS4 stolen after being left at 1212 Quinnipiac; no meaningful

response by case manager Approx. date property left: January 2023 Approx. date discovered missing: May 2023

Location: 1212 Quinnipiac Avenue

Staff involved: Eric Regensburg, case manager

Property involved: PlayStation 4, estimated value approximately \$400

Type: Client property; alleged theft / missing property; failure to document; failure to investigate; staff-response concern

In approximately January 2023, I left a PlayStation 4 at the Turnbridge property at 1212 Quinnipiac Avenue. When I

returned in May 2023, the PS4 was missing and appeared to have been stolen. I raised the missing PS4 with case

manager Eric Regensburg. My recollection is that no meaningful effort was made to retrieve it, locate it, document its

disappearance, or create a report. Every conversation I remember having with Eric Regensburg about the missing PS4

ended up turning into him talking about taking a new job in Florida. The PS4 was never returned. To my knowledge, no

report was ever made. This is included as a client-property and staff-response concern. In a residential-treatment

setting, client belongings should be documented, protected, and investigated when missing. The institutional question

is whether Turnbridge had a property-inventory process, missing-property reporting process, staff accountability

process, or reimbursement procedure when client property disappeared from a Turnbridge residence.

Potential corroboration:

- Texts, emails, or messages about leaving the PS4 at 1212 Quinnipiac
- Texts, emails, or messages about the PS4 being missing in May 2023
- Eric Regensburg's case-management notes
- 1212 Quinnipiac house logs
- Property inventory records, if any
- Client property policies
- Staff schedules for 1212 Quinnipiac during the relevant period
- Other clients who saw the PS4 at 1212 Quinnipiac
- Other clients who knew it was missing
- Communications with family about the missing PS4
- Records of Eric Regensburg leaving or planning to leave for a Florida job
- Missing-property report, if one exists
- Reimbursement / restitution policy

Archive classification: Firsthand client-property loss allegation + staff-response concern.

5. Failure to discipline A.S. after threats of bodily assault

Approx. date: To be narrowed

Clients involved: A.S.; myself; C.

Type: Threats; client safety; failure to discipline / failure to protect

I recall Turnbridge failing to meaningfully discipline or protect after A.S. threatened bodily assault against me and also

against C. This is included because threats between clients in residential treatment are not merely interpersonal

conflict. Clients often cannot easily choose where they sleep, who they live with, or whether they can avoid threatening

peers. Threats in that setting raise housing, supervision, documentation, and safety-plan questions.

Potential corroboration:

- Witnesses to the threats

- Incident reports / shift notes
- Messages or contemporaneous disclosures
- C.'s account, if available
- House rosters and staff schedules
- Safety plans or clinical notes

Archive classification: Firsthand observation / firsthand safety concern.

6. Chris Meyer car / transportation story

Approx. date: Late 2022

Staff involved: Chris Meyer / Chris Myer

Type: Staff conduct; transportation; judgment / supervision concern; professional-boundary concern; confidentiality concern;

local-crime-story boundary concern Separate from the public police-log material concerning Chris Meyer, I personally

remember Chris Meyer being hired to drive me into New York City for a film-related obligation. During that car ride, I

remember Meyer:

- running red lights;
- speaking on the phone with multiple women about ways he was lying to them;
- telling me how much my parents were paying him;
- recounting a story from Fairhaven involving buying drugs with his girlfriend, a large Black man in the car, and a dog;
- telling me about the Fair Haven / "Fast Eddie" murder story;
- saying, as I remember it, that he was the person who was supposed to be killed by the person later charged in the "Fast

Eddie" killing. This is included as a personal recollection relevant to judgment, transportation safety, staff boundaries,

confidentiality around family payment arrangements, and the appropriateness of placing staff in transportation or

authority roles around young clients. This should not be treated as a criminal allegation against Meyer.

The concern is

not that Meyer was

involved in the "Fast Eddie" killing. The concern is that a staff member transporting a vulnerable client allegedly drove

recklessly, disclosed family payment information, discussed chaotic relationship dynamics, and brought up local

drug-world / murder material during a paid client transport. Public reporting separately anchors the existence of the

Fair Haven / "Fast Eddie" murder case. Public reporting identified Edward Andrew "Fast Eddie" Thompson as having

been killed in Fair Haven in 2011, reported that Larry Johnson was arrested on a warrant for murder in the case, and

reported that police said Thompson was not the intended target. Later public reporting stated that Johnson was found

not guilty. This public reporting is included only to anchor the apparent real-world event Meyer was discussing and to

show why Meyer's alleged statement - that he had been the intended target - may be a relevant staff-boundary /

judgment detail. It does not verify Meyer's statement, and no claim is made here that Meyer was involved in the killing.

Potential corroboration:

- Family records or memory of who hired Chris Meyer for transportation
- Texts, calendars, emails, or payment records around the ride
- My parents' recollection of the arrangement
- Employment or transportation records involving Chris Meyer
- Turnbridge transportation policies
- Communications showing Meyer's client-transport duties

- Contemporaneous therapist, family, or client disclosures about the ride
- Public reporting on the Fair Haven / "Fast Eddie" case
- Witness, text, or prior disclosure confirming Meyer discussed being the alleged intended target

Archive classification: Firsthand recollection / staff-conduct concern, not a criminal-record item.

7. Peter McConnell political / ideological boundary concerns with clients

Approx. date: Early-to-mid 2022

Program/location: Phase II, 520 Whitney Avenue / Whitney-Canner Turnbridge property, New Haven

Staff involved: Peter McConnell

Clients involved: Myself and other queer-presenting / left-wing clients

Type: Staff boundary issue; ideological / political pressure; inappropriate use of authority

In early-to-mid 2022, while I was in Phase II at the 520 Whitney Avenue / Whitney-Canner Turnbridge property, Peter

McConnell repeatedly brought up conservatism and told clients that leftist politics were irresponsible.

This often

occurred in the context of waking us up at around 8 a.m., with the implication that we were leftist and lazy. In private

meetings with queer-presenting clients, McConnell would also redirect conversation toward politics, leftists being

personally irresponsible, and conservatism being the answer. This is included as a staff-boundary concern because he

was speaking from a position of authority in a treatment setting, and because the political framing appeared to

pathologize or moralize clients' identities, values, and perceived laziness rather than focusing on treatment, safety, or

care. The property context is relevant because public reporting identifies 520 Whitney Avenue as a Whitney/Canner-area sober-house property bought by CT Clinical Services, Inc., also known as Turning Point. This helps

anchor the location of the Phase II experience described above.

Potential corroboration:

- Other Phase II clients present during early-to-mid 2022
- Queer-presenting clients who had private meetings with McConnell
- Phase II house schedules / wake-up routines
- Staff assignments for the 520 Whitney Avenue / Whitney-Canner property
- Contemporaneous texts, journal entries, or client accounts
- Public property / article records identifying 520 Whitney Avenue as a Turning Point / CT Clinical

Services sober-house

property

Archive classification: Firsthand staff-boundary / ideological-pressure concern + publicly anchored property

context.

8. Dave Murphy Phase 3 East Haven lecture about clients being lazy / burdens on

parents Approx. date: March or April 2022

Program/location: Phase 3 transitional house in East Haven, a few blocks from Hobby Lobby [exact address unknown; public

records not yet located]

Staff involved: Dave Murphy

Clients involved: Myself and other Phase 3 clients

Type: Staff conduct; humiliation / shaming; inappropriate use of authority; family-pressure rhetoric

Sometime in March or April 2022, while I was at a Phase 3 transitional house in East Haven a few blocks from Hobby

Lobby, Dave Murphy woke us up and lectured us about how we were lazy, how our parents could not take care of us,

how our parents had dropped us off at Turnbridge, and how we needed to grow up and stop being a burden on our

parents. I remember the tone as harsh and screaming. The content of the lecture framed clients as burdens whose parents could not handle them, rather than as vulnerable people in treatment. I am including this because it is relevant to staff conduct, emotional safety, family-pressure rhetoric, and the way authority was used in transitional housing. I do not currently remember the exact East Haven address, and public records have not yet surfaced a confirmed property match. My memory is that the house was a few blocks from Hobby Lobby.

Potential corroboration:

- Other Phase 3 clients present during the lecture
- Phase 3 East Haven house rosters from March / April 2022
- Staff schedules showing Dave Murphy assigned to the East Haven transitional house
- Contemporaneous texts, journal entries, or family disclosures after the lecture
- Client accounts of similar "lazy / burden on parents" lectures
- Property records, staff schedules, mail records, or house lists identifying the East Haven transitional

house near Hobby Lobby

Archive classification: Firsthand staff-conduct / humiliation concern; exact property address to confirm.

9. Sexual-boundary incident during Phase II movie trip; alleged extortion / outing

threat afterward; no meaningful action after disclosure to case manager Approx. date: Around November 2022
Program/location: Phase II; weekly Tuesday movie trip; later 520 Whitney Avenue / Whitney-Canner Turnbridge property

Staff involved: Douglas Roberto; another case manager present [name to confirm]

Clients involved: E.; M.S.; myself

Type: Sexual-boundary incident; alleged coercion / extortion; outing threat; harassment; failure to respond; client safety

Around November 2022, while I was in Phase II, Turnbridge had weekly Tuesday movie trips. On one of these trips, we went to see Nope, the Jordan Peele movie. During the movie, E. and I grabbed each other's penises. When we returned to 520 Whitney Avenue and were back in our rooms, exhausted, I told M.S. what had happened. M.S. flew into a rage and told me to Venmo him \$50 or he would tell everyone I was gay. I felt physically imposed on and threatened, and I Venmoed him \$50. I later explained this to Douglas Roberto. Another case manager was also in the room. Douglas responded, "Why would you send him \$50?" The other case manager looked at me like I was an idiot. To my knowledge, no meaningful action was taken. M.S. continued harassing me afterward and texting me threats through social media.

Potential corroboration:

- Venmo record showing \$50 payment to M.S.
- Movie-trip schedule / Phase II Tuesday outing records
- Records showing Phase II clients attended Nope around November 2022
- Other clients present on the movie trip
- 520 Whitney Avenue house roster from that period
- Douglas Roberto's case-management records / notes
- Identity of the second case manager present
- Social-media messages / threat texts from M.S.
- Contemporaneous texts, journal entries, therapist disclosures, family disclosures, or client

conversations

- Other clients aware of M.S.'s later harassment

Archive classification: Firsthand sexual-boundary / coercion allegation + firsthand disclosure to case

manager + alleged
failure to respond.

10. Staff refusal to provide inhaler during asthma attack; staff-boundary /

judgment concerns involving Will Approx. date: Summer 2022

Program/location: Turnbridge house a few blocks from Foxon Boulevard / Hobby Lobby [exact address to confirm]

Staff involved: Will [last name to confirm]

Clients involved: Myself; other clients present [names to confirm]

Type: Medical safety; medication access; staff judgment; alleged failure to respond to asthma symptoms; staff-boundary

concern In summer 2022, while I was at a Turnbridge house a few blocks from Foxon Boulevard / Hobby Lobby, I was

having an asthma attack. I asked a staff member named Will to provide me with my inhaler. Will refused to provide the

inhaler. My memory is that he said I was "faking it" and that other clients had said I was "getting high" off the albuterol.

I am including this as a medical-safety and medication-access concern because asthma symptoms can require urgent

access to prescribed medication, and because a staff member in a residential treatment setting should not dismiss a

client's request for an inhaler based on peer commentary or an assumption that the client is faking symptoms. This

same staff member also raised broader staff-boundary and judgment concerns. My memory is that Will had black hair,

a mustache and beard, and an overweight build. I remember him having a habit of restraining and tickling clients, and

telling clients stories about robbing gas stations in ski masks with toy guns and not getting caught.

These details are

included not as separate proven criminal allegations, but because they may be relevant to identifying the staff member

and evaluating his judgment, boundaries, and appropriateness for direct-care work with vulnerable clients.

Potential corroboration:

- Will's full name and employment records
- Staff schedules for the Foxon Boulevard / Hobby Lobby-area house in summer 2022
- Medication logs showing inhaler access / denial / request timing
- House logs or shift notes from the day of the asthma attack
- Other clients present when I asked for the inhaler
- Other clients who heard Will say I was "faking it" or "getting high" off albuterol
- Other clients who witnessed Will restraining or tickling clients
- Other clients who heard Will tell stories about gas-station robberies with ski masks and toy guns
- Contemporaneous texts, journal entries, therapist disclosures, family disclosures, or medical records
- Records showing the exact house address near Foxon Boulevard / Hobby Lobby

Archive classification: Firsthand medical-safety / medication-access allegation + firsthand staff-boundary /

staff-judgment

10A. Joseph Moura / Holy Family Hospital Pickup / 28-Day Understanding /

Contract-Signing Disclosure Issue

Approximate date: September 28, 2021

Pickup location: Holy Family Hospital, Haverhill, Massachusetts

Destination / intake location: Turnbridge / Turning Point, 189 Orange Street, New Haven, Connecticut

Staff involved: Joseph Moura

Type: Admissions / transportation / informed consent / contract-signing / program-length representation / client

autonomy / family reliance / potential consumer-protection concern

Account

On September 28, 2021, Joseph Moura picked me up from Holy Family Hospital in Haverhill, Massachusetts, and transported me to Turnbridge / Turning Point in New Haven, Connecticut. The drive was approximately three and a half hours.

During that car ride, I spoke with friends on the phone and repeatedly communicated that I believed I would be gone for

"28 days" and would return shortly. Joseph Moura was present for the drive and heard me discussing that understanding while I was in transit to Turnbridge.

That same day, after arriving at Turnbridge, I was directed to sign contracts at 189 Orange Street. After I signed the

contracts, Joseph Moura informed me that Turnbridge was actually a year-long program. My recollection is that he said

he did not want to "ruin" my last day of freedom.

Why this matters

This is included as a serious admissions, informed-consent, transportation, contract-signing, and consumer-protection

concern. If a client is transported for hours while openly stating that he believes he is entering a 28-day program, and

staff know the program is actually expected to last approximately a year, the timing of that disclosure matters.

The institutional question is whether Turnbridge allowed me to sign contracts before I was clearly informed of the true

expected program length. This raises questions about whether I and my family were accurately informed before

admission, whether program-length representations were made clearly and in writing, whether the contract-signing

process was meaningful, and whether a vulnerable client was asked to sign paperwork under materially incomplete or

misleading assumptions.

This item also matters because family payment and program-length expectations are central to residential-treatment

consumer protection. If a family pays substantial money based on one understanding of duration, while the client is not

told until after contract signing that the program is effectively year-long, that discrepancy should be tested through

admissions records, family communications, billing records, transportation records, and signed intake documents.

Potential records / corroboration

- Holy Family Hospital discharge / transfer records from September 28, 2021.
- Transportation records identifying Joseph Moura as the staff member who picked me up.
- Turnbridge intake records from September 28, 2021.
- Contracts signed at 189 Orange Street on September 28, 2021.
- Any admissions materials or communications describing program length.
- Any family communications before admission describing "28 days," "30 days," "long-term," "one year," or expected duration.

- Call logs showing phone calls made during the transport.
- Friends who spoke with me during the drive and heard me say I would be gone for "28 days."
- Joseph Moura staff schedule / assignment records for September 28, 2021.
- Any internal Turnbridge notes concerning my intake, transportation, consent, contract signing, or understanding of program length.

- Billing / financial records showing expected duration, monthly costs, deposits, family payment expectations, or length-of-stay assumptions.

- Any recordings, texts, emails, admissions notes, or family communications from Turnbridge staff describing the expected length of stay.

Archive classification

Firsthand recollection involving transportation, contract signing, program-length representation, and staff disclosure

after paperwork. Records may corroborate date, location, staff identity, hospital pickup, transport duration, contract

timing, phone calls, admissions communications, and family payment expectations.

Recommended consumer-protection framing

If a client was transported from a hospital while openly telling friends he would be gone for "28 days," then directed to

sign contracts at 189 Orange Street before being told by staff that the program was actually year-long, that raises

serious questions about informed consent, admissions representations, family reliance, contract formation, and whether

Turnbridge's business model depended on materially delayed disclosure of program length.

11. J.E. / D.A. nonconsensual sexual recording and distribution; Douglas Roberto case-management /

staff-response concern

Approx. date: Early 2022

Program/location: Turnbridge house near Foxon Boulevard / Hobby Lobby [exact address to confirm]

Staff involved: Douglas Roberto, case manager connected to the house

Clients involved: J.E. [initials used per anonymization request]; D.A. [client alleged to have recorded and distributed the video]

Type: Sexual privacy; alleged nonconsensual intimate recording / distribution; client safety; staff knowledge; internal response; documentation / reporting concern

In July 2026, former Turnbridge client J.E. disclosed to me through direct messages that another client, D.A., allegedly filmed him naked /

masturbating and texted the video to multiple people. J.E. stated that Turnbridge staff knew the details, that staff were complicit, and that D.A.

was downgraded to Phase 1 when police probably should have been involved. J.E. also indicated that he was not meaningfully asked or involved

in the response, and that there should be internal documentation somewhere.

I personally remember seeing the video circulating at the time. My memory is that this occurred in early 2022 at the Turnbridge house near Foxon

Boulevard / Hobby Lobby. I also remember Douglas Roberto as the case manager connected to that house. J.E. requested anonymization, so this

memo uses initials for him and for D.A. unless and until legal counsel, regulators, or the individuals involved determine a different disclosure posture.

This item is included under firsthand accounts because I personally remember seeing the video circulating, while J.E.'s account supplies direct

victim/witness context about the alleged filming, distribution, staff knowledge, internal handling, and lack of meaningful victim-centered

involvement. The account raises serious questions about sexual privacy, nonconsensual intimate-image distribution, staff response, incident

documentation, reporting obligations, police involvement, client protection, device / phone handling, and whether Turnbridge treated the harmed

client as the center of the response.

Potential corroboration:

- J.E.'s direct account and direct-message screenshots
- Any clients who received, saw, or discussed the video
- Records identifying D.A. and confirming his placement / phase status in early 2022

- House rosters and staff schedules for the Foxon Boulevard / Hobby Lobby-area house in early 2022
- Douglas Roberto's case-management notes, staff notes, or communications connected to the house and incident
- Incident reports, clinical notes, house logs, disciplinary records, or phase-down records involving J.E., D.A., Douglas Roberto, or the video
- Internal communications showing staff knowledge, staff response, or discussion of whether police, parents, guardians, or outside authorities should be contacted
- Records showing whether J.E. was interviewed, supported, safety-planned, asked what he wanted, or included in the response
- Records showing whether devices were searched, recipients identified, copies deleted, or phone / message evidence preserved
- Any police report, mandated-reporting record, legal consultation, or documentation showing why police were or were not contacted

Archive classification: Direct former-client disclosure from J.E. + firsthand corroborating memory that the video circulated. Sexual privacy / alleged nonconsensual intimate recording and distribution concern; staff knowledge / internal-response concern; records-preservation issue.

Names and public use should remain anonymized pending legal / regulatory review and additional corroboration.

11A. L.M. pants-pulling / forced-exposure incident at Turnbridge house near 189 Orange

Approx. date: Early 2023

Location/program: Turnbridge house nearest to 189 Orange Street, across the bridge and situated next to / near Fair Haven [exact house address to confirm]

Clients involved: Myself; L.M.; B.H.; A.; one other client present [name to confirm]

Related prior incident: Late-2022 1212 Quinnpic Avenue sexual-boundary incident involving L.M.; Mark David Grasso / Mark Grasso allegedly overheard disclosure; no meaningful protective action followed, according to my recollection.

Type: Client-on-client sexual-boundary violation; forced exposure; sexual humiliation; post-disclosure harassment / escalation; failure-to-protect concern; client safety; staff-response concern

Account:

In early 2023, at the Turnbridge house nearest to 189 Orange Street, across the bridge and near Fair Haven, L.M. pulled down my pants and underwear, exposing my bare penis to B.H., A., and one other client who was present.

This occurred after the prior late-2022 incident at 1212 Quinnpic Avenue in which I allege L.M. had gotten on top of me, grabbed my penis, and refused to get off. I had disclosed that prior incident to E.O., and Mark David Grasso / Mark Grasso allegedly overheard the disclosure. To my knowledge, no meaningful protective action followed. I do not recall being formally interviewed, separated from L.M., given a protective plan, or otherwise protected from further harassment.

The pants-pulling / forced-exposure incident is therefore not an isolated concern. It should be considered in the context of the earlier 1212 Quinnpic disclosure and alleged failure to act. If Turnbridge staff knew or should have known about L.M.'s prior sexual-boundary conduct and did not separate or protect me, then the later forced-exposure incident raises serious questions about client safety, supervision, documentation, and failure to protect after a sexual-boundary disclosure.

Why this matters:

Forcibly pulling down a client's pants and underwear to expose his genitals in front of other clients is a serious sexual-boundary violation and an act of humiliation. In a residential treatment environment, where clients cannot simply leave or choose their living environment freely, this should be treated as a serious safety and dignity issue.

The sequence also matters. The incident allegedly occurred after a prior sexual-assault disclosure involving the same client had already been overheard by staff. If staff were aware of the earlier allegation and did not take meaningful protective action, then the later forced-exposure incident may indicate a failure to separate, supervise, document, or protect after disclosure.

This incident also provides important context for later rumors involving me and L.M. The untrue sexual rumors should be understood against the background of alleged sexual-boundary violations and humiliation involving L.M., not as consensual sexual conduct.

Potential corroboration:

- B.H.'s account

- A.'s account
- The third client present, if identified
- L.M.'s account
- House roster for the Turnbridge house near 189 Orange / Fair Haven in early 2023
- Staff schedules for that house during the relevant period
- Any house logs, incident reports, clinical notes, or staff notes concerning the pants-pulling / exposure incident
- Any records concerning prior or ongoing conflict, harassment, or sexual-boundary concerns involving L.M.
- Records concerning the earlier 1212 Quinpiac Avenue disclosure involving L.M., E.O., and Mark David Grasso / Mark Grasso
- E.O.'s account of the 1212 Quinpiac disclosure
- Mark David Grasso / Mark Grasso's account of what he overheard and what action, if any, he took
- Records showing whether I was separated from L.M. or safety-planned after the prior disclosure
- Contemporaneous disclosures to therapist, family, sponsor, peers, or other clients
- Therapist recollection that this incident or the broader L.M. pattern was previously disclosed and later resurfaced in therapy discussion

Archive classification:

Firsthand recollection resurfaced through later therapy discussion. Client-on-client sexual-boundary violation / forced-exposure allegation involving L.M., with direct relevance to a prior sexual-assault disclosure at 1212 Quinpiac and alleged failure to protect afterward. Requires corroboration through witnesses, house rosters, staff schedules, clinical notes, incident reports, and contemporaneous disclosures.

11B. Dave Murphy sexual-rumor / pronoun-interrogation concern after untrue L.M. rumors

Approx. date: Early 2023

Location/program: Turnbridge house nearest to 189 Orange Street, across the bridge and situated next to / near Fair Haven [exact house address to confirm]

Staff involved: Dave Murphy

Clients involved: Myself; L.M.; R.P.; A.K. as contextual examples of male-female client relationships reportedly tolerated or treated differently

Type: Staff conduct; sexual-rumor response; sexual-boundary framing; gender-identity / pronoun concern; possible differential treatment of same-sex / queer-coded rumor; client humiliation / discomfort; staff-boundary concern

Account:

In early 2023, while I was at the Turnbridge house nearest to 189 Orange Street, across the bridge and near Fair Haven, Dave Murphy heard sexual rumors about me and L.M. The rumors were untrue.

Dave Murphy called me into his office to discuss them. During that meeting, he described his discomfort with the rumors and said that sexuality between clients was not allowed. I remember this as uncomfortable and potentially selective, because male clients dated female clients during the same broader period, including R.P. and A.K., without the same kind of response that I experienced.

During the same conversation, Dave Murphy then asked me pointedly about my use of they/them pronouns. I was uncomfortable and tried to redirect the conversation, but he kept returning to the topic. He then explicitly asked whether my use of they/them pronouns was a "plea for attention."

Why this matters:

This incident raises several related institutional concerns.

First, if staff responded to untrue sexual rumors involving two male or queer-coded clients by calling one client into an office and describing discomfort with the rumors, while male-female client dating was tolerated or treated differently, that raises questions about whether sexuality rules were enforced consistently or whether same-sex / queer-coded rumors were treated as uniquely alarming, shameful, or unacceptable.

Second, the pronoun questioning raises a separate gender-identity and staff-boundary concern. A staff member in a treatment setting asking whether a client's use of they/them pronouns was a "plea for attention" is not a neutral clinical question. If accurately remembered, it framed gender expression or pronoun use as attention-seeking, which could increase shame, discourage identity exploration, and make the client feel pathologized or mocked.

Third, this incident belongs in the broader client-culture and staff-response pattern because it connects sexual rumor, staff discomfort, queer-coded stigma, gender-identity questioning, and possible differential treatment of client relationships. In a residential treatment setting, staff should be trained to respond to sexual rumors and gender-identity disclosures in a way that is consistent, non-shaming, clinically appropriate, and protective.

V. SECONDHAND / OVERHEARD ALLEGATIONS

Complete Consolidated Source, Email, Phone, Reddit, DM, and Witness Accounts

Full-detail controlling section - July 20, 2026

THIS SECTION SUPERSEDES THE EARLIER COMPRESSED DIRECT-SOURCE SECTION. It is intentionally cumulative. No source account is omitted merely because the same incident appears elsewhere in the memorandum.

Scope and evidentiary rule. This section gathers in one place substantive information communicated to the memorandum author by former clients, current clients, parents or loved ones, staff, witnesses, and other sources through Reddit, email, telephone calls, Facebook messages, direct messages, public comments, and in-person conversation. Each entry distinguishes direct observation, source report, hearsay, and the memorandum author's independent recollection. All unverified statements remain allegations or investigative leads.

1. M.J. - elopement, near-fatal intoxication, withheld money, overdose, alleged video circulation, and repeat departure

M.J. reported through Facebook messages received July 15, 2026 that he left Phase 1 with another client, obtained liquor, became severely intoxicated in a winter field or wooded area near baseball fields, and was later located after police and EMS responded. He stated that he believed he would have died without that response. The memorandum author independently remembers M.J.'s original departure, contemporaneous concern that he was missing, and personally witnessed M.J. leave or run off again the following day, but did not witness the liquor-store conduct, field intoxication, or emergency recovery.

M.J. separately reported that staff told him to pack and said they did not care if he left, but then withheld his money after he was prepared to depart. He also reported a Phase 2 fentanyl overdose, hospital treatment, Narcan administration, and alleged that staff later showed other people videos of him nodding off or overdosing. The memorandum author remembers hearing about the overdose at the time but did not witness the overdose or alleged video display. M.J. further reported that meaningful protective intervention did not occur until he himself said he needed detox to separate from the environment for several days.

Records / corroboration / follow-up:

- Police, CAD, EMS, ambulance, hospital, Narcan, detox, transportation, house-log, incident, clinical, device, client-funds, staff-schedule, family-notification, and discharge records.
- The preserved July 15 message screenshots and other clients or staff who witnessed the departure, repeat departure, intoxication response, money dispute, overdose aftermath, or alleged video display.

2. J.E. - alleged nonconsensual intimate recording, distribution, staff knowledge, staff complicity, and non-victim-centered handling

In July 2026, former client J.E. disclosed through direct messages that another client allegedly filmed him naked or masturbating and texted the video to multiple people. J.E. stated that Turnbridge staff knew the details, that staff were complicit, and that the alleged recorder was downgraded to Phase 1 when police probably should have been involved. J.E. also indicated that he was not meaningfully asked, consulted, or involved in the response and that internal documentation should exist somewhere.

The memorandum author independently remembers personally seeing the video circulating in early 2022 at a Turnbridge house near Foxon Boulevard / Hobby Lobby and remembers Douglas Roberto as the case manager connected to that house. This is therefore not merely a secondhand rumor: J.E.'s direct victim account is paired with the memorandum author's firsthand memory that the intimate video circulated. The account raises questions about staff knowledge, alleged staff complicity, recipient identification, device handling, evidence preservation, police or mandated-reporting analysis, phase-down decisions, victim consultation, safety planning, and whether the harmed client was treated as the center of the response.

Records / corroboration / follow-up:

- J.E.'s direct-message screenshots and direct account; accounts of recipients or viewers; house rosters and staff schedules.
- Douglas Roberto's case-management and supervision records; incident reports, clinical notes, disciplinary and phase-down records.

- Records showing whether J.E. was interviewed, supported, safety-planned, asked what he wanted, or included in decisions.
- Device searches, recipient lists, deletion requests, evidence-preservation records, police reports, mandated-reporting analysis, legal consultation, and communications with parents or guardians.

3. Current-client Reddit witness - R. / Drew Behr, Bark Phone, blocked calls, bus ticket, and later staff disparagement

A current Turnbridge client contacted the memorandum author through Reddit in July 2026 and described a March 2026 incident at Phase 1 / 90 Ford Street. According to the witness, R. was an adult in his early thirties, had children, was being treated for methamphetamine addiction, and wanted to leave after approximately 28 days to move to another sober house closer to his area.

The witness reported that Drew Behr did everything within his power to stop R. from leaving, including allegedly trying to turn R.'s family against him, cutting off family calls in the middle of conversations while R. and his family were arranging the move, and then blocking the relevant numbers. According to the witness, R. felt he had no other option and asked to use the witness's Bark Phone to call his girlfriend so they could plan and purchase a bus ticket. The witness personally allowed the call and reported overhearing the girlfriend, who was extremely angry about Drew's alleged interference, say: "Drew is a power tripping bitch." Tickets were purchased after the call, and R. was finally able to leave.

The witness further reported that the next morning, during morning meeting, Drew referred to R. as "toxic" and went on what the witness described as a tirade about hating having to "police" people. The witness characterized this as his primary firsthand account of possible abuse at Turnbridge and said it sounded "very consistent" with the memorandum author's earlier account that Drew instructed his parents not to take his calls and later referenced wanting to "curbstomp" him. The witness consented to his own account being shared "to whoever it needs to," while stating that use materially involving or identifying R. should await R.'s own consent or direct confirmation.

Records / corroboration / follow-up:

- R., his girlfriend, family members, the Reddit witness, message screenshots, Bark Phone and call logs, blocked-number records, and bus-ticket confirmation.
- 90 Ford house logs, Drew Behr schedules, case-management and clinical notes, transfer / discharge / AMA records, phone-use policies, and morning-meeting witnesses.
- Evidentiary distinction: Bark Phone use, the girlfriend's reaction, ticket planning, and later meeting comments were personally witnessed or overheard by the source; alleged family-call interruption, blocking, and family pressure require additional corroboration.

4. Anonymous former-client witness - severe medication reaction involving an adult client (N.B.)

An anonymous former-client witness reported personally observing N.B. shaking continuously, drooling, and losing substantial motor control after receiving medication. The witness opened food for N.B. because he could not open it himself, then substituted yogurt when he appeared unable to chew a granola bar. The witness recalled staff saying N.B. would be taken to a hospital, but reported that transport did not occur that day and that meaningful evaluation appeared delayed until the following day or later. The witness later saw N.B. passed out and drooling on a couch in the clinical building. Statements about what N.B.'s parents were told remain hearsay.

Records / corroboration / follow-up:

- Medication-administration records, prescriber orders, nursing notes, vital signs, incident reports, transport and hospital records, staff schedules, family communications, and quality-assurance review.

5. W.S. - reported suicide attempt, five-day absence, return, phase-down, and continued placement

W.S. directly reported that he attempted suicide while in Phase 3 and was removed from the program environment for approximately five days. The memorandum author independently remembers and can corroborate the approximate five-day absence and W.S.'s later presence at 520 Whitney after being phased down from Phase 3 to Phase 2. W.S. stated that Turnbridge would not allow him to leave or remain outside the program and that he remained for approximately another year despite his objections and stated wishes.

Records / corroboration / follow-up:

- Crisis, hospital, ER, risk-assessment, safety-plan, return-to-program, phase-down, family-contact, billing, discharge, refusal-of-care, autonomy, house-roster, and clinical records.

6. J. airport story - feeling conned, disengagement, plane ticket, and alleged contact with girlfriend's father

In late 2021, former client J. repeatedly said he felt “conned” and had been brought to Turnbridge against his wishes. The memorandum author remembers J. spending extensive time in his room watching *The Wire*, not attending groups, and calling his girlfriend to arrange a plane ticket. The remembered destination was somewhere below the Mason-Dixon line. J. later alleged that after getting off a connecting flight in Florida, his girlfriend called and said Turnbridge had contacted her father and told him J. needed to remain at Turnbridge for his own sake. The memorandum author did not witness the alleged staff-to-father communication.

Records / corroboration / follow-up:

- J., girlfriend and father accounts; call logs, texts, flight records, intake, consent, discharge, AMA, staff communication, and return records.

7. H. denied-access story - girlfriend sought to help him leave; alleged parent intervention

Former client H. stated that he called his girlfriend for help leaving Turnbridge. According to H., Turnbridge spoke with the girlfriend's father, after which the girlfriend called H. crying and said she could not help him. The memorandum author did not witness the alleged staff-to-parent communication. The account is preserved because it may overlap with a recurring pattern in which clients seeking outside help to leave allegedly encountered intervention through a girlfriend's parent or another authority figure.

Records / corroboration / follow-up:

- H., girlfriend and father accounts; phone records, texts, attempted-departure, discharge, clinical, outside-contact, and staff-communication records.

8. C.R. - Steve Tobey sexualized self-disclosure and pressure concerning masturbation

C.R. directly told the memorandum author that Phase I case manager Steve Tobey discussed his own sex addiction, infidelity, and marital breakdown in a Structured Group / Carriage House setting. C.R. further stated that Tobey identified him as “another sex addict,” was frustrated that he masturbated, and pressured him to stop. The memorandum author did not witness the interactions.

Records / corroboration / follow-up:

- C.R. and group-participant accounts, group schedules, case-management records, employment records, and contemporaneous disclosures.

9. Former adolescent client J. - Matt Fields homeless-man / crack comment and alleged request for silence

A former adolescent-program client told the memorandum author that therapist Matt Fields / Matthew Fields, LMFT - described by the source as a bald therapist and recovered Xanax addict - took him on a walk around 189 Orange. According to the source, Fields saw a homeless man and joked that he could sell the adolescent client to the man and use the money to buy a lot of crack. The source stated that Fields then became alarmed and pleaded with him not to tell anyone. The memorandum author did not witness the walk or comment.

Records / corroboration / follow-up:

- The source, other adolescent clients, schedules, appointment and movement records, clinical notes, complaint records, staff supervision, employment records, and contemporaneous disclosures.

10. W.H. / Z.T. / Liam - alleged effort to meet underage former client, quiet termination context, and THC-pen allegation

W.H. later told the memorandum author by phone that staff member Liam was fired after allegedly trying to meet with an underage former adolescent-program client while Liam was an adult support staff member in the young-adult program. The memorandum author earlier remembers Z.T. discussing Liam's firing in a hushed and hesitant way with another client but did not hear the full allegation at that time. The memorandum author also remembers significant program drama around Liam being quietly let go.

A separate relayed allegation stated that Liam gave H.V. and C. hits from a THC pen for approximately two weeks while they were sequestered at a separate property after relapse. The fuller earlier account stated that this allegedly followed threats by H.V. and C. to retaliate against Liam for getting high on the job.

Records / corroboration / follow-up:

- W.H., Z.T., the other participant in the hushed conversation, H.V., C., the former adolescent client, HR and termination records, mandated-reporting records, schedules, drug testing, relapse records, house logs, and internal communications.

11. Younger Phase 1 client - fear after alleged restraint or beating and return to shared housing

In early 2023, a younger, thinner client directly expressed fear to the memorandum author and another client. He stated that a heavier client had restrained and beaten him, had been taken off site for a short period or weekend, and was then returned to shared Phase 1 housing. The younger client was frightened about again living with that person. The names have not yet been reconstructed.

Records / corroboration / follow-up:

- Phase 1 rosters, weekend or offsite records, incident reports, staff communications, medical records, and both clients' direct accounts.

12. Multiple former-client reports - Douglas Roberto, unsecured house, masked intruder, knife, client search, secrecy, and alleged firing

Multiple people told the memorandum author that Douglas Roberto allegedly left a Phase 3 house unsecured and that a man in a ski mask entered. According to the repeated account, Roberto grabbed a knife, brought a client with him to sweep or search the house, told the client not to tell anyone, and was fired shortly afterward. The memorandum author did not witness the event and has not yet interviewed the client allegedly brought into the search.

Records / corroboration / follow-up:

- Direct account from the client allegedly used in the search, other residents, house and staff logs, 911 or police records, incident reports, HR records, termination timeline, and internal communications.

13. K.G. - relayed account of beating and kicking an adolescent client

K.G. recounted in 2024 that he and W.H. beat and kicked an adolescent client while the client was on the ground at an adolescent house. The memorandum author did not witness the underlying event. The allegation raises questions about adolescent supervision, injury documentation, staff awareness, separation, discipline, and protection of the harmed client.

Records / corroboration / follow-up:

- K.G., W.H., the harmed client and witnesses; adolescent-house rosters, incident reports, staff schedules, medical and disciplinary records.

14. T.J. - David Vieau allegedly berated John Stewart in front of clients and staff

T.J. directly told the memorandum author in late 2021 that shortly before September 2021, David Vieau arrived at Phase 1 and berated program director John Stewart, calling him a "fucking idiot" in front of clients and staff. The memorandum author did not witness the confrontation. It is preserved as a staff-culture and leadership-culture allegation, not as proof of the separate client-money allegation involving Stewart.

Records / corroboration / follow-up:

- T.J., Stewart, Vieau, staff and client accounts; schedules, house logs, supervision notes, HR records, and internal communications.

15. Staff-relayed account - transgender woman allegedly emotionally terrorized in the men's program

Around 2023, an unidentified staff member told the memorandum author that a transgender woman placed in the men's young-adult program around early 2021 had been "emotionally terrorized." The account raises questions about placement decisions, foreseeable harassment, safety planning, documentation, staff response, and whether the client was moved or protected.

Records / corroboration / follow-up:

- The staff source and former client; placement records, policies, incident reports, clinical notes, staff communications, safety plans, and other witnesses.

16. Client-culture accounts communicated by clients - racialized violence, mugshot group chat, retaliation after "snitching," and identity-based hostility

Separate client accounts and recollections include: an allegation that L.B. used a racial slur toward D.W., threw fried chicken at him, and a fistfight followed; the memorandum author's memory that a group chat using D.W.'s mugshot or arrest article was widely circulated and mocked, allegedly after being created by Q.R.; and a relayed allegation that a client regarded as a "snitch" was knocked unconscious by another client on the first floor of 189 Orange Street.

Additional communicated accounts include H.V. allegedly using an anti-gay slur toward an adolescent client; D.W. allegedly using an anti-gay slur toward Q.R. during or after group; and the memorandum author's firsthand experience of being sexually shamed through a false statement about L.M. in front of clinical staff, including Chris Rush.

Records / corroboration / follow-up:

- Direct participant and witness accounts, group-chat screenshots, CCTV, incident and medical records, group schedules, 189 Orange schedules, clinical notes, staff communications, and separation or disciplinary records.

17. Killingworth parent / loved-one public Reddit source - attempted hanging, alleged resident-on-resident sexual assault, and vaping

A public Reddit commenter identifying herself as a parent or loved one stated that there had been a recent attempted hanging involving a person she believed was fourteen and believed survived, placing the event in the last week of May 2026. She separately alleged a female-to-female sexual assault between residents in May 2026 and stated that her daughter reported vaping by staff and possession of a vape by a resident. A separate Citizen dispatch-audio item dated June 13, 2026 reported an emergency response near Parker Hill Road Extension for a reported attempted hanging by a fourteen-year-old girl. It remains unresolved whether the two references concern the same event.

Records / corroboration / follow-up:

- DCF significant-event reports, 911/CAD and dispatch audio, EMS, hospital, house logs, rosters, clinical and safety records, mandated-reporting records, staff schedules, and parent follow-up.

18. J.Y. email - early women's-program graduate outreach

J.Y., identified in the source archive as an early women's-program graduate, reached out by email in July 2026. The email stated that allegations involving coercion, abuse, and harassment were consistent with her own experience and offered assistance, including speaking by telephone or in person. No full event-by-event interview had yet been completed in the supplied memorandum. The email must remain in this consolidated section as a named source lead and should not be reduced to a generic statement that "women reached out." Any stronger event-level attribution must follow an interview and confirmation of consent, anonymity, and publication preferences.

Records / corroboration / follow-up:

- Preserve the original email, complete headers, attachments, date and time metadata, and all replies.
- Conduct a source-directed interview covering client dates, houses or phases, specific coercion, abuse, harassment, staff knowledge, witnesses, contemporaneous documents, and desired anonymity posture.

19. Early women's-program client and later Phase 3 case manager - email outreach

A second person reached out by email in July 2026 and stated that she had been both an early women's-program client and later a Phase 3 case manager. She offered to speak. Because no substantive event-level interview had yet occurred in the supplied memorandum, this remains a high-priority dual-vantage-point witness lead rather than testimony about specific incidents.

Records / corroboration / follow-up:

- Preserve the original email and headers; confirm client and employment dates, roles, houses, supervisors, records, specific events, and source-protection preferences.

20. J.P. email - alleged loss of more than \$1,000, severe alcohol withdrawal, parental manipulation, and corroboration

A former client identified as J.P. emailed on July 20, 2026. He alleged that in October 2022, case manager Nick Anderson took more than \$1,000 in cash tips and that the money was never returned when he left. He also stated that when he arrived in March 2021 he was clearly experiencing severe alcohol-withdrawal symptoms, repeatedly informed multiple support staff about his symptoms and drinking history, was isolated alone pending COVID testing, was not sent to detox or an emergency department, and was not checked by a higher-level staff member until day three. He stated that this was his first treatment-program admission and he did not know he should have been in detox, but believed the treatment provider should have recognized the need.

J.P. further alleged extreme manipulation of his parents to keep him in the program throughout both stays. He stated that he remembered most of the incidents described in the archive video and could vouch for them, while requesting anonymity in the memo. That general corroboration must be broken down incident by incident before it is represented as independent proof of any specific event.

Records / corroboration / follow-up:

- Client-funds ledgers, cash-property and safekeeping records, receipts, return-of-funds documentation, Nick Anderson case-management and supervision records, tip records, banking records, and contemporaneous messages.
- March 2021 intake, nursing, CIWA-Ar or other withdrawal assessments, vital signs, medications, observation and isolation logs, COVID records, detox and ER screening, on-call communications, transport records, and staff schedules.
- Family emails, call logs, treatment-extension discussions, discharge objections, billing records, and an incident-by-incident corroboration matrix.

CONTINUATION OF THE SAME CONTROLLING CUMULATIVE SECTION - ENTRIES AFTER J.P.

This material is inserted here, immediately after entry 20 and before the J.P. public addendum. It is not a later cross-reference. It carries the substantive source stories filed later in the memorandum into the section that expressly says no source account is omitted merely because it appears elsewhere.

Placement rule. The entries below are part of "Complete Consolidated Source, Email, Phone, Reddit, DM, and Witness Accounts - Full-detail controlling section - July 20, 2026." Later full-detail addenda remain in place as source records. This continuation is intentionally cumulative and preserves evidentiary distinctions.

21. Actual-Search3197 - 2019 women's-program account: admissions representations, adult autonomy, medical access, privacy/property, compulsory AA, career interference, and financial burdens

A former women's-program client using the Reddit identifier Actual-Search3197 supplied a detailed written account on July 22, 2026. She reports attending from approximately June through December 2019, entering at age twenty-four and turning twenty-five during placement. Before Turnbridge she had completed treatment at Silver Hill Hospital. She says her family was told Turnbridge would likely last about three months and that she could return to work after about one month; instead, she remained roughly seven months.

She reports that promised ice hockey and meaningful basketball access did not materialize; prior treatment was not meaningfully credited; she was placed at the lowest level; requests to process a major breakup were repeatedly deferred; and a request to attend an outside family-dynamics support group was denied. She states she was required to attend AA, obtain a sponsor, and identify as an alcoholic despite not believing she had an alcohol-use disorder.

She says she repeatedly wanted to leave but did not believe she was permitted to discharge, even though she was an adult with savings. Her mother relied on Turnbridge recommendations that leaving was unsafe. She ultimately left only after receiving permission to go home for Christmas and then choosing not to return.

Medical and daily-living allegations include an approximately two-month delay before seeing a physician and obtaining a rescue inhaler, difficulty accessing food her family sent because it was stored in a basement, delayed hygiene supplies, and restrictions on exercise. Privacy/property allegations include searches of her belongings, a phone search followed by staff allegedly telling her they laughed at personal photographs, and a laptop that was allegedly lost when devices were returned. She also says a requested case-manager change was denied, she was reprimanded for computer use that had already been approved for job applications, and she was compared to a homeless woman with methamphetamine addiction and told she was no better.

Career and financial allegations include being discouraged from returning to finance; being required to use a sober companion for an Atlanta job interview at more than \$1,000 in professional fees plus travel expenses; being denied permission to purchase a car and therefore relying on Uber; and perceiving that scholarship clients progressed more quickly than privately paying clients.

Records / corroboration / follow-up: Admissions calls, brochures, contracts, family communications, Silver Hill records, treatment plans, AA/sponsor requirements, discharge/AMA records, medical and inhaler records, food/hygiene/exercise records, device-search and property records, grievance/case-manager reassignment records, job-application and sober-companion records, transportation restrictions, scholarship/private-pay progression, billing, and length-of-stay data.

Archive classification: Direct former-client testimony; detailed but unverified except where future records or witnesses corroborate it. Public use remains limited to the authorized identifier Actual-Search3197.

22. Annie - 2022 direct former-client testimony: transgender-client safety, racial stereotyping, staff boundaries, peer violence, sexual privacy, therapy concerns, transport conduct, and residential conditions

Annie, a former client who states Turnbridge records identify her under a former name, provided text-message and telephone testimony in July 2026. She reports being a Black transgender woman placed in Turnbridge's men's adolescent program in 2022 while primarily seeking mental-health treatment.

Regarding Samantha Trumata, Annie alleges an early racialized exchange in which Trumata guessed Annie was from southeast Washington, D.C. and called it "the hood." Annie later describes a major house crisis involving returning client M., group violence, property destruction, police removal for emergency psychiatric evaluation, and what she viewed as Trumata's failure to de-escalate. Annie says Trumata later told a male staff member that Annie had "turned real ghetto" and suggested Annie might assault her; Annie also alleges insurance was told she had joined the group against staff, which Annie disputes.

She says she left soon afterward with family support and a transport worker told her, "You're free already - you're a lucky one."

Annie separately describes sustained anti-trans harassment of client K., including deadnaming, slurs, exclusion, thrown objects, mocking, and ceremony humiliation. She says she personally witnessed two distinct physical assaults on K.: one surprise attack near dinner and a later multi-client group attack in or near K.'s room while behavioral-health technicians were down the hall. She reports no meaningful prior separation from the clients targeting K.

Annie also describes a male staff member named John [last name to confirm] as engaging in sexualized or personal favoritism, watching her from the doorway while she got ready, making comments about her appearance and transgender identity, discussing handcuffs, shackles, headlocks, police power and juvenile detention, showing political/pro-ICE material, making racialized assumptions about her background and boyfriends, intervening selectively in peer discipline, and giving her his TikTok account. Annie interprets the pattern as sexualized favoritism, transphobic paternalism, political pressure, coercive-power fixation, racial stereotyping, and unequal discipline.

Annie reports a consensual sexual encounter with another client on her final night. She says John remained outside the doorway, laughed, and later told a female staff member; the female staff member asked if Annie was okay and Annie cried. She also alleges her therapist Susie discussed favorite marijuana strains while Annie's mother waited for a Zoom session; a transport worker called her "my prisoner"; cameras often did not work; clients engaged in communal sexual behavior; serious bathroom sanitation problems persisted; and staff used a sexualized nickname for a client.

Records / corroboration / follow-up: Annie's complete file; placement and transgender-safety plans; staff rosters and schedules for Trumata, John, Susie, transport staff, and BHTs; insurance submissions; police/EMS and incident records for the house crisis; separate incident/CCTV/medical records for both assaults on K.; camera-maintenance records; sexual-activity and privacy policies; sanitation records; therapy/supervision records; and direct accounts from K., D., V., J., N., other residents, and staff witnesses.

Archive classification: Direct former-client testimony containing personally experienced events, personally witnessed assaults/harassment, and limited relayed background. Uncertain staff identities remain provisional.

23. A.M. - direct former-client testimony: self-harm disclosure response, psychiatric transport, phase-down, prolonged placement, discharge interference, collective blame, and lasting loss of trust in therapy

A.M., a former women's-program client, reports approximately three continuous years at Turnbridge from about age twenty to twenty-three. She states that when she experienced an urge to self-harm, she followed the safety instruction she had been given and voluntarily surrendered her razor instead of cutting herself. According to A.M., staff called police, had her transported by ambulance to a psychiatric emergency department, and then phased her down. She experienced the sequence as punishment for honesty and help-seeking.

A.M. further states that she was one of two women who remained approximately three years. She alleges that a therapist tried to help her obtain discharge and was later fired. The causal connection between discharge advocacy and termination is not established and requires records. She also says that after she relapsed, Turnbridge blamed her for an entire house relapsing because she relapsed first, and that the women's-program director then gave her hostile looks and refused to speak to her for approximately two weeks.

A.M. says the experience "demolished" her sense of safety in therapy, repeatedly broke her down, made her feel like a monster, and left trauma she is still unlearning. She expressed willingness to participate in accountability efforts while asking that contact remain source-directed.

Records / corroboration / follow-up: Complete file and exact placement dates; self-harm risk assessment, safety plan, sharps log, police/EMS/psychiatric-ER records, phase-down rationale, family/insurer communications; all discharge requests and AMA discussions; identity and HR file of the therapist who allegedly supported discharge; records of the house relapse and any blame assigned to A.M.; program-director identity, supervision and complaint records; and witness accounts.

Archive classification: Direct former-client testimony. The alleged therapist-retaliation causal link remains unverified and must not be stated as established fact.

24. Old-Hedgehog-7363 - preliminary former-client outreach: North Haven adolescent home, Prospect Street women's adult program, two Yale hospitalizations, police/ambulance transports, and alleged absence of documentation

A former client using the Reddit username Old-Hedgehog-7363 reported attending both the North Haven adolescent home and the women's adult program on Prospect Street. She stated that Turnbridge called police on her twice, placed her in an ambulance twice, and that she was hospitalized at Yale on both occasions.

She further stated there was "zero documentation" of those hospitalizations. At this stage, that means she reports not seeing, receiving, or locating documentation in the records available to her; it should not be converted into a finding that no Turnbridge record exists. She stated that she was preparing a detailed Google document covering her experience from start to finish and intended to provide it.

Records / corroboration / follow-up: Completed source document and metadata if voluntarily supplied; exact dates of both episodes; police/CAD/body-camera records; EMS patient-care reports; Yale ED/psychiatric/inpatient records; Turnbridge incident, significant-event, clinical, nursing, risk, safety, medication, house-log, staff-schedule and return/discharge records; family and insurer communications; and any records request showing what documentation was or was not produced.

Archive classification: Preliminary direct former-client outreach. No event details should be inferred beyond what the source has supplied.

25. E.A. - preliminary direct former-client testimony: alleged grooming and explicit messages by male staff member while she was sixteen; prior warnings to adults; preserved-message lead

E.A., a former women's-program client, reports that during her final months in residential treatment, when she was sixteen, a male staff member sent her explicit photographs and engaged in conduct she described as "practically groomed" her. She also relayed that male clients alleged the same staff member was actively getting high.

E.A. says that for months before similar conduct happened to her, she begged and pleaded with her case manager and parents about other clients' testimonies and events she believed were happening in real time. She reports that her family only recognized the program as unsafe after the alleged conduct affected her directly.

E.A. stated that she expected to regain access to the Instagram account she used at the time and might be able to supply historical message screenshots after returning to the United States. Those messages had not yet been supplied when the later entry was drafted, and no claim should be made about their contents or authenticity until preserved.

Records / corroboration / follow-up: E.A.'s complete file; age/admission/discharge and house/phase records; relevant staff rosters, supervision, HR, discipline and separation records; historical Instagram messages and metadata if voluntarily supplied; prior warnings to case management and family; family testimony; direct accounts from male clients who alleged staff drug use; mandated-reporting, DCF, DPH, police or internal-investigation records; and staff-electronic-contact policies for minors.

Archive classification: Preliminary direct former-client testimony plus a relayed staff-drug-use allegation and a potential contemporaneous-message lead. Source identity remains initials-only.

26. A. - direct former-client testimony: duration representations, sexualized leadership conduct, licensing-history context, sexual pathologization, confidentiality breaches, post-graduation tracking, recovery interference, and alleged staff-minor sexual misconduct

A. supplied a detailed written account and documentary attachments on July 28, 2026 and authorizes public identification only by first initial. She reports first entering Turnbridge in early 2017 and returning around August 2017. She says she was initially told she could leave after roughly one month but learned after arrival that clients understood the program to last about a year.

A. describes program director Tom Marzilli as making inappropriate sexual comments, including allegedly screaming at a seventeen-year-old client after sex at a meeting and asking whether the man had ejaculated inside her. A. further alleges Marzilli was barred from the women's house after sexual involvement with a support staff member who had recently graduated from the program. The memorandum author independently remembers hearing while enrolled that Marzilli was banned from the women's house, but not the reason. A. also supplied official Colorado licensing materials showing formal allegations under several statutory categories, including a sexual-contact category, resolved by voluntary surrender/relinquishment rather than findings after a contested hearing. A. additionally alleges conspicuous gambling behavior; a public Foxwoods tournament result is contextual evidence of poker participation only, not proof of gambling

disorder.

A. reports being placed on a “sex contract” and forced to see a sex therapist because of consensual sexual relationships with women; she says the outside therapist refused to treat her because the therapist viewed the behavior as normal under the circumstances. She alleges staff said HIPAA did not apply in housing, spread private information, searched and took her phone, and used information from it to stigmatize her. She specifically alleges Audrey Bell spread private information and damaged her reputation, while reporting that therapist Lila Sussman left because of concerns about the organization; those employment assertions require direct confirmation.

A. says Turnbridge celebrated her at graduation as a “miracle story” and later labeled her a predator, warned current clients about her, and repeatedly investigated or blamed her when girls ran away. She supplied texts in which Turnbridge-affiliated people acknowledged checking whether missing clients were with her while also acknowledging she had not recently been engaging with clients. She alleges the resulting stigma interfered with local recovery meetings and contributed to the context around a relapse after twenty-two months, while expressly accepting responsibility for her own relapse. She says that after relapse she asked Audrey Bell for resources and received no meaningful response.

A. also recounts grief surrounding the overdose death of best friend Isabella Nicolia and alleges Marzilli made disparaging comments at the memorial. She reports a broader leadership culture in which staff spoke negatively about Marzilli. Finally, A. alleges that a woman who had completed Turnbridge, later became a technician/support worker, and at age twenty-six became sexually involved with a sixteen-year-old female client; A. reports DCF interviewed residents and that the minor later ran away with the employee. This last allegation is a serious safeguarding lead requiring official records and direct-source corroboration.

Records / corroboration / follow-up: A.'s complete records from both 2017 placements; admissions and duration materials; Marzilli personnel/access/HR and Colorado licensing files; sex-contract and outside-therapist records; phone/device search records; confidentiality complaints; post-graduation staff contacts and supplied text metadata; relapse/recovery-contact records; memorial witnesses; and DCF, police, HR, elopement, roster, staffing, family-notification and mandated-reporting records concerning the alleged adult-employee/minor relationship.

Archive classification: Direct former-client testimony with documentary and public-record components. Public records establish only what they actually show; motive and unverified allegations remain attributed to A.

26A. A. supplemental account - client-on-client physical violence and alleged coerced sexual activity

In a later direct-message supplement, A. described allegations involving harm to other former clients. She reported that a male Turnbridge client became physically violent toward a woman A. had previously been involved with; A. did not report that the violence was directed at her. She also reported that the same male client coerced another former friend into sexual activity. A. later confronted the male client and alleges staff reprimanded her rather than meaningfully addressing the underlying reports.

The account is relevant to client-on-client violence, sexual coercion, supervision, clinical response, housing/separation, and whether staff knew of or responded to escalating interpersonal danger. Exact dates, locations, participants, witness posture, and any disclosures or medical consequences require structured follow-up.

Records / corroboration / follow-up: A.'s supplemental messages and metadata; direct interview establishing exact chronology and consent; house rosters, staff schedules, incident reports, clinical notes, safety plans, medical records, separation/housing decisions, and contemporaneous disclosures or witnesses.

Archive classification: Supplemental direct former-client testimony relaying alleged harm to other former clients, plus A.'s firsthand account of her confrontation and alleged staff response. The alleged violence and sexual coercion were not reported as having happened to A.

27. smackinbucketsss - Killingworth 2025 former-client account: peer unpredictability, fights/“riots,” nicotine, and THC cartridges

A Reddit user identified as smackinbucketsss stated that he was at Killingworth in 2025. He denied that anyone put hands on him except in fights, but described “mad crazy” and unpredictable peers and characterized many incidents as “riots or sh.” He also stated that his group had nicotine and THC cartridges and described the experience as a “fever dream.”

The account is limited and informal, but it independently overlaps Turnbridge's own 2025 significant-event data regarding physical aggression and substance-related events at Killingworth. It does not establish the number, severity, cause, or staff response to particular fights or “riots.”

Records / corroboration / follow-up: Original Reddit exchange and metadata; source-directed clarification of dates, age, house, injuries, meaning of “riots,” staff response, and contraband access; 2025 Killingworth rosters, incident reports, significant-event reports,

contraband searches, drug screens, staff schedules, and camera records.

Archive classification: Direct former-client Reddit testimony about peer culture and contraband, with limited event-level detail.

28. S.S. (“Support Staff”) - support-staff direct source: psychiatric-acuity retention, knife/homicide threats, CCTV corroboration, direct-care culture, and relayed staff-boundary/substance concerns

A source identified only as S.S. reported approximately three years of work at Turnbridge. S.S. states he observed clients whose psychiatric needs appeared to exceed Turnbridge's level of care remain for extended periods, including at least two clients in severe active psychosis who remained for months before eventual hospital or police escalation.

S.S. describes a specific resident who allegedly threatened to murder other residents and was repeatedly found with knives. S.S. says he personally found three large knives in the client's room over roughly two weeks while the client remained in shared housing. This is a specific firsthand staff-safety account requiring identification of the residence, client, decision-makers and risk records.

S.S. independently identifies himself as one of the clients to whom Drew Behr showed the M.J./C.S. fire-extinguisher CCTV footage, directly corroborating the narrower proposition that Behr displayed the serious incident footage to clients. S.S. also retrospectively stated that case managers and support staff treated the memorandum author badly on a daily basis and expressed regret about having laughed during one difficult moment; this is contextual corroboration, not proof of every underlying event.

S.S. broadly characterized direct-care culture as indifferent to clients. He also relayed, through former case manager Carter, an alleged Tom Marzilli statement that “the parents are the real clients”; S.S. did not hear Marzilli say this directly. S.S. further reported learning that a former support-staff manager was fired after allegedly attempting to have sex with a client, including taking the client to dinner, and stated that staff were allowed to work while high and that he knew of staff who gave marijuana to clients. Follow-up must distinguish what S.S. personally witnessed from what he learned from Carter or other staff.

Records / corroboration / follow-up: Source-directed interview separating firsthand and relayed knowledge; exact S.S. employment dates/roles; psychiatric and hospital-transfer records; house/search/contraband/risk records for the knife case; CCTV access logs and witness accounts; direct interview with Carter; HR/termination/mandated-reporting records for the alleged staff-client sexual-boundary event; and drug-testing, impairment, staffing and incident records concerning staff substance use or marijuana provision.

Archive classification: Mixed direct staff observations, former-client recollection, direct corroboration, broad evaluation, and expressly relayed staff statements. Source identity remains restricted.

29. I.S.C. - women's-program direct former-client account with contemporaneous journals, case-manager messages, behavioral contract, and later complaint material

I.S.C. is a former women's-program client from the late-2022 through 2023 period who supplied an unusually extensive documentary record, including approximately fifty-seven photographed journal pages, more than twenty case-manager communications, a photographed continued-residence contract, later complaint messages, and related records. She reports that she and/or her family were given materially shorter expectations for phases and possible graduation than the placement she ultimately experienced; she also describes substantial unstructured time, inconsistent therapy content, limited life-skills programming, case-management access problems, and turnover.

I.S.C. describes a November 2022 roommate recently returning from psychiatric care whom she believed was manic or psychotic. She says the roommate repeatedly stood near women's beds and asked women for massages, conduct I.S.C. experienced as sexually intrusive and unsafe, and alleges staff minimized the concern rather than creating a clear separation or protection plan.

She alleges staff reviewed private Discord and Venmo activity, prolonged phone/laptop restrictions, and used unclear criteria for restoring access. She reports being without Lamictal for more than three weeks and also without trazodone; when she said she felt horrible and unlike herself, she says a case manager responded “It's all about priorities” and redirected the discussion to electronics. A photographed Contract for Continued Phase 3 Residence dated May 31, 2022 is paired with contemporaneous messages in which I.S.C. twice states she did not have her own copy and the case manager does not dispute that.

I.S.C. also reports an abrupt room switch, conflicts involving work and family-therapy scheduling, delayed or disputed graduation/discharge decisions, and a proposed two-day evaluation by a forensic psychologist whose requesting party and purpose she says were not clearly explained.

Regarding case manager Kelly McCormack, I.S.C. alleges repeated screaming, humiliation, favoritism, arbitrary/prolonged restrictions, invasive searches, gossip, planting marijuana among her belongings, planting or later claiming to find a condom in her property, accusing her of prostituting herself in exchange for a vegan-restaurant gift card, sending her back to Phase 1 for approximately eight weeks without a legitimate clinical basis, and taking or failing to return a Nintendo Switch. June 2023 messages with therapist Jeni preserve contemporaneous conflict over a UA/time-slot issue, alleged disrespectful communication, medication access before work, and Jeni's remark that she tried to hide a gaming laptop so Kelly and I.S.C.'s parents would forget about it. I.S.C. further alleges Turnbridge requested that McCormack take a drug test, McCormack refused, and then left or was removed; exact HR status is unresolved.

I.S.C. also supplied a 2024 public Foxon-community post and identification chain concerning a woman she and Jeni independently identify as McCormack in a theft-related community allegation. That material remains a public/community lead, not proof of the alleged conduct. Public Connecticut court records concerning McCormack are treated separately in the staff-vetting section.

Records / corroboration / follow-up: Complete I.S.C. file; journals/messages/contract metadata; admissions and phase-duration communications; roommate safety and psychiatric records; device-search and restriction records; medication orders/MARs/pharmacy logs; room-move and work/family-therapy records; graduation/discharge and forensic-evaluation communications; complete McCormack supervision, complaint, search/property, phase-down, drug-test and separation records; Nintendo Switch/property records; Jeni communications; and official records for later public leads.

Archive classification: Direct former-client testimony with extensive contemporaneous documentation. Documentary timing strengthens the investigative value but does not independently prove every allegation.

30. O.C. - direct former-client testimony: transport against her will as a minor, 45-day representation versus approximately ten-month placement, repeated assaults, group humiliation, medical-care delays, adult-program treatment, and post-discharge staff-boundary concern

O.C. reports she was sent to Turnbridge on October 6, 2023 at age seventeen after her parents hired people to transport her against her will. She says she was told Killingworth was generally a forty-five-day treatment and that she would be there roughly that long. On approximately day forty-eight she was transferred to adolescent extended care in North Haven/New Haven rather than discharged. She turned eighteen at the end of January, was moved to the adult Prospect Street house on her eighteenth birthday, later progressed through the adult program including Quinnipiac, and reports full discharge on August 6, 2024 - roughly ten months after admission.

O.C. describes three serious peer-violence incidents in adolescent extended care. She says a newly arrived girl heard a false rumor that O.C. had sexually assaulted someone and punched O.C. while O.C. was sleeping; that client was reportedly sent out. A few weeks later, O.C. says the girl who had spread the rumor punched her while she was sleeping because the girl wanted to get kicked out, yet remained in the program for a period. O.C. also reports that a roommate with whom she fought over allegedly stolen clothing threw a full plastic water bottle at O.C.'s head while she was sleeping; O.C. says staff did not meaningfully intervene and the two remained roommates for months.

O.C. identifies Killingworth as the worst part of the placement and describes a weekly "shit talk circle." She says she was frequently the principal target, the full circle screamed at her, and when she tried to stand up and leave, people blocked the door, threatened that she would lose privileges, and told her she needed to sit there and take it because it would make her stronger. She says she was disproportionately bullied and subjected to this more than other girls.

O.C. reports multiple medical-care concerns while in adolescent programming: severe chest pain that made her believe she might die, followed by what she describes as passing out on a clinic couch for hours while little was done before eventual hospital transport; being told to drink tea and squeeze a stress ball while in pain; vomiting for months without seeing a doctor; and a ruptured eardrum for which she says urgent-care access was delayed for weeks while the condition worsened.

After turning eighteen, O.C. says she was told she would be fast-tracked through adult phases. She alleges the adult case managers were among the worst staff she encountered, that staff miscommunication left her unable to complete expectations, and that she was then punished, screamed at, yelled at, and humiliated for failures she did not believe were her fault.

A few months after discharge, O.C. says a Turnbridge program manager named Ian approached her through Instagram after ending a relationship with another recently discharged female client. O.C. says she initially found him attractive but became uncomfortable when he essentially asked to have sex; she declined, saying she did not want to be his rebound, and they did not continue contact. Ian's full identity, age, exact role, dates of employment and prior relationship require confirmation.

O.C. says she later became significantly ill, had to leave college, and continues to experience health problems that she believes were worsened partly by Turnbridge. She remains dependent on her parents for money and health insurance and reports daily reminders while living with the people who sent her. She recently began recognizing the experience as severely harmful, has sought trauma-focused therapists, contacted another survivor and Sarah Eagan, and is interested in obtaining her records and helping document what happened.

Records / corroboration / follow-up: Complete Turnbridge file from October 6, 2023-August 6, 2024; admissions/transport/guardian and 45-day representation records; all placement/phase/housing records; incident reports and medical checks for each peer assault; staff schedules and roommate/separation records; Killingworth group curriculum, notes and witnesses; Orange Street clinic, EMS/hospital, vomiting and eardrum/urgent-care records; adult-program case-management and disciplinary records; Ian employment, supervision, social-media and boundary records; educational and health records O.C. voluntarily authorizes; and her original Reddit/iMessage testimony with timestamps.

Archive classification: Direct former-client testimony concerning events beginning while O.C. was a minor. All allegations remain attributed; medical records and incident records may provide significant independent corroboration.

31. Drew Behr - alleged family-contact interference and “curbstomping” statement at 90 Ford Street

Approximate date: late September / early October 2021. The memorandum author alleges that Drew Behr, then his Phase 1 case manager, instructed his parents not to take his phone calls. After an altercation arising in that context, Behr allegedly brought him into an office and said that he had told his wife he thought about “curbstomping” the author, explicitly invoking American History X to describe the violence.

This is a specific firsthand staff-intimidation allegation relevant to family-contact control, retaliation, violent staff language, supervision, complaint handling, and whether later role progression considered prior client-safety complaints.

Records / corroboration / follow-up: Parents' recollection; family call logs, texts and emails; 90 Ford house logs/staff schedules; Phase 1 phone and family-contact policies; incident and clinical notes; contemporaneous disclosures; Drew Behr supervision, HR, complaint, promotion and role-progression records.

Archive classification: Firsthand allegation by the memorandum author; not an adjudicated finding.

32. Maura / Moira / Mara - 189 Orange group-removal incident after criticism of Turnbridge's influence over parents

Approximate date: summer 2022. The memorandum author recalls a group or therapy session at 189 Orange in which client D. criticized the Turnbridge care team's influence over parents, saying in substance that the care team manipulated parents or exercised excessive influence over them. A staff member remembered as Maura, Moira, or Mara [last name unknown] allegedly removed the memorandum author from the group after the criticism and surrounding discussion.

The exact staff identity, wording, reason for removal, and whether the author was formally removed or simply directed to leave require corroboration.

Records / corroboration / follow-up: Identify Maura/Moira/Mara; summer 2022 group schedules and participant lists; group/clinical notes; any removal record; D.'s direct account; other clients present; staff schedules; family-communication policies and records concerning complaints, resistance, requests to leave and staff guidance to parents.

Archive classification: Firsthand recollection with D.'s statement heard in group as contextual source material.

33. Public parent-video source - fourteen-year-old runaway after alleged AMA / child-protective-services pressure

A public video preserved later in the memorandum describes a mother contacting a troubled-teen-industry parent advocate after her fourteen-year-old daughter had been sent to Turnbridge. According to the speaker, the mother expressed intense concern about the placement and later reported that Turnbridge personnel told her she could not take her daughter home because doing so would be against medical advice and threatened to call child-protective services if she tried.

The speaker reported that the girl was then reported missing from Turnbridge on December 8, was found safe on December 9, and that the mother confirmed to the speaker that the missing girl was her daughter and that she was bringing her home. The speaker interpreted the alleged threat as coercive retention; that interpretation is not proof of motive.

Evidentiary distinction: Public-video speaker -> mother -> alleged Turnbridge statements. The mother's statements and alleged Turnbridge statements remain relayed allegations until independently confirmed.

Records / corroboration / follow-up: Mother and daughter if they freely consent; preserved direct messages; original public video/metadata; police/CAD/dispatch/recovery records; Turnbridge runaway/significant-event report; DCF records; house logs/staffing; custody/court-order records; AMA and parent-rights notices; calls/texts/emails/case notes; insurer/utilization-review and billing records.

Archive classification: Public-source relayed source chain paired with a reported missing-person event.

34. HQNN-reported former adolescent client and mother - Woodbury admissions, humiliation, family wedge-driving, peer humiliation, testing pressure, and transfer escalation

Attributed investigative reporting by Samuel DeFusco / HQNN described a former adolescent client and mother whose Woodbury placement reportedly ran from approximately December 2022 to February 2023. The family alleged they were shown attractive front-facing areas while other areas were run down; were promised a music room/CD-burning access that did not exist; experienced more than a month of delay in school coordination; and were not told an expected length of stay before a placement lasting nearly ninety days.

The mother and former client further alleged that an original therapist told the client he was “never going home,” called him a “genetic trash bag,” referred to other clients as “human trash bags,” spoke negatively about his mother, and stopped family-therapy calls because they were “too stressful.” A different therapist allegedly told the mother the client was suspected of flirting with another boy; the mother interpreted this as part of a pattern encouraging parental doubt about her own child.

The former client also described a stick-and-poke tattoo made by another resident and a staff-facilitated group tradition clients called “Shit Talk Wednesdays,” in which residents allegedly wrote anonymous insults about one another that were repeated to the target. He said the exercise led to fights. This independently overlaps O.C.’s later direct account of a weekly “shit talk circle,” while remaining a separate source from a different period and facility.

HQNN further reported that Turnbridge sought neuropsychological testing; the client refused; and the mother later learned the refusal was cited in a recommendation for a “higher level of care.” After nearly ninety days, the client was reportedly sent back to a Utah wilderness program for approximately three weeks as a bridge to a nine-month residential placement at Crossroads Academy. The mother alleged she was not told the transfer plan in advance.

Evidentiary distinction: Attributed investigative reporting based on a former client and mother, with Turnbridge response elsewhere in the reporting. Their allegations remain allegations unless independently corroborated.

Records / corroboration / follow-up: Complete Woodbury file; admissions materials; school coordination; therapist supervision/reassignment/grievance records; family-session notes; sexuality-related communications; tattoo/contraband reports; group curriculum and incident records for insult exercises; neuropsychological referral/refusal; higher-level-of-care rationale; discharge/transfer communications; educational-consultant and subsequent-program records; billing/utilization review; and consented direct follow-up with source family and relevant staff.

Archive classification: Attributed public-source investigative account, not an adjudicated finding.

35. Google-review timing concern after detailed negative former-client review

A later addendum records that after the memorandum author posted a detailed negative Google review under the name “Samuel Clemens,” a thin five-star review by “Mickey Dice” appeared within hours after an apparent gap of approximately six days since the prior visible review. The author preserved this as a review-integrity timing concern rather than proof of manipulation.

Because the July 20 controlling section expressly includes substantive information communicated through public comments and source channels, the timing concern is preserved here for completeness but must remain clearly separated from direct victim or witness testimony.

Records / corroboration / follow-up: Dated screenshots before and after the review; profile/review-history captures; logged-in/logged-out visibility checks; Google moderation notices; Turnbridge or reputation-vendor communications; internal review-solicitation/response communications; review-count and star-rating changes.

Archive classification: Public-platform observation; not proof of coordinated review activity.

Turnbridge / Turning Point Due-Diligence Memo

PUBLIC ADDENDUM - Direct former-client disclosure received July 20, 2026
Source identified throughout as J.P.

Source status: Direct email from a former Turnbridge client. The source requested anonymity. Both the public and private memoranda identify the source only as J.P.; no full name, email address, or complaint number is retained in these revised addenda.

Evidentiary status: This is a direct former-client account, not an adjudicated finding. The allegations should be tested through records, witnesses, and structured follow-up.

A. J.P. - client funds, alcohol-withdrawal response, family pressure, and corroboration

1. Alleged loss of more than \$1,000 in cash tips

J.P. alleges that in October 2022, case manager Nick Anderson took more than \$1,000 in cash tips from him and that the money was never returned when J.P. left the program. This should be treated as an allegation involving client funds, staff authority, property handling, and financial recordkeeping.

Potential corroboration and records:

- client-funds ledgers, cash-property logs, safekeeping records, withdrawal requests, receipts, and return-of-funds documentation;
- case-management notes, house logs, staff schedules, discharge records, and communications concerning the money;
- tip records, bank deposits, contemporaneous messages, and witnesses who knew J.P. possessed the cash;
- policies governing possession, confiscation, storage, accounting, and return of client money.

Archive classification: Direct former-client allegation concerning client funds and alleged non-return of property.

2. Alleged failure to provide timely detox or emergency evaluation during severe alcohol withdrawal

J.P. reports that when he arrived in March 2021, he was experiencing severe withdrawal symptoms and repeatedly told multiple support-staff members about his symptoms and drinking history. He alleges that because he had not yet received a COVID test, he was isolated alone in a room; that he was not transported to detox or an emergency department; and that no higher-level staff member checked on him until day three. J.P. states that this was his first treatment-program admission and that he did not know he should have been placed in detox, but believes the treatment provider should have recognized the need.

The account raises questions about intake screening, alcohol-withdrawal risk assessment, COVID-era isolation, medical escalation, observation frequency, and emergency-transfer criteria.

Potential corroboration and records:

- March 2021 intake, nursing, withdrawal-assessment, vital-sign, CIWA-Ar, medication, observation, and COVID-testing records;
- detox-screening, emergency-department, ambulance, transportation, physician, APRN, and on-call-clinician records;
- support-staff schedules, room-isolation logs, wellness checks, shift notes, incident reports, and supervisor notifications;
- admissions communications documenting J.P.'s drinking history and reported symptoms;
- policies in force during March 2021 for alcohol withdrawal, isolation, emergency escalation, and medical monitoring.

Archive classification: Direct former-client medical-safety allegation involving alcohol withdrawal, intake triage, isolation, and delayed higher-level review.

3. Alleged manipulation of parents during both stays

J.P. alleges that Turnbridge engaged in extreme manipulation of his parents to keep him in the program throughout both stays. The initial email does not provide event-level detail, so this remains a direct but preliminary allegation pending structured follow-up.

Priority follow-up:

- identify the dates and duration of both stays and the staff members involved;
- separate statements J.P. personally heard from statements later reported to him by his parents;
- obtain family emails, call logs, case-management notes, treatment recommendations, discharge objections, and billing records;
- clarify whether staff invoked relapse, danger, death, psychiatric instability, or family estrangement to discourage discharge or transfer.

Archive classification: Direct former-client allegation concerning family influence, retention, and client autonomy.

4. Corroboration of incidents described in the archive video

J.P. states that he remembers most of the incidents described in the memorandum author's video and can vouch for them. This makes him a priority corroborating witness, but it is not yet incident-specific. Follow-up should identify what he personally witnessed, what he knew contemporaneously, and what he only heard about later.

Use rule: The statement should not be represented as blanket independent proof of every incident in the video.

B. Cross-memo significance

New disclosure	Existing category strengthened
More than \$1,000 allegedly taken and not returned	Client funds, missing property, financial controls, and staff accountability
Severe alcohol withdrawal allegedly left without detailed plan	Medical safety, intake screening, emergency escalation, and withdrawal monitoring
Parents allegedly manipulated during two stays	Client autonomy, family pressure, retention, program duration, and billing
Source remembers most incidents in the video	Witness identification, event-level corroboration, and records preservation

C. Records and source-protection rules

- preserve the original email and full headers separately in a restricted source file;
- use only J.P. in all circulated public and private memoranda;
- preserve Nick Anderson's employment, case-management, supervision, and client-funds records for October 2022;
- preserve March 2021 intake, withdrawal-risk, isolation, medical-observation, escalation, and transfer records;
- preserve records from both stays concerning family calls, treatment extensions, discharge or transfer discussions, and billing;
- create an incident-by-incident matrix for the video events J.P. says he remembers.

D. Archive-safe framing

A former Turnbridge client, identified as J.P., alleges that a case manager took and never returned more than \$1,000 in cash tips in October 2022; that Turnbridge failed to send him to detox or emergency care despite severe alcohol-withdrawal symptoms at intake in March 2021; and that staff manipulated his parents to keep him in the program during two stays. He also says he remembers most incidents described in the archive's video. The account is a direct source disclosure, not an adjudicated finding, and should be tested through financial, intake, medical, staffing, family-communication, and discharge records.

Exhibit JP-1 - Redacted July 20, 2026 source email

The source's name, email address, complaint number, and signature have been redacted. The exhibit is included in both the public and private memoranda at the user's direction.

Turnbridge-related information for **COMPLAINT NUMBER REDACTED** Inbox x

 **J.P. - IDENTIFYING INFORMATION REI** 3:00 PM (37 minutes ago) ☆ 😊 ↩ ⋮

to me ▾

Case manager Nick Anderson stole over \$1,000 in cash tips from me that I never got back upon leaving the program. October 2022

Was not sent to detox when I first arrived when clearly having withdrawal symptoms and telling multiple support staff members about my symptoms and drinking history. I was going through severe withdrawal being isolated in a room by myself because I had not tested for Covid yet. Was never brought to the ER or had any higher up check in on me until day 3. As this was my first time in a program, I did not know that I should have been in detox but a treatment center should for sure know this. March 2021

Extreme manipulation of my parents to keep me in the program throughout both my stays.

I can vouch for what you said in the video because I remember most of those incidents but would like to remain anonymous. Hope you're doing well.

Best,
J.P.

The unredacted original should remain separately preserved in a restricted source archive and should not be circulated with either memorandum.

Turnbridge / Turning Point Due-Diligence Memo - Direct-Source Update

COMPLETE REPLACEMENT ENTRY - July 22, 2026

21. Actual-Search3197 - 2019 women's-program account: admissions representations, restricted adult autonomy, delayed medical access, privacy and property concerns, compulsory AA, career interference, and financial burdens

Source and status. A former Turnbridge women's-program client using the Reddit username Actual-Search3197 provided the memorandum author with a detailed written account on July 22, 2026. She attended Turnbridge from approximately June 2019 through December 2019, entered at age twenty-four, and turned twenty-five during the placement. The username is used as an anonymous public identifier at the source's direction. This is direct former-client testimony, not an adjudicated finding. Statements are framed as recollections and allegations where records have not yet independently verified them.

Source-history clarification. Actual-Search3197 had previously stated that revisiting Turnbridge was harming her well-being and that she could not provide further details at that time. She later reinitiated contact and supplied the detailed testimony below. This later voluntary submission supersedes the earlier instruction that she should not be contacted or described as an available source. Future contact must still remain source-directed, trauma-informed, and non-pressuring.

Prior treatment and admission context. Before Turnbridge, Actual-Search3197 had completed treatment at Silver Hill Hospital, including approximately two weeks at a higher level of care followed by twenty-eight days in a mental-health residential program. She reports that her family was told Turnbridge would likely last about three months and that she would be able to return to work after approximately one month. Instead, she remained for about seven months.

A. Admission representations and individualized treatment concerns

- Before admission, she was told she would be able to participate in ice hockey and basketball, two of her biggest interests. After arrival, she reports there was no ice-hockey program and no meaningful access to basketball.
- Despite completing treatment at Silver Hill, she was required to begin at the lowest program level. She felt her prior treatment and progress were not meaningfully considered and that she was discouraged and shamed rather than recognized for work already completed.
- She recalls little individualized assessment at arrival and remembers being told she would likely remain for a long time before staff appeared to know her circumstances.
- Her requests to process a significant breakup in therapy were repeatedly deferred with instructions to "table it."
- After learning at an AA meeting about an outside support group for complicated family dynamics, she requested approval from her case manager to attend. The request was denied. She recalls no explanation and believed the group could have been beneficial. At the time, the case manager had regular calls with her mother.
- She was required to attend AA and obtain a sponsor even though she did not believe she had an alcohol use disorder. She found this extremely distressing and inappropriate for her circumstances.
- She further states that everyone entering the program was expected to attend AA and identify as an alcoholic regardless of whether that label accurately reflected the individual's condition. She experienced this as coercion into an identity she did not believe applied to her.

B. Adult-client autonomy and ability to leave

- She repeatedly wanted to leave. She was an adult with sufficient savings to support herself, but she did not believe she was permitted to discharge.
- Her mother relied heavily on Turnbridge recommendations and was told it was unsafe for her to leave. As a result, her mother did not support discharge.
- At no point before the Christmas visit did she believe she had a realistic ability to leave. Although she was twenty-five, she understood that she could not simply discharge herself and that repeated requests to leave would not be honored.
- She ultimately left only after receiving permission to go home for Christmas in December 2019. She packed her belongings and chose not to return.

Institutional significance. This account raises questions about whether adult clients were clearly informed of their discharge rights, whether staff accurately distinguished clinical advice from legal authority, how families were counseled when an adult requested discharge, and whether continued placement depended on family pressure rather than the adult client's informed consent.

C. Medical care and daily living

- She experienced breathing problems and periodically needed a rescue inhaler. To the best of her recollection, approximately two months passed before she was permitted to see a physician and obtain one.
- Her family sent food because she was often hungry, but the food was stored in a basement and she frequently had difficulty getting staff to retrieve it because staff were busy or understaffed.
- She reports an extended delay before receiving basic hygiene products after admission.
- She had always been active and enjoyed working out, but staff restricted her exercise because they expressed concern about her workouts.

Institutional significance. These allegations raise medical-access, medication-access, nutrition, staffing, basic-needs, and individualized-activity questions. They should be tested through medication records, physician referrals, nursing notes, food-storage policies, staffing schedules, property logs, and treatment plans.

D. Privacy, property, and staff interactions

- Staff searched her belongings because they suspected drug use and left her room in disarray afterward.
- Her phone was searched. Staff later told her they had laughed about personal photographs found on it. She experienced this as humiliating and invasive.
- When she was eventually allowed to regain access to her phone and laptop, she was told the laptop had been lost.
- She requested a different case manager but was not permitted to change.
- While using a computer with prior approval to apply for jobs, a staff member who did not know about the approval verbally reprimanded her and ordered her off the computer despite her explanation.
- During the placement, she was compared to a homeless woman struggling with methamphetamine addiction and told she was no better than that woman. She experienced the comparison as degrading and deeply upsetting.

Institutional significance. The account raises questions about device-search authority, client privacy, staff access to personal images, humiliation, property inventory and loss, grievance procedures, case-manager reassignment, internal communication about approved activities, and staff use of degrading comparisons.

E. Career interference, compulsory supervision, and financial impact

- Her family was led to believe she could return to work after about one month. Instead, she was discouraged from returning to finance because staff said she could not handle that level of stress.
- When she was finally permitted to interview for a job in Atlanta, Turnbridge required her to travel with a sober companion. She states that she had to pay more than \$1,000 in professional fees, plus the

companion's airfare, meals, and other travel expenses. She was not offered the option to travel independently.

- Even after receiving more freedom, she was not allowed to purchase a car. She relied on Uber, which created a significant financial burden and limited her independence.
- She perceived that clients receiving scholarships progressed more quickly than privately paying clients. This gave her the impression that financial considerations influenced treatment length.
- The seven-month stay significantly disrupted her career and personal life.

Institutional significance. These allegations raise questions about pre-admission work representations, restrictions on employment, mandatory companion arrangements, companion fees and disclosures, transportation autonomy, privately paid versus scholarship-client progression, length-of-stay criteria, billing incentives, and whether financial conditions influenced clinical recommendations.

F. Full source statement

The following statement is preserved in substance as supplied by Actual-Search3197. Minor formatting changes were made only to integrate headings and bullet points; the meaning has not been altered.

"I attended Turnbridge from approximately June 2019 through December 2019. I was admitted at age 24 and turned 25 during my stay. Before entering Turnbridge, I had already completed treatment at Silver Hill Hospital, including approximately two weeks in a higher level of care followed by 28 days in a mental health residential program. My family was told Turnbridge would likely be about a three-month program and that I would be able to return to work after approximately one month. Instead, I remained there for about seven months. These events had a lasting emotional impact on me. While I may not remember every exact date, conversation, or staff member after several years, the overall experience and its effect on me remain clear. I have continued to think about these experiences for years. Preparing this summary required me to revisit events that I had tried to put behind me, but I felt it was important to share my experience in case it helps others."

G. Records / corroboration / follow-up

- Admissions calls, emails, brochures, website captures, contracts, intake notes, and family communications describing a three-month expectation, return to work after one month, recreation offerings, and program duration.
- Silver Hill discharge and treatment records establishing prior level of care and completed treatment.
- Treatment plans, level/phase-placement decisions, individualized assessments, clinical notes, therapy notes, and records concerning requests to process the breakup.
- AA attendance requirements, sponsor requirements, program policies on substance-use diagnosis, and documentation showing whether she was required to identify as an alcoholic.
- Case-manager notes and family-call records concerning her request for the outside family-dynamics support group and the reason for denial.
- All discharge requests, AMA discussions, risk assessments, family communications, legal-rights notices, and Christmas-pass or home-visit records.
- December 2019 packing, property-release, sign-out, non-return, discharge-classification, billing, and refund records.
- Medical, nursing, physician-referral, inhaler, medication-administration, respiratory-symptom, and emergency-escalation records.
- Food-delivery, food-storage, nutrition, hygiene-supply, staffing, and exercise-restriction records.
- Room-search, property-search, phone-search, device-access, privacy, grievance, and staff-conduct policies; staff notes concerning personal photographs; laptop inventory and missing-property records.
- Case-manager reassignment requests and grievance records.

- Job-application approvals, computer-use permissions, Atlanta interview communications, sober-companion contract and invoice, professional fees, airfare, meal, travel, and reimbursement records.
- Transportation policies, vehicle restrictions, Uber-related records if maintained, work-readiness assessments, finance-career recommendations, scholarship status, private-pay status, phase progression, billing, and length-of-stay data.

H. Due-diligence questions generated by the account

1. What was the written and oral expected length of stay communicated before admission?
2. Why was prior treatment at Silver Hill not reflected in initial placement or level assignment?
3. What individualized assessment supported a seven-month stay and restrictions on work, transportation, exercise, and outside support?
4. What legal and clinical information was given to a competent adult who repeatedly requested discharge?
5. What was said to her mother about danger, safety, discharge, and the need for continued placement?
6. Why did access to a rescue inhaler allegedly take approximately two months?
7. What authority permitted staff to search her phone, and why were staff allegedly discussing or laughing at personal photographs?
8. What happened to the missing laptop, and was any property-loss report created?
9. Why was a sober companion required for a job interview, how were costs disclosed, and what less restrictive options were considered?
10. Were AA participation and alcoholic self-identification imposed without an individualized alcohol-use diagnosis?
11. Did scholarship and privately paying clients progress at different rates, and if so, what clinical criteria explained the difference?

I. Archive classification and source-use rule

Direct former-client testimony concerning admissions representations, treatment individualization, compulsory AA, adult-client autonomy, family pressure, medical access, daily living, privacy, property loss, staff humiliation, career interference, transportation restrictions, mandatory sober-companion costs, program length, and possible financial retention incentives. The account remains unverified except where future records or witnesses corroborate it. Public and circulated versions may identify the source as Actual-Search3197. Do not publish her legal name, contact information, or other identifying information unless she separately authorizes it.

Cross-memo integration rule. This entry replaces the earlier A.S. summary and withdrawal-only account. It should be treated as the controlling version of this source's testimony and integrated into the existing admissions/program-length, adult-autonomy, family-pressure, medical-access, privacy/property, compulsory-AA, career-impact, and financial-retention pattern sections. The earlier source boundary reflected her condition at that moment; the present detailed statement was later supplied voluntarily and controls the current archive posture.

Turnbridge / Turning Point Due-Diligence Memo - Source Exhibit

EXHIBIT ACTUAL-SEARCH3197-1 - Detailed written testimony received July 22, 2026

Source identifier: Actual-Search3197. The Reddit username is used as an anonymous public identifier at the source's direction. The legal name and contact information are not included. This exhibit preserves the submitted testimony in a clean text format. It is direct source testimony, not an official finding.

My Experience at Turnbridge (2019)

Background

- I attended Turnbridge from approximately June 2019 through December 2019. I was admitted at age 24 and turned 25 during my stay.
- Before entering Turnbridge, I had already completed treatment at Silver Hill Hospital, including approximately two weeks in a higher level of care followed by 28 days in a mental health residential program. My family was told Turnbridge would likely be about a three-month program and that I would be able to return to work after approximately one month. Instead, I remained there for about seven months.

Admission and Treatment Planning

- Before admission, I was told I would be able to participate in ice hockey and basketball, which were two of my biggest interests. After arriving, there was no ice hockey program and no meaningful access to basketball.
- Despite completing treatment at Silver Hill before admission, I was required to start at the lowest level of the program. My previous treatment and progress did not appear to be taken into account. I felt discouraged and shamed rather than recognized for the work I had already done.
- When I arrived, I felt there was very little individualized assessment. I remember being told I would likely be there for a long time before anyone seemed to know me or my circumstances.
- My requests to process a significant breakup in therapy were repeatedly deferred, and I was told to "table it."
- During an AA meeting, I met someone who recommended a support group for individuals dealing with complicated family dynamics. Because I needed approval to attend outside meetings, I asked my case manager if I could go. She denied my request. At the time, my case manager had regular phone calls with my mother. I do not know why my request was denied, but I believed that group could have been beneficial to me and was never given an explanation that I remember.
- I was required to attend AA meetings and obtain a sponsor even though I did not believe I had an alcohol use disorder. I found this experience extremely distressing because I did not feel it was appropriate for my situation.
- Everyone who came through the program was expected to attend AA meetings and identify themselves as alcoholics, regardless of whether that accurately reflected their circumstances. I felt coerced into adopting a label that I did not believe applied to me.

Ability to Leave the Program

- I repeatedly wanted to leave the program. I was an adult with the financial means to support myself, but I did not believe I was permitted to discharge. My mother relied heavily on Turnbridge's recommendations and was told it was not safe for me to leave. As a result, she did not support my discharge.
- At no point did I believe I had a realistic ability to leave the program before my Christmas visit home. Although I was 25 years old, I believed I could not simply discharge myself. I repeatedly asked to leave, but I understood that I would not be allowed to do so.

- I ultimately left only after I was permitted to go home for Christmas in December 2019. I packed my belongings and chose not to return.

Medical Care and Daily Living

- I experienced breathing issues and periodically needed a rescue inhaler. To the best of my recollection, it took approximately two months before I was allowed to see a physician and obtain one.
- My family sent me food because I was often hungry, but it was stored in the basement, and I frequently had difficulty getting staff to retrieve it because they were busy or understaffed.
- It took an extended period before I was able to obtain basic hygiene products after admission.
- I have always been very active and enjoyed working out, but my exercise was restricted because staff expressed concern about my workouts.

Privacy, Property, and Interactions with Staff

- My belongings were searched because staff suspected drug use, and my room was left in disarray afterward.
- My phone was searched, and staff later told me they had laughed about some of my personal photos. I found this humiliating and invasive.
- When I was eventually allowed to have my phone and laptop back, I was told my laptop had been lost.
- I was not permitted to change case managers despite requesting it.
- While I was using a computer with prior approval to apply for jobs, a staff member who was unaware of that approval verbally reprimanded me and ordered me off the computer despite my explaining that I had permission.
- During my stay, I was compared to a homeless woman struggling with meth addiction and told I was no better than she was. I found those comments degrading and deeply upsetting.

Length of Stay, Work, Transportation, and Financial Impact

- My family was led to believe I would be able to return to work after about one month. Instead, I was discouraged from returning to my career in finance because I was told I could not handle that level of stress.
- When I was finally allowed to interview for a job in Atlanta, Turnbridge required me to travel with a sober companion. I was required to pay for the companion's professional fees (over \$1,000), airfare, meals, and other travel expenses. I was not given the option to travel independently.
- Even after I was permitted more freedom, I was not allowed to purchase a car. I had to rely on Uber for all transportation, which became a significant financial burden and limited my independence.
- It appeared to me that individuals on scholarship progressed through the program more quickly than those paying privately, giving me the impression that financial considerations influenced treatment length.
- My stay resulted in significant disruption to my career and personal life.

Closing

- These events had a lasting emotional impact on me. While I may not remember every exact date, conversation, or staff member after several years, the overall experience and its effect on me remain clear.
- I have continued to think about these experiences for years. Preparing this summary required me to revisit events that I had tried to put behind me, but I felt it was important to share my experience in case it helps others.

Preservation and source-protection instruction

- Preserve the original Reddit messages, the detailed written statement, timestamps, and consent communications in the restricted source archive.

- Public and circulated versions may identify the source as Actual-Search3197, but should not include her legal name, phone number, email address, or other identifying information without separate authorization.
- The source's earlier inability to continue should remain preserved as context showing the emotional difficulty of disclosure, but the later voluntary detailed testimony controls the current archive entry.
- Any follow-up should be source-directed, trauma-informed, and limited to records, dates, staff names, or clarifications she chooses to provide.

22. Annie - 2022 direct former-client testimony: transgender-client safety, racial stereotyping, staff boundaries, peer violence, sexual privacy, therapy concerns, and residential conditions

Source and identification. Annie is a former Turnbridge client who initially contacted the memorandum author using the name Tanner and states that Turnbridge records will identify her under that former name. At her direction, this memorandum identifies her as Annie and notes the former record name only to permit accurate retrieval of institutional records. Annie is a Black transgender woman who reports that she was placed in Turnbridge's men's adolescent program in 2022 and was primarily seeking mental-health treatment rather than treatment for hard-drug or serious alcohol use. The testimony below was provided through text messages and a later telephone interview in July 2026. It is direct former-client testimony, not an adjudicated finding. Other clients are identified only by initials. Staff are identified by full name where Annie or the memorandum author could identify them; uncertain identities remain expressly provisional.

Source-use and evidentiary rule. Annie personally experienced some events, personally witnessed others, and learned limited background facts from other residents. Each item below states the source posture as clearly as possible. Quotations are preserved as Annie recalled them. Records, staff schedules, client rosters, insurance communications, clinical notes, incident reports, video, and additional witnesses should be used to confirm or challenge the account.

A. Samantha Trumata - racialized assumptions, crisis response, insurance characterization, and discharge context

Annie identifies Samantha Trumata as a blonde director or senior therapist and states that Trumata was a major reason she left. Annie reports that Trumata had little interaction with her. On approximately Annie's second day, Trumata allegedly asked where Annie was from. When Annie answered Washington, D.C., Trumata allegedly responded, "Let me guess, southeast," and then said, "That's the hood." Annie understood the exchange as a racialized assumption about her background.

Annie also recalls Trumata saying that she wished clients could vape and smoke marijuana but that the program did not permit it. Annie separately recalls Trumata stating, "You can only drink on weekends." The precise context and whether this referred to clients, staff, or a joking or hypothetical remark requires clarification.

Annie describes a major house crisis involving a returning client, identified here as M., who Annie understood to have been connected to an earlier fire-extinguisher incident. Annie says other residents disliked M. because he made racist and homophobic comments. Residents allegedly placed his designer shoes in a toilet, blocked him from retrieving them, and, after physical escalation, at least four clients attacked him. Annie says she opposed group attacks and told the others to stay away from her. She was angry at Trumata for allegedly remaining in her office and failing to de-escalate the violence and resulting disorder.

According to Annie, police were called for an emergency psychiatric evaluation of M. and removed him. Annie says the house continued to be chaotic and residents damaged property. She alleges that Trumata came out laughing and asked, "What are y'all gonna do, jump me?" Annie then cursed at Trumata, criticized her conduct as a therapist, briefly banged on her door, and, after Trumata invoked her children and asked, "Is your mom proud of you?", Annie responded, "Fuck your kids." Annie does not minimize her own language, but says her anger was directed at the failure to respond professionally, not at joining the group violence.

The next morning, Annie says she overheard Trumata tell a male staff member who was not Annie's therapist that "Tanner turned real ghetto on me last night" and that she believed Annie was going to beat her. Annie felt racially stereotyped and placed at risk of being viewed as threatening by male staff. Annie further alleges that Trumata told insurance that Annie had lashed out at her and tried to gang up with the other clients. Annie disputes that account and says she was telling the group to stay away from her and was not participating in the assault or property destruction.

Two days later, Annie spoke with her mother, described what had happened, and was told she could return home. Annie reports that the same transport workers who had brought her to Turnbridge picked her up. One allegedly told her, "You're free already - you're a lucky one."

B. K. - sustained anti-trans harassment and two separate physical assaults

Annie identifies another transgender client as K. K. was housed in the same men's adolescent residential environment. Annie describes K. as more visibly transgender and more vulnerable to peer targeting. Annie believes other clients treated Annie comparatively better because they found her attractive, perceived her as more conventionally feminine-presenting, and believed she would defend herself. Annie expressly rejected being used as proof that the group was not transphobic and said she would not serve as their token transgender person.

Annie reports a sustained pattern of abuse directed at K.:

- Clients allegedly deadnamed K. as "C." and used her preferred name sarcastically as a form of mockery.

- Clients allegedly called K. anti-gay and anti-trans slurs directly to her face, excluded her from activities, threw objects at her, and mocked Annie for doing K.'s hair.
- When K. complained that the conduct was transphobic, clients allegedly pointed to their comparatively favorable treatment of Annie as proof that they were not prejudiced.
- At K.'s ceremony, clients allegedly said they would not miss her while using an anti-trans slur.
- After staff identified K. as the client who had masturbated while watching pornography in a communal basement area, PlayStation access was removed. Annie says residents blamed K., intensified the harassment, threw things at her, and repeatedly used slurs. Annie came downstairs while sick and found K. crying.

First separate assault - dinner-area attack. Annie says she personally witnessed one male client approach K. from behind while residents were getting dinner and begin beating her. Annie attempted to intervene but did not fully enter the fight because she feared becoming involved with Connecticut police while away from home. This is a separate event from the later group assault described below.

Second separate assault - group jumping in or near K.'s room. Annie says clients including J. and N. entered or gathered at K.'s room and asked words to the effect of, "If we hit you right now, will you fight back?" Annie reports that J. began fighting K., N. joined, and other boys then joined the attack. Annie described the scene as resembling serious street violence. She says the door was open and behavioral-health technicians were down the hall and should have been able to hear the assault. Annie reports no meaningful prior separation of K. from the clients targeting her.

Prior flag-football conflict. Annie recalls that approximately one week before one of the conflicts, K. jokingly threw a shoe at a male client during flag football. The client told K. to kill herself, and K. responded that his mother should have killed him. This context may explain an ongoing interpersonal conflict but does not justify the later assault, group attack, slurs, or failure to protect.

C. John [last name to confirm] - alleged sexualized favoritism, surveillance, coercive-power statements, racial comments, political pressure, unequal discipline, and juvenile-detention comment

Annie recalls a Hispanic male staff member named John and states that "John was always really weird" toward her. His full name and role require confirmation through the 2022 staff roster. Annie reports the following direct interactions and observations:

- John allegedly told Annie, regarding her being transgender: "I don't usually agree with that lifestyle, but you make me feel really differently about it."
- John allegedly stood at Annie's doorway and watched while she got ready, spoke to her in a lowered or intimate tone while waking her, and checked her room before bed.
- After a razor was found in a drawer on approximately Annie's second day, John allegedly accused her of placing it there and became aggressive when she told him to leave her alone. Later, he allegedly said that if it had been her razor, he would have let her keep it so she could do her eyebrows and "look good."
- While clients played football, John allegedly asked, "How would you feel if I put them all in a headlock?"
- John allegedly said, "They need to have handcuffs and shackles here. I would use them on everybody but you."
- When discussing police work, John allegedly said, "If it was up to me I would have way more power," and later, "Everybody wants to be so gentle nowadays. I could really show somebody what's up," and, "You're lucky they wouldn't let me be a police officer. You wouldn't want me to catch you on duty."
- John allegedly said he wanted to work in juvenile detention because he could "do what he needs to do." Annie interpreted this as an interest in coercive authority over children rather than as sexual.
- John allegedly asked whether Annie would change her views for a "good Christian man" or "real God-fearing man" and said she would have to mature for someone to take care of her.
- John allegedly showed Annie Republican and pro-ICE material on his phone, said he missed when Donald Trump was president, and allegedly said immigrants should be shackled and placed in cages.
- John allegedly asked Annie whether she was "really from the trenches," assumed she had "Young Thug boyfriends" at home, and said that if they came to the porch looking for her, they would be killed.
- Annie reports that residents frequently mocked one another, but when criticism turned toward her, John would intervene and threaten a noncompliance consequence. She recalls John giving V. a noncompliance consequence and then telling Annie, "I did this for you." Annie believes that consequence contributed to V. being sent back or losing an expected home visit.
- Annie recalls that other clients said John was a creep. She also reports that John tried to fight a client and continued working afterward, but the specific client, date, location, and exact conduct require clarification.
- John allegedly gave Annie his TikTok account while she was a client.

Annie interpreted these interactions as a pattern of sexualized or personal favoritism, transphobic paternalism, political pressure, coercive-power fantasies, racial stereotyping, and unequal discipline. Her interpretation of motive remains an inference, but the alleged quotations and conduct are concrete subjects for corroboration through witnesses, schedules, supervision records, disciplinary records, and client notes.

D. Consensual client sexual encounter, John outside the doorway, disclosure, and rumor circulation

Annie disclosed that she had consensual sex with another client, identified here as D., during her last night at Turnbridge. She emphasizes that the encounter was consensual but believes clients in a residential treatment setting should not have been able to engage in sexual activity without supervision or a meaningful safety response. Annie states that this was her first sexual experience and that she later told her therapist, who appeared not to treat the event as significant.

Annie now clarifies that John was outside the doorway during the encounter and did not enter the room. She reports that he laughed and later told another female staff member. The female employee subsequently asked Annie whether she was okay, and Annie cried. This correction replaces the earlier provisional identification of Chris Meyer and the earlier description that a staff member entered the room.

Annie says information about the encounter later spread. She reports that D. portrayed the situation as though Annie had made advances and he had rejected her, while omitting that consensual sex had occurred. Annie believes D. did not want to be perceived as gay because Annie was transgender. This interpretation concerns D.'s motive and should remain attributed to Annie rather than stated as an established fact.

E. Therapy and clinical-boundary concerns involving Susie [last name to confirm]

Annie says that there was "no accountability in therapy at all" and that, while at Turnbridge, she did not believe anything she was doing was wrong. She describes her therapist, Susie [last name to confirm], as someone who "would eat up anything" Annie said rather than challenging or helping her examine behavior. Annie recalls Susie asking, while Annie's mother was waiting for a Zoom session, "What's your favorite strain? Mine is Blue Dream and Strawberry Cough." This allegation raises questions about professional boundaries, clinical purpose, substance-use framing, family-session timing, treatment planning, and whether therapy meaningfully addressed Annie's stated mental-health needs.

F. Transport-staff custody language and boundary concerns

Annie reports that a transport worker referred to her as "my prisoner." She also says a transport worker gave her \$20 after she left the bathroom during the departure trip. The worker's identity, exact role, and whether the same worker made both statements require confirmation. The juvenile-detention comment is attributed to John, not to transport staff.

G. Broader residential supervision, sanitation, and sexualized client-culture concerns

Annie reports additional conditions that she says were part of the 2022 residential environment:

- Cameras were allegedly not working much of the time.
- Five clients allegedly masturbated together in a shower area.
- Clients allegedly placed feces in the upper portion of toilets and urine remained across a bathroom floor for approximately three days.
- Staff allegedly used a sexualized nickname, "B.J." for "blowjob," for client J.
- Residents frequently mocked and "roasted" one another, while staff responses appeared inconsistent and sometimes protective of Annie but not of more vulnerable clients such as K.

These allegations concern supervision, sanitation, infection control, privacy, staff professionalism, bullying, camera maintenance, and whether sexualized or degrading behavior became normalized in the residence.

H. Evidentiary distinctions

- Annie personally experienced the alleged remarks and interactions directed at her by Samantha Trumata, John, Susie, and transport staff.
- Annie personally witnessed the dinner-area assault on K. and says she personally witnessed the separate multi-client group assault on K.
- Annie personally observed substantial anti-trans harassment of K., including deadnaming, slurs, exclusion, mocking, thrown objects, and ceremony humiliation, although the identity of every participant requires confirmation.
- Background concerning M.'s earlier fire-extinguisher conduct and some reasons residents disliked him were learned from other clients and should remain attributed as reported context unless independently corroborated.
- The exact identities of John, Susie, the transport workers, and the behavioral-health technicians down the hall require staff-roster and schedule confirmation.
- The dinner assault and group jumping of K. are separate incidents and must not be merged.

I. Records, corroboration, and follow-up

- Complete 2022 Turnbridge file for Annie, including records under the former name Tanner, with lawful authorization and appropriate privacy protection.
- Admission, placement, housing, gender-identity, safety-plan, discrimination, accommodation, grievance, discharge, and family-communication records for Annie and K.
- Staff rosters, schedules, titles, photographs, and supervision records for Samantha Trumata, Susie [last name to confirm], John [last name to confirm], all transport personnel, and behavioral-health technicians assigned to the relevant house.
- Insurance, utilization-review, clinical, discharge, incident, and case-management records containing any claim that Annie lashed out at Samantha Trumata or joined a group against staff.
- Police, emergency-evaluation, incident, house-log, shift-note, CCTV, medical, injury, and disciplinary records concerning M.'s removal and the surrounding house disturbance.
- Incident reports, CCTV, house logs, staff notes, medical records, separation plans, safety plans, clinical notes, and family notifications concerning each of the two separate assaults on K.
- Records concerning anti-trans harassment of K., deadnaming, slurs, thrown objects, PlayStation restrictions, the basement pornography incident, ceremony comments, and complaints made by K. or Annie.
- Camera-maintenance, outage, access, and retention records for the residence during Annie's placement.
- Records concerning noncompliance consequences imposed on V., including the identity and role of John and whether a consequence affected V.'s phase, home visit, or discharge.
- Therapy notes, family-session records, supervision notes, and complaint records involving Susie and the alleged marijuana-strain discussion.
- Room-check, sharps, razor, contraband, hygiene, sanitation, bathroom-cleaning, infection-control, and environmental inspection records.
- Policies and records governing client sexual activity, room access, staff presence at doorways, privacy, staff disclosure of intimate information, LGBTQ and transgender-client safety, staff use of social media, staff-client gifts or money, and transport-worker language or conduct.
- Direct accounts from K., D., V., J., N., the female staff member who checked on Annie after the sexual encounter, clients present during both assaults, residents present during the Samantha Trumata crisis, and staff assigned down the hall during the group assault.

J. Archive classification and safe use

Direct former-client testimony from Annie concerning racial stereotyping, transgender-client placement and safety, two separate assaults on K., sustained anti-trans harassment, alleged failure to separate or intervene, staff boundary concerns, sexualized favoritism, political and ideological pressure, coercive-power statements, sexual privacy, staff disclosure, therapy quality, insurance characterization, transport conduct, sanitation, supervision, and residential culture. The testimony is unverified except where future records or witnesses corroborate it. Public and circulated versions may identify the source as Annie and may state that Turnbridge records identify her under the former name Tanner solely for records retrieval. Other clients must remain identified by initials unless they separately authorize identification. Staff names may be used where identified, but uncertain identities must remain marked as provisional or incomplete.

23. A.M. - direct former-client testimony: self-harm disclosure response, psychiatric transport, phase-down, prolonged placement, discharge interference, collective-blame practices, and lasting loss of trust in therapy

Source and status. In July 2026, a former Turnbridge women's-program client contacted the memorandum author through direct messages after seeing the public archive. At the source's request and for all circulated versions, she is identified only as **A.M.** Her legal name, social-media name, username, profile image, and account information are excluded. A.M. described being at Turnbridge for approximately three continuous years, from about age twenty to age twenty-three; exact admission and discharge dates, residences, phases, and staff assignments remain to be confirmed. This is direct former-client testimony, not an adjudicated finding.

Source-use and consent posture. A.M. voluntarily supplied the account below and expressly stated that she would like to participate in efforts concerning Turnbridge. That supports preservation and confidential sharing with counsel, regulators, or investigators. Public use should remain initials-only and source-directed unless A.M. separately confirms broader publication terms. Original unredacted messages should remain in a restricted source archive; circulated exhibits must remove all identifying social-media information.

A. Self-harm disclosure, surrender of razor, police / ambulance response, psychiatric ER transport, and phase-down

A.M. reports that she struggled with self-harm while at Turnbridge. She states that, instead of cutting herself, she followed the safety instruction she had been given: she told staff that she was experiencing an urge and voluntarily surrendered her razor. According to A.M., staff then called police, had her transported by ambulance to a psychiatric emergency department, and subsequently phased her down in the program.

A.M. experienced this sequence as punishment for honesty and help-seeking. The institutional issue is not whether emergency evaluation can ever be clinically appropriate after disclosure of self-harm urges. The question is whether Turnbridge clearly explained the risk assessment, treated voluntary disclosure as a protective act, used the least restrictive clinically appropriate response, and avoided turning the disclosure into a punitive phase consequence.

Records / corroboration / follow-up:

- Exact date, residence, phase, and staff members involved in the razor surrender and self-harm disclosure.
- Risk assessment, suicide / self-harm screening, safety plan, clinical notes, nursing notes, house logs, and incident reports.
- Police, EMS, ambulance, psychiatric-ER, hospital, transport, and discharge records.
- Property / sharps log showing the surrendered razor and how staff documented the voluntary surrender.
- Records explaining the clinical rationale for emergency transport and the later phase-down.
- Family notifications, insurer / utilization-review communications, and any grievance or complaint records.
- Policies distinguishing supportive disclosure, emergency escalation, administrative consequence, and phase reduction.

B. Approximately three-year placement and alleged interference with discharge

A.M. states that she was one of two women who remained at Turnbridge for approximately three straight years. She further reports that her therapist tried to help her obtain discharge and that Turnbridge fired him. The present account does not yet identify the therapist, explain the stated reason for termination, establish who made the discharge recommendation, or establish whether the therapist was terminated because of that advocacy. Those points require direct clarification and records.

Even at this preliminary stage, the allegation raises serious questions about adult-client autonomy, discharge rights, treatment duration, staff retaliation, clinical independence, family and insurer influence, and whether professionals who supported discharge were overridden or removed.

C. Blamed for an entire house relapsing and alleged two-week silent treatment by women's-program director

A.M. reports that after she relapsed, Turnbridge blamed her for an entire house relapsing because she had relapsed first. She further states that the women's-program director gave her hostile looks and refused to speak to her for approximately two weeks.

If accurate, this would raise concerns about collective blame, humiliation, retaliatory withdrawal by leadership, clinically inappropriate isolation, and the use of shame after relapse. A treatment program may address how one client's conduct affects a house, but attributing an entire group's relapse to one person and then withholding ordinary communication would require a clear clinical rationale, supervision, documentation, and safeguards against scapegoating.

D. Lasting impact and stated willingness to participate

A.M. states that Turnbridge "demolished" her sense of safety in therapy and in places presented as sources of help. She describes three years of being repeatedly broken down, losing important parts of how she understood herself, and being made to feel like a monster. She states that the trauma from Turnbridge remains something she is still unlearning every day.

A.M. also stated that she would like to participate in efforts concerning Turnbridge on behalf of the person she was between ages twenty and twenty-three, when she says she was forced to remain there. Her statement reflects willingness to engage, but future contact should remain trauma-informed, non-pressuring, and source-directed.

E. Evidentiary distinctions

- A.M. personally reports the self-harm urge, voluntary surrender of her razor, police / ambulance response, psychiatric-ER transport, and phase-down.
- A.M. personally reports her approximately three-year placement, her repeated experience of being broken down, and the lasting loss of trust in therapy.
- The allegation that her therapist was fired after trying to help her discharge is presently A.M.'s report; the causal connection, decision-makers, and stated termination reason require corroboration.
- The allegation that she was blamed for an entire house relapsing and ignored by the women's-program director for two weeks is a direct source allegation requiring dates, names, witnesses, and records.
- No identifying social-media information should appear in circulated versions. The source should be identified only as A.M.

F. Records, corroboration, and follow-up

- Complete Turnbridge file for A.M., subject to lawful authorization and privacy protection.
- Exact admission and discharge dates, all residences and phases, treatment plans, level changes, progress reviews, and billing / insurance authorization records for the approximately three-year placement.
- All discharge requests, AMA discussions, adult-rights notices, family communications, risk assessments, transfer discussions, and records identifying the therapist who allegedly supported discharge.
- Employment, supervision, HR, termination, complaint, and quality-assurance records for that therapist, including the stated reason and timing of separation.
- Clinical, incident, house, staffing, and communication records concerning the house relapse and any attribution of responsibility to A.M.
- Identity and records of the women's-program director who allegedly refused communication for approximately two weeks.
- Witness accounts from house residents, the therapist, program leadership, family members, and staff who knew of the self-harm disclosure, ER transport, phase-down, discharge efforts, relapse response, or alleged silent treatment.
- Policies governing voluntary self-harm disclosure, surrendered sharps, emergency evaluation, use of police / ambulance transport, phase-down after crisis, relapse response, collective accountability, staff withdrawal of contact, discharge advocacy, and retaliation protections.

G. Archive classification and safe use

Direct former-client testimony from A.M. concerning self-harm disclosure, voluntary surrender of a razor, emergency police / ambulance and psychiatric-ER response, subsequent phase-down, an approximately three-year placement, alleged interference with discharge, alleged termination of a therapist who supported discharge, collective blame after relapse, alleged withdrawal of communication by program leadership, and lasting psychological harm. The account is unverified except where future records or witnesses corroborate it. Circulated versions must use only the initials A.M. and must omit all social-media names, usernames, profile images, handles, links, and account metadata.

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24. Old-Hedgehog-7363 - preliminary direct-source outreach: North Haven adolescent home, Prospect Street women's adult program, two Yale hospitalizations, police / ambulance transports, and alleged absence of Turnbridge documentation

Source and status. On July 26, 2026, a former Turnbridge client using the Reddit username Old-Hedgehog-7363 responded to archive outreach. The source stated that she is preparing a Google document describing her experience from start to finish and in detail, and that she intends to send it when completed. This entry preserves only the limited facts supplied in the initial message. It is preliminary direct-source outreach, not a completed interview, not a full testimony, and not an adjudicated finding.

Programs and locations identified by the source.

- The source states that she attended the adolescent home in North Haven.
- The source also states that she attended the women's adult program on Prospect Street.
- Exact admission and discharge dates, age at each placement, program names, house addresses, phases, staff assignments, and the sequence between the two settings remain to be supplied in her forthcoming written account.

Two police / ambulance transports and Yale hospitalizations.

The source states that Turnbridge called police on her twice, placed her in an ambulance twice, and that she was hospitalized at Yale Hospital on both occasions. She further states that there was “zero documentation” of these hospitalizations. At this stage, the statement should be understood as her allegation that she did not see, receive, or later locate Turnbridge documentation of the events. It should not be converted into a definitive finding that no record exists until Turnbridge, Yale, police, EMS, ambulance, insurer, and related records are requested and compared.

Why this matters.

- Two separate police, ambulance, and hospital episodes should ordinarily create multiple independent records trails.
- The account raises questions about crisis assessment, use of police, emergency transport, clinical escalation, family notification, continuity of care, discharge or return decisions, and whether the events were accurately incorporated into the client's Turnbridge clinical record.
- Because the source attended both an adolescent setting and the women's adult program, the account may provide a cross-program view of Turnbridge practices in North Haven and on Prospect Street.
- The forthcoming Google document may contain event dates, staff names, precipitating incidents, statements made by staff, hospital details, witnesses, and additional records leads. Those details should not be inferred before the source supplies them.

Records and corroboration to request or preserve.

- The source's completed Google document, version history, creation and modification dates, and any attachments she chooses to provide.
- The original Reddit message thread, screenshot, timestamps, username, and consent communications.
- Exact dates of both police calls, ambulance transports, and Yale hospitalizations.
- Police incident, CAD, dispatch, body-camera, crisis-intervention, and supplemental reports for both events.
- EMS and ambulance patient-care reports, dispatch logs, transport records, and destination records.
- Yale emergency-department, psychiatric-emergency, inpatient, discharge, diagnosis, medication, restraint, observation, and follow-up records, subject to lawful authorization.
- Turnbridge incident reports, significant-event reports, clinical notes, risk assessments, safety plans, nursing notes, medication-administration records, house logs, shift notes, staff schedules, transportation records, and return-to-program or discharge documentation.
- Family or guardian notifications, insurer and utilization-review communications, billing records, and any records describing the clinical justification for police or ambulance involvement.

- North Haven adolescent-home rosters, property records, staff assignments, and policies in effect during the source's placement.
- Prospect Street women's-program rosters, staff assignments, house logs, crisis-response policies, and records in effect during the source's placement.
- Any grievance, complaint, records request, discharge packet, patient portal record, or correspondence showing what documentation the source requested or was able to obtain.

Priority follow-up questions for the source.

- What were the approximate dates and sequence of the North Haven and Prospect Street placements?
- What precipitated each police call and hospitalization?
- Who called police, who authorized ambulance transport, and which staff members accompanied or communicated with the hospital?
- Was the source returned to Turnbridge after either hospitalization, transferred elsewhere, phased down, discharged, or placed under new restrictions?
- What does the source mean by "zero documentation" - no incident report shown to her, no hospital episode in her Turnbridge file, no discharge papers, no insurance record, or a later records response that omitted the events?
- Did family members, guardians, other clients, staff, or hospital personnel witness either event?
- What identification and publication terms does the source authorize after the full account is submitted?

Source-use and consent posture. The source has offered to send a detailed written account, but the initial message does not by itself establish permission to publish her legal name, medical details, profile image, or complete testimony. Until she gives explicit publication instructions, the archive should identify her only by the Reddit username Old-Hedgehog-7363 or a more restrictive anonymous label, preserve the original message privately, and treat the forthcoming Google document as source-directed material. The source should be allowed to review any public summary based on the completed document.

Archive classification. Preliminary direct former-client outreach involving two Turnbridge settings, two reported police / ambulance transports, two reported Yale hospitalizations, and an allegation that the events were not documented in the records available to the source. The account is incomplete pending the promised Google document, structured follow-up, consent clarification, and records corroboration.

Exhibit OH-1 - Initial Reddit response, July 26, 2026

Source screenshot preserved as preliminary direct former-client outreach. The screenshot should not be treated as a complete testimony. Public use should remain limited to the source's authorized identifier and should exclude additional identifying information unless separately approved.



Old-Hedgehog-7363 6:19 PM

Hi! Thank you for reaching out I'm currently making a google doc with my experience there start to finish and everything that happened in detail. I will send you it when it's done

I was also at the adolescent home in north haven, and the woman's adult program on prospect street

I was hospitalized 2 times there at Yale hospital with zero documentation of it they called the police on me and put me in ambulance 2 times but yeah I'll send you the google doc when I'm done

25. E.A. - preliminary direct former-client testimony: alleged grooming and explicit messages by a male staff member while she was sixteen; prior warnings to adults; preserved-message lead

Source and status. On July 28, 2026, a former Turnbridge women's-program client contacted the memorandum author through Instagram direct messages after seeing the archive. At her request, all circulated versions identify her only as **E.A.** Her legal name, social-media name, username, profile image, and contact information are excluded. This is direct former-client testimony, not an adjudicated finding.

Source-use and consent posture. E.A. expressly asked whether she could remain anonymous. The memorandum author agreed that she would be identified only by initials or made-up initials and that no identifying details would be published. Her original messages should remain in a restricted source archive. The redacted exhibits included here preserve the substance of the exchange while removing her identifying account information.

A. Alleged explicit messages and grooming by a male staff member at age sixteen

E.A. reports that during her final months in Turnbridge residential treatment, when she was sixteen years old, a male staff member sent her explicit photographs and, in her words, "practically groomed" her. She further reported that male clients alleged the same staff member was actively getting high. The present messages do not identify the staff member, exact residence, exact dates, employment title, or the specific communications beyond E.A.'s summary. Those details must not be inferred.

The account raises serious questions about staff-client sexual boundaries, electronic communications with a minor, supervision, mandated reporting, staff impairment or substance use, complaint handling, and whether Turnbridge preserved or reviewed staff-client messages.

B. Prior warnings to case management and family; family recognition only after direct harm

E.A. states that for months she had begged and pleaded with her case manager and parents about other Turnbridge clients' testimonies and events she believed were unfolding in real time. She reports that it took similar conduct happening to her before her family understood that Turnbridge was not what they had believed. This is E.A.'s account of her warnings and family response; the substance, timing, recipients, and records of those warnings require corroboration.

C. Preserved-message lead and present limits

E.A. states that she is currently outside the United States but expects, after returning home, to access the Instagram account she used at the time and provide screenshots of messages with the male staff member. Those materials have not yet been supplied. No claim should be made about their contents, completeness, authenticity, or evidentiary effect until they are received and preserved. E.A. should not be pressured to retrieve or disclose them, and she remains free to stop or limit participation at any time.

D. Lasting impact and survivor-community context

E.A. described the disclosure as emotionally heavy, expressed hope that survivors may heal and obtain justice, and stated that knowing she is not alone makes the experience slightly easier while also creating deep pain about the broader reality. These statements are included as impact and source-context evidence, not as proof of any additional event.

E. Evidentiary distinctions

- E.A. personally reports receiving explicit photographs and experiencing grooming conduct from a male Turnbridge staff member while she was sixteen.
- E.A. personally reports having warned her case manager and parents about other clients' accounts before similar conduct happened to her.
- The allegation that the staff member was actively getting high was attributed by E.A. to male clients and is presently relayed information requiring direct-source corroboration.
- The existence and content of historical Instagram messages remain a preservation lead; the archive has not yet received them.
- No identifying account information should appear in circulated versions. The source should be identified only as E.A.

F. Records, corroboration, and follow-up

- E.A.'s complete Turnbridge file, subject to lawful authorization and privacy protection, including admission and discharge dates, age records, houses, phases, treatment plans, case-management notes, clinical notes, and family communications.
- Complete staff rosters, schedules, employment files, supervision records, HR records, discipline records, complaints, separation records, and device / communication policies for the relevant women's-program period.
- Original historical Instagram messages, full conversation context, usernames, timestamps, message metadata, account-download data, and any attachments E.A. voluntarily chooses to preserve or provide.
- Records of any complaint, disclosure, warning, or concern E.A. communicated to her case manager, therapist, other staff, parents, guardians, or outside providers.
- Family communications and testimony concerning E.A.'s prior warnings and the point at which her family concluded the program was unsafe.
- Direct accounts from male clients who allegedly observed or knew of the staff member getting high, together with drug-testing, incident, supervision, and employment records.
- Any mandated-reporting analysis, DCF report, DPH complaint, police report, internal investigation, legal consultation, or outside-agency communication involving the staff member or E.A.
- Policies governing staff electronic contact with minors, exchange of photographs, social media, grooming prevention, staff-client boundaries, staff impairment, reporting, evidence preservation, and protection from retaliation.

G. Priority follow-up questions

- What were E.A.'s exact admission and discharge dates, residence, phase, and age when the alleged communications occurred?
- Who was the staff member, what was his role, and did he have authorized access to E.A.'s phone number or social-media account?
- What messages, images, timestamps, usernames, and surrounding context remain available?
- What did E.A. tell her case manager and parents before the alleged conduct happened to her, and what action followed?
- Did Turnbridge receive any other complaints or warnings about the same staff member?
- Did Turnbridge investigate possible staff impairment or drug use, and were any employment or disciplinary actions taken?
- Were DCF, DPH, law enforcement, parents, guardians, or other mandated-reporting authorities notified?

H. Archive classification and safe use

Preliminary direct former-client testimony from E.A. concerning alleged explicit messages and grooming by a male Turnbridge staff member while she was sixteen, prior warnings to adults, a relayed allegation of staff drug use, and a potential contemporaneous-message record. The account remains unverified except where future records, messages, witnesses, or official documentation corroborate it. Circulated versions must use only the initials E.A. and omit all names, usernames, profile images, handles, links, phone numbers, and account metadata. Future contact must remain trauma-informed, non-pressuring, and source-directed.

Exhibit EA-1 - Redacted initial Instagram disclosure and anonymity request

The source's name, username, profile image, and other identifying account information are redacted. The exhibit preserves E.A.'s request for anonymity and her preliminary disclosure that, at age sixteen, she was allegedly sent explicit photographs and groomed by a male staff member. It is not a complete interview or adjudicated finding.

Exhibit EA-1 - Public redacted summary of initial disclosure and anonymity request

The original Instagram screenshot is intentionally omitted from this public copy because it contained E.A.'s profile image, account name, username, and other identifying account information.

E.A. requested anonymity and is identified publicly only by the initials E.A. She reported that, while she was sixteen and in Turnbridge residential treatment, a male staff member sent her explicit photographs and engaged in conduct she described as grooming. This is preliminary direct former-client testimony, not an adjudicated finding.

The complete original screenshot is preserved separately in a restricted source archive for authorized counsel, regulators, or investigators. It must not be circulated publicly.

Exhibit EA-2 - Public redacted summary of historical-message preservation lead

The original Instagram screenshot is intentionally omitted from this public copy because it contained E.A.'s profile image and identifying account information.

E.A. stated that she was outside the United States at the time of the exchange and expected, after returning home, to access the Instagram account she used during the relevant period. She indicated that the account may contain messages with the male staff member and that she might provide screenshots. Those materials had not yet been supplied when this memorandum was prepared.

E.A. should not be pressured to retrieve or disclose any material. Any original messages she voluntarily provides should be preserved with full context and metadata in a restricted source archive. They should not be published without separate, explicit authorization.

Turnbridge / Turning Point Due-Diligence Memo

COMPLETE CONSOLIDATED DIRECT-SOURCE ENTRY - A. - July 28, 2026

Integration status. This entry is intentionally full-detail and controlling. It belongs in the consolidated direct-source section immediately after E.A. and before the cross-source evidentiary rules. It must also be cross-referenced in the admissions/program-length, sexual-safety, confidentiality/privacy, staff-retaliation, post-discharge interference, recovery-access, adolescent-safeguarding, and staff-vetting sections. It does not replace or narrow A.'s original email or attachments.

26. A. - direct former-client testimony: deceptive program-length representations, sexualized leadership conduct, licensing-history concerns, coercive sexual pathologization, confidentiality breaches, post-graduation stigmatization and tracking, recovery-community interference, relapse impact, staff abandonment, and alleged employee-minor sexual misconduct

Source and status. On July 28, 2026, a former Turnbridge women's-program client sent the memorandum author a detailed written statement and documentary attachments. She authorizes public identification only by her first initial, **A.** She has separately authorized investigators and regulators to receive her full legal identity and has stated that she is willing to speak with them directly. Her legal name, email address, social-media handles, employer, profile image, and other identifying information must remain in a restricted source file and must not appear in public circulation.

Evidentiary rule. This is direct former-client testimony, not an adjudicated finding. The entry distinguishes what A. personally experienced, what she personally witnessed, what she reports hearing contemporaneously, what she learned from others, and what public records independently show. The complete original email, headers, attachments, and consent messages should be preserved without alteration.

A. Program dates and repeated duration-disclosure concern

A. reports first entering Turnbridge in early 2017. She describes that first period as comparatively acceptable, except for a central admissions issue: she says she was told she could leave after approximately one month, but after arrival she learned from clients that the program was understood to last approximately one year. She later returned around August 2017 and describes the program environment during the second placement as "AWFUL."

This account independently overlaps the memorandum author's September 28, 2021 Joseph Moura / 28-day understanding and post-contract disclosure account; Actual-Search3197's three-month / return-to-work representations; Ryan C.'s public review alleging a three-month representation that became a one-year expectation; and other direct and public accounts involving materially delayed disclosure of expected duration.

Records / corroboration / follow-up:

- A.'s intake, admissions, contract, family-communication, placement, billing, discharge, and re-admission records from 2017.
- Recorded admissions calls, brochures, website captures, emails, texts, and written statements concerning one month, one year, expected phases, and discharge criteria.
- Family testimony and financial records concerning what was represented before each admission and the total amount paid.

B. Influx of minors and residential safeguarding context

A. reports that by her second placement around August 2017, Turnbridge had begun housing a significant influx of minors in the women's environment. Exact ages, houses, licensing status, and supervision arrangements require records confirmation. This context matters because several of A.'s later allegations involve a seventeen-year-old client, a sixteen-year-old client, and adults or employees holding authority within the same broader program structure.

C. Tom Marzilli - graphic sexual interrogation of a seventeen-year-old

A. reports that program director Tom Marzilli made completely inappropriate sexual comments. She describes a specific incident involving her friend, who was seventeen at the time and had sex with a man at a meeting. According to A., when the client was questioned, Marzilli screamed at her and asked, in substance and as directly quoted by A., whether the man "came inside her." A. states that she will ask this former client whether she is willing to speak directly.

The account raises questions about sexualized interrogation of a minor, trauma-informed interviewing, staff tone and authority, clinical purpose, confidentiality, mandated reporting, pregnancy and medical-safety response, and whether the conversation was documented or supervised.

D. Alleged Marzilli sexual relationship with recently graduated client / support staff and restriction from women's house

A. alleges that Marzilli became barred from the women's house after sexual involvement with a support staff member who had recently graduated from the program. The memorandum author independently recalls hearing while enrolled at Turnbridge that Tom Marzilli was banned from the women's house. The author's recollection independently supports that a restriction or ban was being discussed within the institution, but does not independently establish the reason. A. is presently the direct source connecting the alleged restriction to sexual conduct involving a recently graduated former client who became staff.

This allegation must be tested through HR files, access restrictions, house assignments, staff schedules, supervision records, complaints, internal communications, former-client / employee testimony, mandated-reporting analysis, and the reason Marzilli remained employed in senior residential leadership.

E. Colorado licensing action and alleged sexual-contact charge category

A. supplied screenshots from an official Colorado Board proceeding concerning Thomas Paul Marzilli. The order identifies case number 2015-1632 and states that the Board alleged violations of former Colorado statutory provisions including § 12-43-222(1)(f)(I), (g)(I), (i), (p), and (r). The supplied statutory screenshots indicate that subsection (g)(I) concerned failure to meet generally accepted professional standards; subsection (p) concerned failure to comply with mandatory client disclosures under § 12-43-214; and subsection (r) concerned sexual contact, sexual intrusion, or sexual penetration with a client during the therapeutic relationship or within two years afterward. The order also states that Marzilli denied the allegations and that the matter was resolved through a final agency order / voluntary surrender rather than findings after a contested hearing.

The defensible archive conclusion is therefore not that every allegation was adjudicated as proven. It is that Colorado regulators formally alleged multiple categories of professional misconduct, including a statutory sexual-contact category, and Marzilli voluntarily surrendered / relinquished the credential in the final resolution. This materially expands the earlier staff-vetting entry, which described only voluntary surrender without the underlying charge categories.

F. Gambling context

A. alleges that Marzilli had a compulsive gambling problem and named a Turnbridge softball team "Minus 160," a betting-odds reference. Separately, a February 13, 2016 Foxwoods Poker public post identifies Thomas Marzilli as the chip leader in Event #12, Flight A, with 265,100 chips. Tournament participation and a chip-leader result do not independently prove compulsive gambling. They provide dated public-source context that supports further inquiry into A.'s specific recollection that gambling language and behavior were conspicuous in his Turnbridge leadership presentation.

G. Sexual pathologization, "sex contract," and coerced sex-therapy referral

A. states that she entered Turnbridge at nineteen after using heroin since approximately age thirteen and, during and after the program, had consensual sexual relationships with multiple women. She does not conceal or minimize that history. She alleges that Turnbridge villainized and demonized her for it, used what she describes as political or reputation-management tactics against her, placed her on a "sex contract," and forced her to see a sex therapist. According to A., the sex therapist refused to treat her because the therapist believed A. was a normal young person engaging in normal behavior under the circumstances.

This raises questions about whether Turnbridge pathologized consensual sexuality, whether rules were applied consistently, what diagnosis or assessment supported the contract and referral, whether sexual orientation or same-sex conduct influenced treatment, whether the restriction was clinically indicated, and whether the outside therapist documented rejecting the premise of the referral.

H. Confidentiality and privacy allegations

A. reports that Turnbridge personnel told clients there was no HIPAA privacy in housing, only in clinical services. She alleges that private information was nevertheless disclosed outside legitimate need-to-know channels by therapists and other staff. She specifically identifies Audrey Bell, who led the house, as a person who spread private information and damaged A.'s reputation in the New Haven recovery community. A. further reports that her therapist, Lila Sussman, left Turnbridge because she objected to how the organization operated and that Turnbridge then attacked Sussman's professional reputation. Those assertions require direct confirmation from Sussman and employment / HR records.

A. also reports that staff searched her phone, took it during the night, and used information from it in the broader campaign of stigmatization. These allegations overlap other direct-source accounts involving phone searches, staff discussion of personal photographs, private information circulating across houses, and staff rumor-spreading.

I. “Predator” labeling and reversal from “miracle story” to institutional warning target

A. alleges that Turnbridge called her a predator. She states that Turnbridge simultaneously staged a highly celebratory graduation and described her as a miracle story, but after she left, lived independently, and worked in finance, staff warned current clients about her. The dramatic reversal - public graduation success narrative followed by post-discharge danger framing - is significant because it raises questions about whether praise was conditional on compliance and whether former clients who maintained relationships with current clients were stigmatized, surveilled, or used as institutional scapegoats.

J. Post-graduation tracking, false attribution of missing clients, and documentary text evidence

A. reports that when girls ran away, Turnbridge personnel repeatedly blamed or investigated her, including on an occasion when she was outside Connecticut. She alleges that staff fabricated a narrative that she was helping a girl move drugs through the Canner house and that police sat outside her apartment while she worked from home. She further alleges that Turnbridge personnel contacted her friends' parents and her own parents with a false narrative.

The supplied text screenshots are important because they preserve acknowledgments from Turnbridge-affiliated people that staff contacted A. and others while trying to locate a missing client. In one exchange, the responder stated that parents were trying to track down their daughter, someone in the community said the client was with A., and staff were “just checking.” The responder also expressly stated that A.'s name had not come up in a long time and that Turnbridge knew she had not been engaging with clients. In another exchange, a Turnbridge-affiliated responder told A. that her name had been brought to staff and described the outreach as “due diligence,” while referencing that staff had once exercised similar responsibility for A. A. repeatedly asked to be left alone and stated that she avoided Turnbridge people and even recovery meetings because she feared being blamed again.

These texts do not independently prove every broader allegation about police surveillance or drug accusations. They do corroborate that A. remained a subject of staff inquiry after graduation and that Turnbridge-affiliated people acknowledged checking whether missing clients were with her despite also acknowledging that she had not recently been involved with clients.

K. Recovery-community interference and relapse impact

A. reports that the continuing stigma made attendance at local recovery meetings intimidating and difficult because Turnbridge clients or staff would leave, react, or treat her as dangerous. She states that she lost twenty-two months of recovery. A. expressly accepts her own responsibility for relapse while also insisting that the institutional environment and post-discharge scapegoating cannot be omitted from the causal context. This should be preserved as her impact account, not reduced to a claim that Turnbridge alone caused relapse.

L. Request for help after relapse and alleged abandonment

A. reports that after relapse - following what she describes as more than \$1 million paid by her mother - she contacted Audrey Bell asking for resources because the two had once had a close relationship. A. states that Bell left the message unread or unanswered. The precise message, date, platform, and any follow-up should be preserved. This allegation is relevant to post-discharge continuity, former-client support, and whether institutional concern for A. operated mainly when she was being monitored or blamed rather than when she requested help.

M. Death of Isabella Nicolia and Marzilli's alleged comments at memorial

A. reports that her best friend Isabella Nicolia died of an overdose after being removed from Turnbridge. A. states that she attended the memorial while severely intoxicated and that friends cried because of her condition and closeness to Isabella. She alleges that Tom Marzilli made disparaging or “smart” comments severe enough that Audrey Bell rebuked him. This is a direct source account of memorial conduct and grief context; it does not establish the circumstances of Isabella's death or Turnbridge's legal responsibility for it. Records and witness interviews should distinguish removal / discharge chronology, aftercare, overdose circumstances, memorial witnesses, and Marzilli's exact remarks.

N. Leadership and staff-culture context

A. states that Audrey Bell and other staff frequently spoke negatively about Marzilli. She also alleges that founder David Vieau had sold the company, was no longer meaningfully aware of daily conditions, and had benefited financially while direct-care technicians were overworked. The ownership and operational assertions require corporate, employment, and transaction records; the staff-culture account is relevant as a contemporaneous perception of leadership distance and frontline strain.

O. Alleged 26-year-old employee / former client sexual relationship with sixteen-year-old client and DCF involvement

A. alleges that a woman who had previously completed Turnbridge later became a technician or support staff member and, at age twenty-six, became sexually involved with a sixteen-year-old female client. A. reports that DCF became involved, interviewed residents individually, and that the minor later ran away with the employee. A. states that no meaningful action occurred. This is among the most serious allegations in her account and must be treated as a records-intensive safeguarding lead rather than a proven conclusion.

If accurate, the matter should have generated DCF intake and investigation records, mandated reports, HR suspension or separation records, police or prosecutor review, house logs, missing-person / elopement records, staff schedules, client rosters, family communications, and internal safeguarding review. The identities of the employee and minor must remain restricted unless the affected person authorizes identification or a regulator requires it.

P. Evidentiary distinctions

- A. personally reports what she was told about program length, her own sex contract and referral, phone seizures/searches, confidentiality harm, predator labeling, graduation, post-discharge staff contact, meeting avoidance, relapse impact, resource request, grief experience, and the effect on her reputation and career.
- A. personally reports witnessing or directly knowing the seventeen-year-old interrogation context, Marzilli's program conduct, staff gossip, and certain post-discharge contacts; exact witness posture for each event should be confirmed in interview.
- The alleged Marzilli relationship with a recently graduated former client / staff member and the reason for the women's-house restriction are A.'s direct allegations. The memorandum author independently remembers hearing that Marzilli was banned from the women's house, but not the reason.
- The 26-year-old employee / sixteen-year-old client allegation, DCF interviews, and later elopement are reported by A. and require direct-source and official-record corroboration.
- The Colorado order and Foxwoods poker post are public-source materials. The order preserves formal allegations and final disposition; it does not establish that all allegations were proven at hearing. The poker result proves tournament participation and chip position, not compulsive gambling.

Q. Records, witnesses, and preservation

- Preserve A.'s original email, complete headers, attachments, metadata, and consent messages in a restricted source archive.
- Interview A. in a source-directed manner to establish exact dates, houses, phases, staff titles, witness names, and what she personally saw versus learned from others.
- Obtain complete Turnbridge files for A. from both 2017 placements, including admissions, contracts, family communications, clinical notes, case-management notes, phone-search records, sex-contract documents, outside therapist referral and records, grievances, graduation materials, discharge, billing, and post-discharge communications.
- Request complete Tom Marzilli personnel, supervision, access, restriction, complaint, HR, licensing-review, background-check, and women's-house assignment records.
- Obtain the complete Colorado final agency order, complaint, stipulation, investigative file to the extent public, and credential history.
- Preserve the February 13, 2016 Foxwoods Poker page and metadata; do not use it as standalone proof of gambling disorder.
- Request records and testimony from Lila Sussman, Audrey Bell, the seventeen-year-old former client if she consents, the recently graduated former client / staff member, house residents, and staff who knew of Marzilli's access restriction.
- Request DCF, police, HR, elopement, staff-schedule, client-roster, incident, mandated-reporting, and family-notification records concerning the alleged twenty-six-year-old employee and sixteen-year-old client.

R. Archive classification and safe use

Direct former-client testimony from A. concerning alleged deceptive duration disclosure; sexualized and humiliating leadership conduct; a reported women's-house restriction involving Tom Marzilli; coercive pathologization of consensual sexuality; confidentiality and device-search concerns; post-graduation stigmatization, tracking, and scapegoating; recovery-community interference; relapse and grief impact; alleged abandonment after a request for help; and alleged staff sexual misconduct involving a minor with reported DCF involvement. Public use must identify the source only as **A.** Her legal identity may be shared confidentially with investigators or regulators consistent with her authorization. The account must remain attributed, evidence-typed, and records-based.

CONSOLIDATED-SOURCE CATCH-UP INSERT - August 7, 2026

Correction / integration purpose. The July 20, 2026 "Complete Consolidated Direct-Source, Relayed, Email, Phone, Reddit, DM, and Witness Section" states that it is intentionally cumulative and that no source account is omitted merely because the same incident appears elsewhere. Later updates were added elsewhere in the memorandum after that section was created. To make the controlling section actually cumulative, the later source pages reproduced immediately after this note are now incorporated by reference and physical reproduction before the existing cross-source evidentiary rules.

No original material is deleted. The original later locations remain in the memorandum for chronology and exhibit continuity. Their reproduction here is deliberate duplication so the controlling source section contains the same substantive source material rather than forcing a reviewer to discover later additions hundreds of pages away.

Later material incorporated into the controlling section

- A. supplemental direct-source testimony concerning reported client-on-client physical violence, alleged sexual coercion, staff response, and alleged reprimand of A. after she confronted the accused client.
- smackinbucketsss - August 2, 2026 Killingworth former-client account concerning unpredictable peers, fights / reported riots, and nicotine / THC cartridges.
- S.S. (Support Staff) - August 3, 2026 direct-source account concerning psychiatric acuity and delayed higher-level care, a knife / homicide-threat safety incident, direct corroboration that Drew Behr showed the M.J. / C.S. CCTV footage to clients, retrospective observations about staff treatment, and relayed internal-culture statements.
- S.S. relayed chains preserved at their correct evidentiary level, including Carter allegedly repeating Tom Marzilli's statement that "the parents are the real clients," Carter's alleged characterization of direct-care staff indifference, a relayed staff-client sexual-boundary / termination lead, and staff-substance allegations whose basis of knowledge requires clarification.
- I.S.C. - August 6, 2026 controlling direct-source replacement supported by journals, case-manager communications, contract material, later complaint messages, and public-record context concerning Kelly McCormack.
- O.C. - August 7, 2026 complete direct-source entry generated for this update and placed after the reproduced later-source material.

Evidentiary rule. Reproduction in the consolidated section does not upgrade any source. Direct testimony remains direct testimony; relayed statements remain relayed; public-source material remains public-source material; and unresolved allegations remain unresolved. The original source-protection, anonymity, and publication restrictions continue to control.

Navigation rule. When a later source page conflicts with an older compressed summary, the later controlling replacement or fuller source entry governs. Reviewers should use the reproduced pages here for source completeness while retaining the original later location for exhibit and chronology context.

Turnbridge / Turning Point Due-Diligence Memo

SUPPLEMENT TO A. DIRECT-SOURCE TESTIMONY - ADDITIONAL CLIENT-ON-CLIENT SEXUAL-VIOLENCE AND STAFF-RESPONSE ACCOUNT

Source and status. On July 28, 2026, A. supplied an additional Instagram direct-message account after her longer written testimony had already been incorporated into this memorandum. This supplement is part of A.'s controlling direct-source entry. Public and circulated versions must continue to identify her only as **A.** The account is direct former-client testimony, not an adjudicated finding.

A. Additional account concerning physical violence, alleged coerced sexual activity, and staff response

A. reports that, during the broader period connected to Turnbridge and the New Haven recovery community, she had an on-and-off sexual relationship with another female former client for approximately two years. According to A., a male Turnbridge client with whom that woman had also been involved became physically violent toward the woman. A. did not report that the violence was directed at her. A. further reports that the same male client coerced another former friend into sexual activity. A. states that she recognized one of the stories previously posted by the archive as concerning the same broader situation or individual.

A. clarified that the alleged aggressor was a Turnbridge client, not a staff member. She states that the physical violence was directed at the woman A. had been involved with, not at A. She alleges that Turnbridge staff did nothing meaningful in response and instead reprimanded A. when she confronted or went after the male client because of the reported conduct.

B. Evidentiary distinctions

- A. personally reports her own relationship history and her later confrontation with the male client; she does not report being the person physically harmed or coerced.

- The allegation that the male client became physically violent toward the woman was communicated to A. by that woman and is therefore a direct-source report of a disclosure, not conduct A. states she personally witnessed.

- The allegation that the male client coerced another former friend into sexual activity is presently A.'s report and requires direct confirmation from the person allegedly harmed and any other witness.

- A. personally alleges that staff reprimanded her for confronting the male client and did not meaningfully address the underlying reported violence or coercion.

- The identities of all private clients should remain anonymized unless they independently authorize identification or regulators obtain the information through a confidential process.

C. Institutional significance

This account adds another sexual-safety and client-protection concern to A.'s testimony. If staff received or became aware of reports that a client had been physically violent toward a sexual partner and had coerced another person into sexual activity, the program should have had a documented process for immediate safety assessment, separation, clinical response, victim support, mandated-reporting analysis, family or guardian notification where applicable, and referral to law enforcement or outside authorities where legally required. Reprimanding the person who confronted the alleged aggressor, without meaningfully addressing the underlying allegations, would raise separate questions about retaliation, misplaced discipline, protection of dominant clients, and whether reporting sexual or physical harm was made unsafe.

D. Records and corroboration to preserve or request

- A.'s complete Instagram thread and original screenshot metadata.

- Direct accounts from the woman who allegedly disclosed physical violence and the former friend who was allegedly coerced into sexual activity, if they choose to participate.

- Identity, placement dates, house assignments, and case-management records for the male client, maintained confidentially.

- Incident reports, clinical notes, house logs, shift notes, safety plans, separation decisions, grievance records, and staff communications concerning any reported violence, sexual coercion, retaliation, or confrontation.

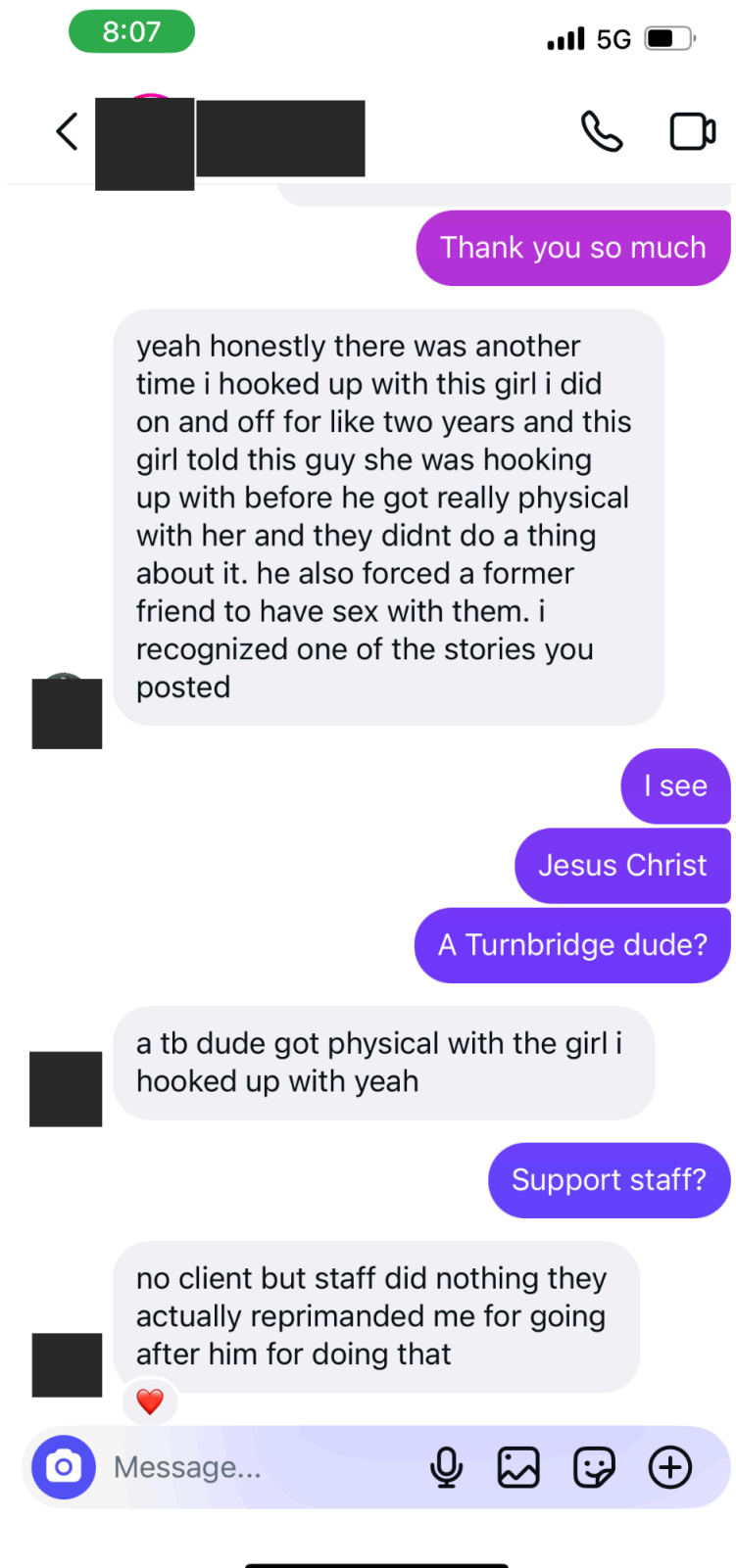
- Records identifying which staff reprimanded A., what conduct was cited, what was documented about the underlying allegations, and whether any victim-centered interview or external report occurred.
- Policies governing client-on-client sexual violence, dating, coercion, retaliation, reporting, mandated reporting, law-enforcement referral, and protection from reprisal.

E. Archive classification and use rule

Supplemental direct former-client testimony from A. relaying allegations that a male Turnbridge client was physically violent toward a woman A. had been involved with and coerced another former friend into sexual activity, together with A.'s firsthand allegation that staff failed to meaningfully respond and reprimanded her for confronting the accused client. A. does not report that the physical violence or sexual coercion happened to her. The underlying conduct remains unverified and must be attributed precisely. This supplement should be integrated into A.'s controlling entry and the memorandum's sexual-safety, complaint-response, retaliation, and client-protection pattern sections without being collapsed into a proven institutional finding.

Exhibit A-SUP-1 - Redacted Instagram follow-up from A.

This exhibit preserves A.'s additional direct-message account. It is included as source documentation, not as an adjudicated finding. The source is identified publicly only as A. Private-client identities remain omitted. The screenshot records A.'s statement that a male Turnbridge client allegedly became physically violent toward a woman with whom A. had been involved, allegedly forced another former friend into sexual activity, and that staff did not meaningfully respond but reprimanded A. for confronting him.



Turnbridge / Turning Point Due-Diligence Memo

KILLINGWORTH 2025 REDDIT SOURCE ADDENDUM - August 2, 2026

27. smackinbucketsss - direct former-client account of peer unpredictability, fights, riots, nicotine, and THC cartridges at Killingworth in 2025

Source and status. On August 2, 2026, a Reddit user identified by the handle **smackinbucketsss** responded to the memorandum author after stating that the source had attended Turnbridge's Killingworth adolescent program during 2025. The source's response is preserved as direct former-client testimony about conditions personally experienced or observed. It is not an adjudicated finding, and the exchange does not establish exact admission dates, age, house assignment, staff roster, or the dates of particular incidents.

Initial safety clarification. The source stated that nobody at Turnbridge put hands on the source "in no typa way" except in connection with fights. The wording is best read as a denial of staff assault or restraint directed at the source, while acknowledging physical contact associated with peer fights. The exchange does not identify who fought the source, how often fights occurred, whether injuries resulted, or how staff responded.

The source then described the Killingworth environment in the following terms:

"There was just mad crazy ass jits who were always mad unpredictable ... most incidents were riots or sh ... My group had nic and carts too ... Rehab js a fever dream fr."

A. Peer unpredictability, fights, and reported riots

The source described other adolescents as highly unpredictable and stated that many incidents were "riots or sh[...]." The source also referred to fights. The exchange does not define what the source meant by "riot," identify the number of events, distinguish large group disturbances from smaller fights, or state whether police, EMS, restraint, injury treatment, family notification, or significant-event reporting followed. Those details require structured follow-up and records review.

B. Nicotine and THC cartridges in the peer group

The source stated that the source's group possessed "nic and carts," reasonably understood in context as nicotine products and vape cartridges, including THC cartridges. This is direct testimony that contraband nicotine and cannabis-vape products were present within the peer group. The exchange does not identify who possessed them, how they entered the residence, whether staff knew, whether searches or drug tests occurred, or whether any medication, intoxication, or safety event was linked to them.

C. Cross-corroborative significance

This account independently overlaps several existing adolescent-program concerns already preserved in the memoranda: recurrent peer violence, large disturbances, unpredictable residents, contraband vaping, and the broader impression that the residential experience became chaotic and difficult to process. It also gives qualitative context to Turnbridge's own 2025 reporting of substantial significant-event activity at Killingworth, including physical-aggression and medication-error categories. The source's statement should not be treated as proof that every reported event was a riot or that the source personally witnessed every event in the annual report. Its value is as a direct 2025 participant account that converges with the institutional data and other former-client reports.

D. Records and corroboration to request

- Exact admission and discharge dates, age, house/group assignment, and the source's clarification of what events were called riots, including dates, participants, injuries, restraint, police/EMS involvement, and family notification.
- All 2025 Killingworth significant-event reports, incident narratives, house logs, shift notes, CCTV, staff schedules, injury records, police/CAD/EMS records, and post-event reviews relating to group disturbances and fights.
- Contraband, search, drug-testing, vaping, nicotine, THC-cartridge, confiscation, visitor, transport, package-screening, medication, and intoxication records for the source's residence or group; plus accounts from peers, staff, and parents.

E. Evidentiary classification and source-use rule

Direct former-client Reddit testimony concerning the Killingworth adolescent program in 2025. The source personally denies being physically handled by staff in the manner asked about, while acknowledging fights and describing unpredictable peers, incidents characterized as riots, and nicotine and THC cartridges within the group. The account remains preliminary and should be preserved with the full Reddit thread, timestamps, username, and any later clarification. Public use may identify the source only by the Reddit handle unless the source authorizes broader identification. The account should not be expanded beyond the source's words without follow-up.

Exhibit SB-1 - Reddit exchange concerning Killingworth in 2025

Clean-text preservation of the August 2, 2026 Reddit exchange. This exhibit preserves spelling, slang, and fragmented formatting in substance. It is not a complete interview or adjudicated finding.

HedgehogMinimum9299 - 12:02 AM

First off I agree with you tramadol sucks and that's wild - you were at the Killingworth house during the same year covered by Turnbridge's own 2025 adolescent residential report. I've been putting together a detailed regulator-facing memo based on my experience, accounts from other former clients, public records, and Turnbridge's internal materials.

Did you have any bad experiences at Killingworth - anything involving staff, other clients, medication, safety, being unable to leave, physical fights or assaults, restraint, or anything else that felt wrong? Turnbridge's own 2025 report lists 75 significant-event reports at Killingworth, including 58 reports involving physical aggression across the two adolescent sites, as well as self-harm risks, elopements, substance-use incidents, and 48 medication-error events at Killingworth.

You can share as much or as little as you're comfortable with. I won't use your name or anything identifying without your permission.

smackinbucketsss - 6:50 AM

Got damn son did the research [crying emoji]

Nb ever put

They hands on me in no typa way

Except for fights

There was just mad crazy ass jits who were always mad unpredictable

And most in

Incidents were riots or sh

My group had nic and carts too

Rehab js a fever dream fr

Preservation note

Preserve the original Reddit thread and screenshots, including timestamps, account metadata visible to the memorandum author, and any later messages clarifying the source's dates, age, house, definition of "riots," injuries, staff response, contraband access, and publication preferences. Do not infer the source's legal identity or publish additional identifying information without permission.

Turnbridge / Turning Point Due-Diligence Memo

SUPPORT STAFF DIRECT-SOURCE ADDENDUM - AUGUST 3, 2026

Source identifier: S.S. ("Support Staff")

Source status: A Turnbridge support-staff source who reported approximately three years of work at the program. The source's identity, precise employment dates, and present employment status are withheld in all circulated versions. This account is direct source testimony and a records-request lead, not an adjudicated finding.

Source-protection rule: Use only the identifier S.S. in public, legal, regulatory, journalistic, or survivor-facing circulation unless the source separately authorizes identification. Preserve the original messages, timestamps, account information, and any later consent instructions in a restricted source archive. Do not publish screenshots or identifying employment details without explicit permission.

1. Clients allegedly retained despite need for hospital-level psychiatric care

S.S. reported that he had seen clients whose psychiatric needs appeared to exceed Turnbridge's level of care remain in the program for extended periods. He stated that at least two clients were in active and very intense psychosis and were kept at Turnbridge for months before the circumstances escalated enough that they were ultimately sent to a hospital or called police themselves.

S.S. characterized both clients as clearly presenting danger to themselves or others while no timely higher-level transfer occurred. His account raises questions about psychiatric screening, emergency transfer criteria, clinical authority, utilization review, family notification, financial or census incentives, and whether unlicensed residential staff were left managing clients whose needs required inpatient or hospital-based care.

Evidentiary distinction: S.S. presents this as information known through his work and direct exposure to the program. Follow-up should establish which facts he personally observed, which were documented in staff communications, and which were communicated by case managers or other personnel.

2. Specific knife and homicide-threat safety account

S.S. described a specific client housed in a residence where S.S. worked. According to S.S., the client threatened to murder other residents and was repeatedly caught with knives, yet remained in the house. S.S. stated that he personally found three large knives in the client's room over approximately a two-week period.

If accurate, this presents an acute client-safety, weapon-control, psychiatric-escalation, and supervision concern. The central question is why a resident allegedly making homicide threats and repeatedly possessing large knives remained in shared housing, what risk assessments were completed, who was notified, and what protective measures were used for the other residents.

Priority records:

- House rosters, staff schedules, room-search logs, contraband logs, sharps or weapon inventories, photographs, and chain-of-custody records for each knife discovery.
- Incident reports, clinical notes, psychiatric evaluations, safety plans, homicide-risk assessments, emergency-transfer discussions, and utilization-review communications.
- Notifications to supervisors, clinicians, families, police, mobile crisis, hospitals, DPH, DCF where applicable, or other outside authorities.
- Records showing whether the client was searched, restricted, moved, discharged, hospitalized, or permitted to remain after each threat or knife discovery.
- Witness accounts from residents and staff assigned to the house.

3. Independent corroboration of Drew Behr showing M.J. incident footage to clients

S.S. independently identified himself as one of the clients to whom Drew Behr showed the M.J. incident footage. This directly corroborates the memorandum author's existing firsthand account that Behr replayed surveillance footage of a serious client-on-client incident to multiple clients.

The existing entry describes footage of M.J. chasing and spraying C.S. with a fire extinguisher while attempting to strike him with it. S.S.'s statement supports the narrower proposition that Behr showed the footage to clients. Additional follow-up should determine whether S.S. also remembers Behr laughing, calling C.S. a "dumbass," or making other comments while displaying it.

Cross-reference: Firsthand Observations, item 1 - staff replaying CCTV footage of the M.J. / C.S. fire-extinguisher incident.

4. Retrospective account of the memorandum author's treatment and L.M. concerns

S.S. stated that when he first revisited the period, he mainly remembered the memorandum author getting in trouble. As he thought more carefully, he recalled how badly case managers and support staff treated the memorandum author on a daily basis. He also described L.M. in extremely negative terms and stated that he regretted laughing at the memorandum author during a difficult moment.

This is relevant as a retrospective account from a source with direct personal familiarity with the memorandum author during the program period. It does not independently prove every event involving L.M. or every staff interaction, but it supports the broader concern that institutional narratives about a client being "in trouble" may obscure how staff and peers were treating that client.

The memorandum author responded that S.S. had also been supportive at times and recalled shared positive experiences. This preserves the complexity of the source relationship rather than reducing it to either complete hostility or complete corroboration.

5. Direct-care culture and reported higher-level statements

S.S. described the direct-care culture in strongly critical terms, stating in substance that direct-care personnel did not care about clients. This is a broad evaluative statement rather than a discrete fact and should be tested through specific incidents, staffing records, supervision, turnover, complaints, and other staff or client testimony.

S.S. also relayed a statement through the following chain: Tom Marzilli allegedly said that "the parents are the real clients"; a former case manager identified as Carter reportedly told this to S.S.; S.S. then relayed it to the memorandum author. S.S. did not hear Marzilli make the statement directly. This is therefore a multi-level relayed allegation requiring direct confirmation from Carter, Marzilli, other staff who heard the statement, or contemporaneous communications.

If corroborated, the statement would be relevant to the recurring concern that the paying parent or family - rather than the resident receiving care - functioned as the institution's primary customer and source of authority.

6. Reported staff-client sexual-boundary and staff-substance concerns

S.S. reported learning that a former support-staff manager was fired after allegedly attempting to have sex with a client, including taking the client to dinner. The exact staff member, client, dates, ages, program, source of S.S.'s knowledge, and employment action remain to be established. This should be treated as a relayed staff-client sexual-boundary and termination lead, not a proven event.

S.S. further stated that staff were allowed to work while high and that he knew of staff members who gave marijuana to clients. The present exchange does not establish whether he personally witnessed these events, reviewed records, or learned of them from other staff. Follow-up must clarify the basis of knowledge before stronger use.

7. Institutional significance

- Possible retention of clients whose psychiatric acuity exceeded the program's safe and licensed level of care.
- Possible failure to respond adequately to homicide threats, repeated weapon possession, and foreseeable danger to residents and staff.
- Independent corroboration that sensitive surveillance footage was shown to clients by a case manager.
- A staff-culture concern in which client trouble or noncompliance may have obscured daily mistreatment by staff and peers.
- A reported parent-centered business orientation that may have placed paying families above resident autonomy and welfare.
- Potential staff-client sexual-boundary violations, impaired staff, and staff provision of substances to clients.
- The significance of support-staff witnesses later reevaluating both the institution and the treatment of specific residents.

8. Records, witnesses, and follow-up

- A source-directed interview with S.S. separating firsthand observations, contemporaneous staff knowledge, statements from Carter, statements from other employees, and later rumor.
- Exact work dates, job titles, houses, supervisors, and programs for S.S., preserved confidentially.
- Identification of the two clients allegedly retained during active psychosis, with lawful privacy protections and regulator access where appropriate.
- All incident, clinical, nursing, psychiatric, utilization-review, discharge, hospital, police, mobile-crisis, and family-notification records for those clients.
- Identification of the residence and client involved in the knife and homicide-threat account; all search, contraband, safety, risk, and staffing records.
- CCTV access logs, staff device access, incident footage, and witnesses concerning the M.J. / C.S. video display.
- Direct interview with Carter concerning what Tom Marzilli allegedly said, the identity of the former support-staff manager, and any other internal matters Carter communicated to S.S.
- HR, supervision, complaint, disciplinary, termination, mandated-reporting, police, DCF, and DPH records concerning any staff-client sexual-boundary incident.
- Drug-testing, impairment, shift, medication, supervision, HR, and incident records concerning staff allegedly working while high or providing marijuana to clients.
- Preservation of the complete August 3, 2026 message exchange, including metadata and any later clarifications or consent instructions.

9. Archive classification and safe-use rule

Direct-source testimony from a Turnbridge support-staff source, identified only as S.S. The account contains multiple evidentiary layers: direct staff observations, direct former-client recollections, independent corroboration of a prior CCTV-display allegation, broad evaluative statements, and relayed information from a former case manager or other staff. No allegation is presented as an adjudicated finding. Each proposition must remain tied to its source level and tested through records and witnesses.

Public-use rule: Public versions may state that S.S. means "Support Staff," but must not identify the source, display the source's social-media account, reveal identifying employment details, or publish original screenshots without explicit authorization. Regulator and counsel versions may preserve restricted identity information separately if the source authorizes confidential disclosure.

EXHIBIT CSS-1 - CLEAN-TEXT SOURCE SUMMARY

Direct-message exchange received August 3, 2026

This exhibit summarizes the substance of the source exchange without reproducing account names, profile images, phone numbers, or other identifying metadata. It is not a verbatim transcript and does not replace the preserved original messages.

Category	Source statement preserved in substance
Higher level of care	At least two clients were reportedly in active and intense psychosis for months before hospitalization or police involvement occurred.
Knife / threat account	S.S. reported personally finding three large knives in one client's room within about two weeks. The client allegedly threatened to murder other residents and remained in the house.
CCTV corroboration	S.S. identified himself as one of the clients shown the M.J. incident footage by Drew Behr.
Retrospective treatment account	S.S. stated that he initially remembered the memorandum author mainly as getting in trouble, but later remembered daily mistreatment by case managers and support staff.
Parent-customer statement	S.S. reported that Carter told him Tom Marzilli had said, in substance, that the parents were the real clients.
Sexual-boundary lead	S.S. reported learning that a former support-staff manager was fired after allegedly attempting a sexual relationship with a client and taking the client to dinner.
Staff impairment / substances	S.S. stated that staff were allowed to work while high and that he knew of staff providing marijuana to clients; the basis of knowledge requires clarification.

Preservation instruction: Maintain the complete original exchange, screenshots, timestamps, and any later voice or phone notes in a restricted archive. Any public exhibit should remain clean-text and identity-protective unless the source expressly authorizes otherwise.

S.S. CROSS-SECTION INTEGRATION

Support Staff testimony - targeted additions to existing sections

Source label: S.S. means Support Staff. The source has direct knowledge of Turnbridge operations. The source is not identified by name, and no statement is made in circulated versions about whether the source is a former or current employee.

Use rule. This insert does not convert any allegation into an adjudicated fact. It cross-references newly received testimony into three existing memo subjects: Tom Marzilli and parent-facing business culture; Drew Behr and replay of the M.J. / C.S. fire-extinguisher CCTV footage; and direct-care staff culture. Each proposition below states the source chain.

1. Tom Marzilli section - alleged statement that "the parents are the real clients"

S.S. reports that case manager Carter told him that Tom Marzilli had said, in substance, "the parents are the real clients." S.S. did not hear Marzilli make the statement directly. The attribution chain is therefore: Marzilli allegedly made the statement; Carter allegedly repeated it to S.S.; S.S. then reported it to the memorandum author.

The statement is relevant to existing concerns about whether Turnbridge treated paying parents as the primary audience and economic customer while clients bore the restrictions, phase consequences, family-contact controls, and prolonged placement. It also overlaps accounts in which staff allegedly influenced parents during discharge disputes or represented continued placement as necessary for safety.

Archive classification: Third-hand / relayed leadership-culture statement. It should not be presented as a direct quotation from Marzilli without confirmation from Carter, Marzilli, another person who heard it, or contemporaneous records.

Records and corroboration:

- Carter's direct account of what Marzilli allegedly said, including approximate date, setting, and other people present.
- Marzilli's account and any leadership, training, admissions, family-engagement, or business-development materials addressing whether parents were treated as the primary customer.
- Internal communications concerning family retention, parent management, discharge objections, billing, client complaints, and language describing parents or families as the program's clients or customers.
- Other staff who heard similar language from Marzilli or other leaders.

2. Fire-extinguisher CCTV section - direct corroboration of Drew Behr replaying footage

The memorandum already contains the author's firsthand account that Drew Behr replayed CCTV footage of the M.J. / C.S. fire-extinguisher incident to multiple clients while laughing and calling C.S. a "dumbass." S.S. now independently reports that he was personally one of the clients to whom Drew showed the footage.

This is incident-specific corroboration of the narrow proposition that Drew displayed the footage to clients. S.S. has not yet supplied a complete account of every statement Drew made while showing it, the number of viewers, the exact location, or whether S.S. independently remembers the "dumbass" remark. Those details should not be attributed to S.S. unless he separately confirms them.

Cross-reference significance. The new testimony strengthens the existing concerns about access to surveillance footage, client confidentiality and dignity, preservation of violent-incident evidence, casual or mocking replay of footage, and whether supervisors knew that direct-care or case-management staff showed sensitive video to residents.

Archive classification: Direct corroborating witness testimony from S.S. concerning Drew Behr showing the M.J. / C.S. footage to clients. The underlying violence and any additional comments remain separately evidence-typed.

Records and corroboration:

- S.S.'s full account of when and where Drew showed the footage, who else was present, what Drew said, and how the footage was accessed.
- CCTV access logs, export history, device logs, camera-system permissions, and any record showing playback outside a formal incident-review process.
- Accounts from other clients shown the footage, including the memorandum author and any additional viewers.
- Incident, supervision, discipline, privacy, evidence-preservation, and quality-assurance records involving the M.J. / C.S. event or later display of the footage.

3. Direct-care culture section - Carter's alleged statement about staff indifference

S.S. reports that Carter told him, in substance, that "not a single direct-care member gives a single fuck about the clients." This is Carter's alleged characterization as relayed by S.S.; S.S. did not present it as a statement personally heard from every direct-care employee, and it should not be converted into a factual conclusion about every worker.

The statement is nonetheless relevant as an alleged internal assessment from a case manager about direct-care culture. It overlaps employee-review concerns involving weak training, low morale, turnover, underqualified or disengaged staff, inadequate clinical support, and clients being managed by personnel who may have held substantial practical authority despite limited professional preparation.

It also provides context for S.S.'s own view that the program's problems were severe enough that he had considered starting a different program. That opinion should remain attributed to S.S. and should not be treated as proof of any specific event.

Archive classification: Secondhand / relayed staff-culture statement from Carter through S.S. It is evidence of what S.S. says Carter told him, not proof that every direct-care employee lacked concern for clients.

Records and corroboration:

- Carter's direct account, including the date, setting, intended scope, and basis for the statement.
- Direct-care employee surveys, exit interviews, supervision notes, complaints, training records, turnover data, staffing ratios, and performance or disciplinary records.
- Client and employee accounts describing staff responsiveness, indifference, cruelty, protective conduct, or failures to escalate safety concerns.
- Policies defining direct-care responsibilities, minimum qualifications, supervision, crisis escalation, and accountability for client welfare.

Integration instruction. These three targeted additions should be read together with the full S.S. addendum. The fire-extinguisher item is direct corroboration. The Marzilli and Carter quotations are relayed statements with explicit attribution chains. No source identity should be published without separate authorization.

CONTROLLING REPLACEMENT DIRECT-SOURCE ENTRY - I.S.C.

Replacement / identity rule. This entry supersedes any earlier reference to this source as "Cere_Bell_Umm." In all circulated versions, the source must be identified only as **I.S.C.** unless she separately authorizes broader identification. Earlier abbreviated summaries may remain for historical continuity only if they are read as superseded by this controlling entry.

Source and status. I.S.C. is a former Turnbridge women's-program client from the late-2022 through 2023 period. She supplied approximately fifty-seven photographed journal pages written during treatment, more than twenty case-manager communications, a photographed Contract for Continued Phase 3 Residence dated May 31, 2022, later complaint messages, and additional records. The contemporaneous timing materially strengthens the value of the account, but no allegation is converted into an adjudicated finding.

A. Admissions, duration, program structure, and autonomy

- Her journal records representations that phases would last roughly six to eight weeks, that graduation in roughly six months was possible, that she might leave in approximately three months, and that Phase 3 was optional. She later documented substantially longer phases, delayed phone access, and questions about timing being framed as "future tripping."
- She documented substantial unstructured time, inconsistent therapeutic content, limited life-skills work, difficulty reaching case management, and significant staff turnover.
- She experienced program progression, electronics access, weekend plans, work, family therapy, housing, and graduation as subject to broad staff discretion rather than transparent criteria.

B. Sexual-safety and psychiatric-acuity concern involving roommate

A November 2022 journal entry describes a roommate recently coming from psychiatric care who allegedly behaved in a manic or psychotic manner. I.S.C. specifically alleges that the roommate repeatedly stood near women's beds and asked women for massages, conduct I.S.C. experienced as sexually intrusive and unsafe. She states that staff minimized the concern instead of creating a clear protection or separation plan. The exact frequency, context, clinical acuity, staff knowledge, and response require incident, clinical, room-assignment, and safety-plan records.

C. Device searches, privacy, behavioral control, and property

- Journal entries and texts describe staff review of private Discord messages and Venmo activity, extended phone and laptop restrictions, unclear criteria for ending restrictions, and a behavioral contract tying continued Phase 3 residence and privileges to broad requirements.
- I.S.C. produced a photographed Contract for Continued Phase 3 Residence dated May 31, 2022. In contemporaneous texts she twice stated that she had not been given her own copy; the case manager did not dispute that and said it would be reviewed in session.
- I.S.C. alleges McCormack took or failed to return her Nintendo Switch. She also alleges other electronics and property were used as leverage or subjected to restriction. Property inventories, sign-out sheets, storage logs, receipts, family communications, and reimbursement records should be requested.

D. Medication access

I.S.C. documented being without Lamictal for more than three weeks and also without trazodone while reporting that she felt physically and emotionally unwell. In a contemporaneous text, after she stated that she felt horrible and unlike herself, the case manager replied, "It's all about priorities," and redirected the conversation to electronics use. The cause of the medication gaps remains a records question requiring MARs, pharmacy and refill data, prescriber notes, nursing records, and incident / adverse-effect review.

E. Room move, work, and family therapy

- Texts show I.S.C. being told she would switch rooms with Vivian that night and that the decision had already been made. She stated she did not understand prior comments as a formal room-move request and experienced the change as sprung on her.
- Texts document repeated conflicts between imposed family-therapy times and her job. I.S.C. explicitly warned that attendance could cost her employment. The case manager said family therapy would not move again and framed nonattendance as refusal.

F. Graduation, discharge, and proposed forensic evaluation

- Texts document a dispute over graduation, aftercare completion, canceled meetings, and responsibility for delay. I.S.C. says she was denied the graduation she expected after her parents told the program not to let her graduate.
- A text asks how she would feel about a forensic psychologist traveling to Connecticut to evaluate her for two days. When I.S.C. asked who requested it, the case manager replied, "Guess." The requesting party, purpose, consent process, funding, clinical rationale, and any resulting report require clarification.

G. Kelly McCormack - direct allegations of searches, planted items, humiliation, phase regression, and property loss

- I.S.C. alleges repeated favoritism, screaming, humiliation, invasive searches, prolonged restrictions, and gossip about other clients.
- She alleges McCormack planted marijuana / weed among her belongings and planted or later claimed to find a condom in her bag or property.
- She alleges McCormack accused her of "sucking dick for" a gift card to a vegan restaurant.
- She alleges McCormack sent her back to Phase 1 for approximately eight weeks without a legitimate clinical reason.
- She alleges McCormack took or failed to return her Nintendo Switch.
- Her later written complaints to McCormack predate the current investigation and specifically allege searches, drug-related accusations, screaming, prolonged restrictions, humiliation, and gossip. Those messages provide a contemporaneous complaint trail even though each underlying allegation still requires records review.

H. June 2023 communications with therapist Jeni

In June 2023, I.S.C. messaged therapist Jeni that weekend plans had again been taken after I.S.C. had warned McCormack that she would not make a UA and that a time slot with Jennie did not work. I.S.C. stated that McCormack had known about the scheduling issue for weeks and described the way McCormack spoke to her as unacceptable. She wrote that the situation could not continue. The next morning she contacted Jeni because Kelly was not present and she needed medication packing before work.

In later messages, I.S.C. told Jeni that she appreciated Jeni reaching back out and that Jeni was the first person she called. Jeni replied that I.S.C. deserved to feel supported and stated, regarding a gaming laptop, that she had tried to hide it so "Kelly and parents would forget." The exchange is relevant to contemporaneous notice, electronics / property control, and the quality of I.S.C.'s relationship with McCormack.

I. Alleged circumstances of McCormack's departure

I.S.C. alleges that Turnbridge later requested that McCormack take a drug test and that McCormack refused. I.S.C. has described McCormack as then leaving, being fired, or otherwise being removed from the role. The exact employment classification is unresolved. Regulators should obtain the drug-test request, policy basis, communications, HR notes, leave or suspension records, resignation / termination documents, unemployment records if applicable, and any audit of McCormack's open cases after separation.

J. 2024 Concerned Citizens of Foxon / police / DCF lead

I.S.C. supplied or discussed a screenshot from the Facebook group *Concerned Citizens of Foxon* showing two people whom the post alleged had been arrested in West Haven after driving around in a white box truck and stealing property. The post also contains a comment asking whether they were the same people who stole a woman's luggage. I.S.C., who knew McCormack personally as her case manager, identified the woman pictured as Kelly.

Turnbridge therapist Jeni separately identified the same woman as Kelly and confirmed that this was the page she had been discussing. Jeni stated that information had been provided privately to an alleged victim, that the woman contacted East Haven Police, and that there was reportedly an open investigation. Jeni also stated that a DCF report had been placed in connection with concern for a child and that Kelly's sister had become involved in the child's care. I.S.C. separately described the alleged property victim as autistic. These points require police, DCF, victim, family, and court corroboration and must not be converted into findings from the messages alone.

K. Public criminal-record context concerning McCormack

Connecticut Judicial Branch screenshots supplied for this update identify Kelly Elizabeth McCormack, birth year 1984, and show confirmed guilty findings for sixth-degree larceny in 2017 and 2019; second-degree breach of peace and second-degree threatening in 2019; and violation of probation in 2020. A 2012 Connecticut news report separately described Kelly McCormack, then 27, as charged with disorderly conduct after a property dispute. Additional 2011, 2013, and 2024 search-result cards remain docket leads pending official case-detail verification. These records do not prove I.S.C.'s allegations, but they materially sharpen the institutional question of what Turnbridge knew, what it screened, and how it supervised McCormack while giving her authority over vulnerable clients and their property.

L. Records, corroboration, and preservation

- Complete I.S.C. Turnbridge file, including all houses, phases, progress reviews, phase-downs, graduation decisions, discharge / aftercare records, family communications, and billing / utilization records.
- All Kelly McCormack case-management notes, supervision records, complaint and grievance records, HR file, performance reviews, background checks, criminal-history disclosures, disciplinary records, and separation records.
- All room / property searches, contraband logs, drug-test / UA records, condom or marijuana documentation, photographs, chain-of-custody records, incident reports, and staff witness statements.
- Property inventory, electronics logs, Nintendo Switch records, gaming-laptop records, storage / return / reimbursement records, and family communications about electronics.
- Medication administration records, refill and pharmacy records, Lamictal and trazodone prescribing records, nursing communications, medication-error reports, and adverse-effect documentation.
- Behavioral contract drafts, signature / distribution records, records showing whether I.S.C. received a copy, and the clinical rationale for each restriction.
- Family-therapy scheduling records, employment schedule communications, job-impact notes, and records supporting or contradicting characterization of missed sessions as refusal.
- Forensic-psychologist referral, requesting party, consent documentation, purpose, payment, travel, report, and communications with family or counsel.
- Jeni's complete relevant communications, supervision records, records concerning the gaming laptop, and any complaints or disclosures she received from I.S.C. about McCormack.
- Any Turnbridge drug-test request directed to McCormack, refusal, specimen / testing records, HR communications, suspension, resignation, termination, exit interview, and post-separation case audit.
- East Haven and West Haven police reports, CAD, arrest records, body-camera / incident records, DCF intake or investigation records, and court records concerning the April 2024 property allegations.

M. Evidentiary distinctions and archive classification

I.S.C. personally reports her own treatment experience and allegations concerning McCormack. Her journal pages and case-manager messages are contemporaneous or near-contemporaneous documentary support for many broader aspects of the account, but they do not automatically prove every alleged planted item, property loss, motive, or later employment event. Jeni's messages are independent contemporaneous communications from a Turnbridge therapist but remain statements requiring records corroboration where they concern police, DCF, McCormack's condition, or third parties. Court records are treated separately as public-record facts where official Judicial Branch detail pages were supplied.

Archive classification: **Direct former-client account with extensive contemporaneous documentation; high-priority source for regulators, counsel, and journalists subject to source consent. Use only I.S.C. in circulated versions.**

COMPLETE CONSOLIDATED DIRECT-SOURCE ENTRY - O.C. - August 7, 2026

30. O.C. - direct former-client testimony: transport against her will as a minor, 45-day representation and approximately ten-month placement, repeated peer assaults, coercive group humiliation, delayed medical care, case-management punishment and humiliation, post-discharge staff-boundary concern, and ongoing health / functional impact

Source and status. On August 7, 2026, a former Turnbridge client who initially contacted the archive through Reddit and then voluntarily moved the conversation to text provided a detailed written account. She selected the initials O.C. for all documentation. Her legal name and contact information are not included in this circulated entry. O.C. reports that she entered Turnbridge as a minor, turned eighteen during placement, and was fully discharged on August 6, 2024. This is direct former-client testimony, not an adjudicated finding.

Source-use and consent posture. O.C. expressly supplied the account because she wants what happened documented and hopes it may help prevent similar harm. She should be identified only as O.C. unless she separately authorizes broader identification. Original Reddit messages, text messages, screenshots, timestamps, and any future records should remain preserved in a restricted source archive. Follow-up should remain source-directed and non-pressuring.

A. Admission, forced transport, 45-day representation, and full placement chronology

- O.C. states that she was sent to Turnbridge on October 6, 2023, while still a minor. In her initial account she said her parents hired people to take her there against her will and that she was forced into a car. She personally characterizes that experience as having been "kidnapped." This memorandum preserves her description but does not convert it into a legal conclusion about the transport.

- She states that she was told she would be staying for approximately 45 days and understood Killingworth itself as generally a 45-day treatment program.

- She reports that on approximately her 48th day she was sent from Killingworth to Turnbridge adolescent extended care, describing a North Haven house and the New Haven clinical office.

- She reports that on her eighteenth birthday, near the end of January 2024, Turnbridge moved her into the women's adult program on Prospect Street.

- She says she was told she would be fast-tracked through the adult phases. She reports that this happened to some degree, but that the transition also exposed her to additional bullying from other women.

- In an earlier message she reported progressing through the adult program and spending about a month at a Quinnipiac / "Quinnie" house before graduating. She later supplied the exact date August 6, 2024 as the date she was fully discharged.

The interval from October 6, 2023 through August 6, 2024 is approximately 305 days. The 45-day statement should therefore be tested carefully against the scope of the original representation: whether 45 days referred only to Killingworth, to the expected total course of care, or to another level of care; what O.C. and her parents were told before transport; and what written admissions, extension, utilization-review, and billing records show.

B. Repeated peer assaults and alleged failure to protect in adolescent extended care

- O.C. reports that after arriving in the adolescent extended-care setting, a girl who had been there only about a day heard a false rumor that O.C. had sexually assaulted someone and punched O.C. while O.C. was sleeping. O.C. states that this girl was then sent out of the program.

- A few weeks later, O.C. states that the girl who had originated or spread the false sexual-assault rumor wanted to get kicked out and punched O.C. while O.C. was sleeping. O.C. says this client remained in the program for a period afterward and, in O.C.'s view, did not receive meaningful punishment.

- O.C. reports a separate conflict with a roommate after the roommate allegedly stole O.C.'s clothing. O.C. states that the roommate later threw a full plastic water bottle at O.C.'s head while O.C. was sleeping.

- O.C. says staff did not meaningfully address the roommate incident and that the two remained roommates for months afterward. She describes the roommate relationship as persistently hostile and unsafe.

These accounts are separate incidents and must not be merged. The institutional questions include whether incident reports were created, whether O.C. received medical checks after being struck while asleep, whether the false sexual-assault rumor was investigated, whether aggressors were separated from O.C., whether family / guardians were notified, and why the roommate assignment allegedly continued after the bottle incident.

C. Killingworth "shit talk circle," blocked exit, threatened loss of privileges, and group humiliation

O.C. identifies Killingworth, particularly periods in which residents were isolated together, as the worst part of her Turnbridge experience. She describes a weekly group practice she calls the "shit talk circle."

- She says she was frequently the principal target of the circle for many of the weeks she was at Killingworth.
- She reports sitting while the group screamed at her and says she was not allowed to leave the circle.
- When she tried to stand up and leave, she says people blocked the door and told her she would lose privileges if she left.
- She says she was told she needed to sit there and "take it" and that enduring the treatment would make her stronger.
- She believes she was bullied and singled out disproportionately compared with other girls.

The account is materially different from a general complaint that group therapy felt harsh. O.C. specifically alleges attempted exit, physical blocking of the doorway, threats of lost privileges, and compelled exposure to group screaming. Records review should identify the formal name, written protocol, clinical rationale, staff supervision, attendance rules, privilege consequences, and whether any incident or complaint records describe clients asking to leave these groups.

D. Adolescent-program medical-care allegations

1. Severe chest pain, collapse / loss of consciousness, delayed escalation, and eventual hospital visit

O.C. reports that she went to the clinic / Orange Street office complaining of severe chest pain and believed she might die. She says she "kind of" passed out on a couch for several hours while staff did little. She reports that staff eventually took her to a hospital, where she was told she was medically okay, but emphasizes that she spent hours in significant pain before transport. She recalls being told during the delay to drink tea and squeeze a stress ball.

2. Months of vomiting without physician evaluation

O.C. separately reports vomiting for months and says she did not get to see a doctor for that problem during the relevant period.

3. Ruptured eardrum and alleged weeks-long delay in urgent-care access

O.C. reports that she ruptured an eardrum and that Turnbridge would not take her to urgent care for weeks. She states that the condition became significantly worse during the delay.

These are concrete medical-safety allegations that may generate independent records trails. The chest-pain episode may be testable through hospital arrival records, Turnbridge transportation records, clinical notes, house / office logs, and staff schedules. The ear injury and vomiting complaints may be testable through nursing notes, appointment requests, outside physician or urgent-care records, medications, family communications, and insurance claims.

E. Adult-program case-management, punishment, and humiliation

- After turning eighteen and moving to the adult women's program, O.C. says her case managers were among the worst parts of the experience.
- She reports repeated situations in which staff miscommunicated instructions or expectations, leaving her unable to complete a task correctly, and then punished her for the resulting failure.
- She reports being screamed at, yelled at, and humiliated in connection with these disputes.
- She further reports that being fast-tracked through phases increased hostility or bullying from other women in the program.

Follow-up should identify the relevant case managers, dates, phase rules, written instructions, noncompliance / consequence records, grievance records, and whether staff communications document conflicting directions.

F. Post-discharge staff-boundary concern involving Ian [full identity / title to confirm]

O.C. reports that a few months after she left Turnbridge in August 2024, she encountered a man named Ian at a recovery meeting she regularly attended. In her initial disclosure she described the person as a program manager; in her later detailed account she said she knew he worked at Turnbridge, primarily in the men's program. His exact surname, age, title, work dates, and authority over O.C. while she was a client remain to be confirmed.

- O.C. says Ian had recently dated another woman who had also just left Turnbridge around the same period as O.C.
- O.C. reports that immediately after that relationship ended, Ian messaged her on Instagram.
- O.C. says she initially found him attractive but also thought the contact felt unusual because of his Turnbridge connection.
- She states that Ian then essentially asked to have sex with her. O.C. responded that she did not want to be his rebound, and they did not continue communicating afterward.

The present account does not allege that sexual contact occurred between Ian and O.C. It does raise a staff-boundary and post-discharge safeguarding question, particularly because O.C. had only recently left a program where Ian allegedly worked and because O.C. reports he had just been in a relationship with another recently discharged Turnbridge client. The exact employment relationship, whether Ian knew O.C. while she was a minor or client, Turnbridge's post-discharge contact policy, and the other former client's account should be established before stronger characterization.

G. Ongoing health, educational, housing, and family impact

- O.C. reports ongoing health problems that she says became significantly worse after or during her time at Turnbridge and that she attributes in part to the program experience.
- She states that she attended college but became very sick and had to drop out. In an earlier message she said she went to college after graduating from Turnbridge; the exact college timeline should be confirmed rather than assumed.
- She currently lives with the parents who sent her to Turnbridge and reports being reminded of the experience every day through those interactions.
- She says family members continue to tell her that Turnbridge was not that bad and that what happened was her fault. She describes only recently - within roughly two weeks of contacting the archive - beginning to accept that the experience was seriously harmful.
- She wants to move out but reports being dependent on her parents' money and health insurance because of ongoing health problems.
- She describes feeling stuck and uncertain how to begin rebuilding her life.

These are impact statements and present circumstances as reported by O.C. They should not be converted into a medical diagnosis or a legal causation finding. They are relevant to continuity-of-care, discharge planning, functional outcome, family dynamics, and the need to compare pre-program, in-program, and post-program medical and educational records.

H. Present outreach, treatment search, records request, and accountability goal

- O.C. states that she wants to talk about what happened if doing so may help create accountability or prevent similar harm to others.
- On August 7, 2026, after receiving support and referral information, she reported contacting several therapists, texting another former women's-program client, and emailing Sarah Eagan.
- She expressed interest in obtaining her complete Turnbridge records and asked how to request them.

These present-day actions are included as source-context and preservation leads, not as proof of the underlying allegations. Any records O.C. receives should be preserved in original form with cover letters, production metadata, page counts, omissions, and the exact scope of the request.

I. Records, corroboration, and preservation roadmap

- Complete Turnbridge record for O.C. from October 6, 2023 through August 6, 2024, including Killingworth, North Haven adolescent extended care, New Haven clinical services, Prospect Street, Quinnipiac / "Quinnie," and any other residence or phase.
- Admissions calls, transport records, contracts, brochures, written expectations, parent communications, utilization-review submissions, insurance authorizations, billing records, and any material referring to 45 days, extension, aftercare, or expected total duration.
- Transport company identity, transport authorization, pickup records, parent instructions, intake documentation, and any records of objection or resistance by O.C. while she was a minor.
- Incident reports, CCTV, house logs, staff notes, medical checks, injury documentation, separation plans, safety plans, family notifications, disciplinary records, and witness accounts for each reported punch and the water-bottle incident.
- Roommate assignments, room-change requests, case-management communications, and records explaining why O.C. and the roommate allegedly remained together after the bottle incident.
- All documents describing the Killingworth weekly group O.C. calls the "shit talk circle": curriculum, staff instructions, attendance expectations, privilege consequences, grievance records, group notes, staff schedules, and accounts from other residents.
- Clinical, nursing, medication, symptom, vital-sign, transport, hospital, emergency, urgent-care, appointment-request, and family-notification records concerning severe chest pain / collapse, months of vomiting, and the ruptured eardrum.
- Case-management notes, phase records, consequence / noncompliance records, communication logs, grievance records, and staff schedules concerning alleged miscommunication, punishment, yelling, humiliation, and fast-tracking after O.C. turned eighteen.
- Employment and staff-roster records sufficient to identify Ian, his exact title, program assignment, client contact, supervision, and any policy governing staff relationships or sexual contact with recently discharged clients.
- If the other recently discharged woman independently consents, her account and any preserved messages concerning Ian. Do not contact or identify her publicly without her permission.
- O.C.'s post-discharge medical, college, disability / leave, insurance, and therapy records only with her authorization and only to the extent relevant to claims she chooses to pursue.

J. Due-diligence questions generated by O.C.'s account

- What exactly was represented to O.C. and her parents about 45 days, and when were they first told that treatment could extend for many additional months and multiple programs?
- What incident and medical response followed each assault of O.C. while she was sleeping, and why was she allegedly left living with a roommate after the water-bottle incident?
- What was the formal clinical purpose and policy basis for a group in which O.C. says peers screamed at her, blocked her exit, and threatened loss of privileges if she left?
- Why did severe chest pain and apparent collapse allegedly result in hours of delay before hospital transport, and why were vomiting and an eardrum rupture allegedly not evaluated promptly?
- What staff instructions, supervision, or grievance process existed when O.C. says she was punished for tasks she could not complete because staff had miscommunicated the requirements?
- What post-discharge boundary rules applied to an employee contacting a recently discharged former client for sex, and what records identify Ian and his relationship to O.C. while she was in treatment?

K. Archive classification and controlling-use rule

Direct former-client testimony from O.C. concerning admission as a minor and transport against her will; a reported 45-day expectation followed by an approximately 305-day placement; three separate peer-violence incidents; alleged failure to separate or protect; coercive and humiliating group practices at Killingworth; alleged delayed medical care for severe chest pain / collapse, prolonged vomiting, and a ruptured eardrum; adult-program case-management punishment and humiliation; a post-discharge staff-boundary concern involving Ian; and ongoing health, educational, housing, and family impact. The account remains unverified except where future records or witnesses corroborate it.

This entry is controlling for O.C. within the consolidated source section. Do not publish her legal name, phone number, Reddit username, text-message metadata, family identifiers, medical records, or other identifying information without her separate authorization. Preserve all allegations as allegations and distinguish O.C.'s direct experience from interpretation, inference, and any future relayed information.

Cross-source evidentiary rules and preservation requirements

- Do not collapse distinct accounts into a single proven institutional finding.
- Preserve each original email, DM thread, Reddit exchange, phone note, screenshot, attachment, and full header or metadata record.
- For each factual proposition, identify whether the source personally witnessed it, personally experienced it, overheard it, learned it contemporaneously, or heard it later.
- Preserve exact source consent, anonymity, regulator-sharing, publication, and identification restrictions.
- Where a source has offered only preliminary outreach, do not substitute a generic summary for the original email; preserve the actual outreach and obtain a full interview.
- Use source accounts as records-request roadmaps. Request the incident, clinical, medical, staffing, phone, device, HR, transportation, billing, discharge, family-communication, police, EMS, and mandated-reporting records that should exist.

Integration instruction. This complete section should be treated as the controlling direct-source section. Earlier compressed summaries may remain elsewhere for navigation, but they must not be relied on as substitutes for the full accounts above.

Potential corroboration:

- Dave Murphy's account of the meeting
- Staff schedules confirming Dave Murphy's role and presence at the relevant house in early 2023
- House address / placement records identifying the Turnbridge house nearest to 189 Orange Street across the bridge near Fair Haven
- Clinical notes, case-management notes, or staff notes from the meeting
- Any documentation of sexual-rumor concerns involving me and L.M.
- Client accounts confirming the existence or spread of the untrue rumors involving me and L.M.
- Client accounts confirming male-female client relationships during the same period, including R.P. and A.K.
- Records or witness accounts showing how Turnbridge enforced "sexuality between clients is not allowed" across same-sex, queer-coded, and male-female contexts
- Any policies on client sexuality, client dating, gender identity, pronoun use, and LGBTQ client support
- Contemporaneous disclosures to therapist, family, sponsor, or peers about the meeting
- Therapist recollection that this incident had previously been disclosed and later resurfaced in therapy discussion

Archive classification:

Firsthand recollection resurfaced through later therapy discussion. Staff-conduct / sexual-rumor response / pronoun-interrogation concern. Requires corroboration through records, staff schedules, clinical notes, witness accounts, policy documents, and contemporaneous disclosures.

V. Secondhand / Overheard Allegations

A. Client Autonomy / Attempted Departure / Outside-Contact Interference

1. J. airport story: alleged client brought to Turnbridge against his wishes; later

allegation that Turnbridge contacted girlfriend's father during attempted departure

Approx. date: Late 2021

Program/location: Turnbridge / Turning Point

Client involved: J.

Other people involved: J.'s girlfriend; girlfriend's father

Type: Client autonomy; consent / placement concern; alleged interference with client departure; alleged family-contact

boundary issue; secondhand allegation requiring corroboration In late 2021, I remember a fellow client, J., being at

Turnbridge after, according to him, being brought there against his wishes. J. repeatedly told people around him that he

felt "conned." My memory is that he spent much of his time in his room watching *The Wire* and did not attend groups. I

am certain that J. called a girlfriend to get him a plane ticket. I do not remember the final destination, but my memory

is that it was somewhere below the Mason-Dixon line. J. later alleged that after he got off a connecting flight in Florida,

his girlfriend called him and told him that Turnbridge had contacted her father to say that J. needed to stay at

Turnbridge for his own sake. I did not personally witness any call between Turnbridge and the girlfriend's father. This

item is included because I directly remember J. repeatedly expressing that he felt conned, directly remember his

disengagement from programming, and directly remember him arranging a plane ticket through his girlfriend.

The

allegation about Turnbridge contacting the girlfriend's father should be treated as J.'s allegation unless corroborated.

Potential corroboration:

- J.'s direct account
- J.'s girlfriend's account
- Girlfriend's father's account
- Flight / airline records, if J. preserved them
- Texts or call logs between J. and his girlfriend
- Turnbridge records concerning J.'s intake, consent status, discharge attempt, departure, or return
- Staff notes or communications around J. leaving / attempting to leave
- Other clients who heard J. say he felt "conned"
- Other clients who knew J. was watching The Wire and not attending groups
- Contemporaneous texts, journal entries, or family disclosures from the time

Archive classification: Firsthand memory of J.'s statements, behavior, and plane-ticket arrangement + secondhand allegation

from J. regarding Turnbridge contacting girlfriend's father.

2. H. denied-access story: alleged girlfriend / girlfriend's father contact after

client tried to leave Turnbridge Approx. date: Early 2022

Program/location: Turnbridge / Turning Point

Client involved: H.

Other people involved: H.'s girlfriend; girlfriend's father

Type: Client autonomy; consent / placement concern; alleged interference with client departure; alleged third-party

family-contact pressure; secondhand allegation requiring corroboration In early 2022, client H. allegedly called his

girlfriend to help get him out of Turnbridge. H. recalled that Turnbridge spoke to his girlfriend's

father. According to H.,

his girlfriend then called him in tears and said she could not help him. I did not personally witness the call between

Turnbridge and the girlfriend's father. This item is included because it may be relevant to a broader pattern in which

clients trying to leave Turnbridge through girlfriends or outside support allegedly encountered intervention through the

girlfriend's parent or family authority figure. This should be treated as H.'s recollection / allegation unless corroborated.

Potential corroboration:

- H.'s direct account
- H.'s girlfriend's account
- Girlfriend's father's account
- Texts or call logs between H. and his girlfriend
- Turnbridge records concerning H.'s intake, consent status, attempted departure, discharge request, or outside contact
- Staff notes or communications around H. attempting to leave
- Other clients who heard H. describe the incident at the time
- Contemporaneous texts, journal entries, family disclosures, or therapist disclosures

Archive classification: Secondhand allegation / H.'s reported recollection regarding Turnbridge contacting girlfriend's father

after H. sought help leaving.

3. Current-client witness account: Drew Behr alleged interference with R.'s March 2026 attempt to leave Phase 1 / 90 Ford Street for another sober house; phone-call cutoff / number-blocking concern; later derogatory "toxic" comment

Approx. date: Early March 2026

Program/location: Phase 1 / 90 Ford Street

Staff involved: Drew Behr

Clients involved: R. [client seeking to leave]; D4rkhunter55 [current-client witness / source]; other clients present during morning meeting [to confirm]

Other people involved: R.'s family members; R.'s girlfriend

Type: Client autonomy; attempted departure; family-contact interference; phone-access interference; staff power / coercion concern; staff disparagement of client after departure; complaint-response and records-preservation concern

Account:

In July 2026, a current Turnbridge client using the Reddit handle D4rkhunter55 contacted me after reading the Turnbridge archive material. D4rkhunter55 stated that he personally witnessed a concerning March 2026 incident involving Drew Behr and a client identified here as R.

According to D4rkhunter55, R. was a Phase 1 client at 90 Ford Street. R. was in his early 30s, had children, and was being treated for methamphetamine addiction. After approximately 28 days at Turnbridge, R. wanted to leave Phase 1 and move to a sober house closer to his own area.

D4rkhunter55 reported that Drew Behr did everything within his power to try to stop R. from leaving. The alleged conduct included trying to turn R.'s family against him, actively cutting off phone calls to family members in the middle of conversations while R. and his family were making plans to move him to another sober house, and then blocking the relevant phone numbers.

According to D4rkhunter55, R. felt he had no other options and asked to use D4rkhunter55's Bark Phone to call his girlfriend so that they could plan and purchase a bus ticket. D4rkhunter55 allowed R. to use the phone. D4rkhunter55 reported that, from what he overheard, R.'s girlfriend was extremely upset with Drew because of Drew's alleged attempts to block communication. D4rkhunter55 specifically recalled the girlfriend saying, "Drew is a power tripping bitch."

After that phone call, tickets were purchased and R. was finally able to leave.

D4rkhunter55 stated that he personally found the incident strange because R. had a legal right to leave Turnbridge and pursue other treatment options, but Drew allegedly did everything he could to prevent him from leaving. D4rkhunter55 also reported that the following morning, during morning meeting at 90 Ford Street, Drew referred to R. as "toxic" and then went on what D4rkhunter55 described as a tirade about hating having to "police" people.

D4rkhunter55 characterized this as his primary firsthand witness account of potential abuse at Turnbridge. He also stated that, after reading my account about Drew allegedly instructing my parents not to take my phone calls and later making the "curbstomping" / American History X comment, the R. incident sounded "very consistent" with what he personally saw Drew do.

Consent / use status:

D4rkhunter55 stated that he personally consents to what he has said being shared forward to "whoever it needs to," but also stated that he needs to talk to R. first. This entry should therefore be treated as authorized for preservation as D4rkhunter55's witness account, but any use that could identify R. or materially involve R.'s personal story should wait for R.'s own consent or direct confirmation.

Why this matters:

This account is significant because it independently overlaps with existing Drew Behr concerns already preserved in the archive. The previously preserved Drew-related material includes allegations that Drew interfered with my family contact at 90 Ford Street, instructed my parents not to take my phone calls, privately described wanting to "curbstomp" me, and replayed CCTV footage of client-on-client violence while mocking clients.

The March 2026 R. account suggests a possible broader pattern involving Drew Behr, client autonomy, attempted departure, family-contact interference, staff control over phone access, and derogatory staff framing of clients who tried to leave or move to other treatment settings.

If accurate, the conduct described raises serious institutional questions:

- Did R. have a legal right to leave Turnbridge and pursue another sober house?
- What authority did Drew Behr have at 90 Ford Street to cut off or block phone calls between R. and family members?
- Were calls actually cut off or numbers blocked?
- Were R.'s family members told information designed to discourage them from helping R. leave?
- Was there any written clinical rationale for interfering with R.'s outside contact?
- Did Turnbridge document R.'s request to leave or transfer to another sober house?
- Did Turnbridge document any alleged family-contact restrictions?
- Did Drew or other staff refer to R. as "toxic" after he left?
- Were clients discouraged from helping one another contact outside support?
- Did Turnbridge treat attempted departure as a clinical issue, a safety issue, or staff defiance?
- Were clients who attempted to leave characterized negatively in group settings after departure?

Potential corroboration:

- R.'s direct account, if he consents
- R.'s girlfriend's account
- R.'s family members' accounts
- D4rkhunter55's direct account and message screenshots
- Bark Phone logs, if available

- Call logs showing attempted calls to family / girlfriend
- Records showing whether numbers were blocked
- Bus ticket records or travel confirmation from March 2026
- 90 Ford Street house logs from early March 2026
- Phase 1 staff schedules showing Drew Behr's role / assignment during the incident
- Case-management notes concerning R.'s attempted departure or transfer request
- Clinical notes concerning R.'s desire to leave after approximately 28 days
- Any discharge, AMA, transfer, or referral records involving R.
- Family-contact policies and phone-use policies
- Records showing whether Turnbridge restricted family contact during attempted departures
- Other clients present in morning meeting at 90 Ford Street when Drew allegedly called R. "toxic"
- Any staff or client witnesses to Drew's alleged comments about having to "police" people
- Any internal communications about R.'s attempted departure, family contact, girlfriend contact, or transfer to another sober house
- Any records showing whether Turnbridge had a policy requiring or forbidding staff to block phone numbers or interrupt calls during discharge planning

Archive classification:

Current-client witness account / consented anonymous lead. The account is mixed in evidentiary type: D4rkhunter55 personally witnessed and overheard parts of the incident, including R. using his phone, R.'s girlfriend's reaction, the bus-ticket planning, and Drew's later alleged "toxic" / "police" comments in morning meeting. Other elements, including the alleged cutting off of family calls, number blocking, and attempts to turn family members against R., should be treated as reported or overheard allegations requiring corroboration. The account concerns alleged client-autonomy interference, family-contact interference, phone-call cutoff / number-blocking, and staff disparagement involving Drew Behr and client R. at Phase 1 / 90 Ford Street in March 2026. The account is preserved with the source's permission, but R.'s identity and direct story should remain anonymized and should not be used in a way that identifies or materially involves R. without R.'s own consent or independent corroboration.

B. Sexual Safety / Client-Culture Legal-Proceeding Allegations

2A. "Scarface Adam" / T.K. sexual-assault legal-proceeding allegation

Approx. date heard: 2021, while I was at 90 Ford Street

Program/location: 90 Ford Street / Turnbridge Phase 1 context

People involved: Client known among clients as "Scarface Adam"; female Turnbridge client T.K.; multiple clients who communicated the allegation to me [names to identify if legally / ethically appropriate]

Type: Secondhand allegation; client-culture knowledge; sexual-assault allegation; legal-proceeding lead; sexual-safety concern; records-preservation issue

Account:

In 2021, while I was at 90 Ford Street, it was widely understood among clients and communicated to me by multiple different clients that another client, referred to by clients as "Scarface Adam," was facing legal proceedings related to the alleged rape of a female Turnbridge client, T.K.

I did not personally witness the alleged assault or any legal proceeding. This item is included because multiple clients communicated the same general understanding to me while I was in the Turnbridge environment, and because the allegation, if accurate, would raise serious questions about client safety, sexual-assault response, client placement, staff knowledge, documentation, separation, family notification, and how Turnbridge handled clients accused of sexual violence against other clients.

This should not be stated publicly as a proven fact unless corroborated through court records, police records, direct witness accounts, T.K.'s account, "Scarface Adam's" identity and case records, or Turnbridge documentation. The current safe framing is that multiple clients told me, and it was widely understood among clients, that "Scarface Adam" was facing legal proceedings related to an alleged rape of T.K.

Why this matters:

This allegation is serious because it concerns an alleged sexual assault involving one Turnbridge client and another Turnbridge client. If a client was accused of raping another client and was facing related legal proceedings, Turnbridge should have had clear records concerning staff knowledge, client separation, incident reporting, police involvement, family communication, clinical response, housing decisions, and whether other clients were informed or protected.

The fact that the allegation was allegedly widely discussed among clients also matters. If clients understood that another client had been accused of raping a female client, the institutional question becomes what staff knew, how the information circulated,

whether the accused client remained in proximity to other vulnerable clients, whether the harmed client was protected, and whether the situation was addressed clinically rather than becoming rumor or fear within the client culture. This entry also belongs in the broader sexual-safety pattern because it predates later sexual-boundary concerns in 2022 and

2023. It suggests that serious sexual-assault allegations may have been part of the client-safety environment before the later

incidents preserved elsewhere in the memo.

Potential corroboration:

- T.K.'s direct account, if legally and ethically obtainable
- Identification of the client known as "Scarface Adam"
- Court records, docket records, police reports, or legal filings involving "Scarface Adam" and T.K.
- Clients who told me about the allegation in 2021
- Other clients at 90 Ford Street who understood or discussed the allegation
- Staff who were aware of the allegation or legal proceedings
- 90 Ford Street house rosters from 2021
- Staff schedules and house logs from the relevant period
- Turnbridge incident reports, clinical notes, safety plans, or internal communications involving "Scarface Adam" or T.K.
- Records showing whether the accused client and T.K. were separated
- Records showing whether families, police, outside providers, regulators, or outside authorities were contacted
- Any contemporaneous texts, journals, therapy disclosures, family disclosures, or client messages referencing the allegation

Archive classification:

Secondhand allegation / client-culture legal-proceeding lead communicated by multiple clients in 2021. Serious sexual-safety and records-preservation concern requiring corroboration. Should be framed as an allegation or reported client understanding unless independently verified through court records, police records, direct accounts, or Turnbridge documentation.

C. Staff Boundary / Substance / Safety Allegations

3. Allegation that staff member Liam tried to meet up with underage former

adolescent-program client Approx. date of allegation discussion: Late 2022 or 2023; later phone confirmation / report in 2023 or 2024

Staff involved: Liam [last name to be identified]

Sources: Z.T. discussion overheard / partially observed in program context; later W.H. phone account

Type: Staff boundary issue; adolescent-program concern; alleged misconduct; termination-context concern

In late 2022 or 2023, I remember Z.T. discussing the case of why Liam was fired with another client in a hushed voice.

Z.T. became very hesitant to tell me the details when I became aware of the discussion. My memory is that the

conversation clearly suggested a serious allegation or sensitive reason for Liam's departure, but I did not receive the

full substance from Z.T. at that time. Later, in 2023 or 2024, W.H. informed me on the phone of the allegation

concerning why Liam was fired. According to W.H., Liam allegedly tried to meet up with an underage former client of

the adolescent program while Liam was an adult support staff member in the young-adults program. This item should

be treated carefully. I did not personally witness Liam contact the former adolescent-program client. The allegation

comes from W.H.'s later phone account, with earlier program-context support from my memory of Z.T. discussing

Liam's firing in a hushed, hesitant way. The underlying allegation requires corroboration through direct witnesses,

employment records, termination records, internal communications, or the former client's own account.

There was

significant drama around Liam being "quietly" let go, which I experienced firsthand in the program environment, though the specific allegation was relayed to me secondhand.

Potential corroboration:

- W.H.'s direct account of the phone conversation and how W.H. learned the allegation
- Z.T.'s account of what he was discussing in late 2022 or 2023
- The other client who was speaking with Z.T. during the hushed discussion
- Employment records identifying Liam
- Liam's staff termination / separation timeline
- Internal Turnbridge communications concerning Liam's departure
- Any complaint, incident report, HR record, or mandated-reporting record concerning Liam
- Former adolescent-program client's direct account, if legally and ethically obtainable
- Other clients who heard the same allegation
- Contemporaneous texts, call records, notes, or disclosures from the 2023/2024 W.H. phone conversation

Archive classification: Secondhand allegation from W.H. + firsthand observation of earlier Z.T. hushed discussion / hesitation

+ firsthand observation of surrounding institutional drama concerning Liam's departure. Requires corroboration before stronger use.

4. Allegation that Liam gave THC pen hits to H.V. and C. while they were

sequestered after relapse Approx. date: 2021-2023 window, exact date to be narrowed

Staff involved: Liam [last name to be identified]

Clients involved: H.V.; C.

Type: Substance-use misconduct; staff boundary violation; relapse-management failure

I heard that the same staff member, Liam, gave H.V. and C. hits from a THC pen for approximately two weeks while

they were sequestered at a separate property after both had relapsed. This allegedly occurred after H.V. and C.

threatened to retaliate against Liam for getting high on the job. This allegation is distinct from the underage-former-client allegation, but both belong in the Liam staff-boundary / staff-misconduct cluster because they

concern alleged conduct by the same staff member, alleged surrounding institutional drama, and questions about why

Liam was quietly let go.

Potential corroboration:

- H.V. and C. as direct witnesses
- W.H.'s account if W.H. heard related information
- Z.T.'s account if Z.T. heard related information
- Staff schedules showing Liam assigned to the separate property
- Drug-testing / relapse documentation
- House logs / shift notes
- Other clients aware of the sequestering arrangement
- Employment records surrounding Liam's departure
- Internal Turnbridge communications concerning Liam's termination or separation

Archive classification: Secondhand allegation; potentially corroborable through witnesses and staffing records.

5. Early-2023 concern about returning a client after alleged restraint / beating

incident Approx. date: Early 2023

Program/location: Phase 1

Clients involved: Names not remembered

Type: Client safety; alleged inadequate separation; uncorroborated concern

In early 2023, a skinny younger client whose name I cannot currently remember expressed concern to me and another

client that a heavier client he was scared of had been returned to Phase 1 after being taken off site for

a weekend following an incident in which the heavier client had allegedly restrained and beaten him. The younger client was concerned because they were again living together. I cannot currently remember the names of the clients involved, so this item should be treated as uncorroborated unless further witnesses, house logs, shift notes, incident reports, or client names can be identified.

Potential corroboration:

- Phase 1 house logs from early 2023
- Incident reports involving client restraint / assault
- Records of any client being taken off site for a weekend after violence
- The second client who heard the concern
- The younger client's account, if identified
- Staff communications regarding returning the heavier client to Phase 1

Archive classification: Firsthand memory of a client's expressed safety concern; underlying assault allegation uncorroborated at present.

6. Allegation that Douglas Roberto left a Phase 3 house open and involved a client

in searching the house after an intruder entered Approx. date: To be narrowed

Program/location: Phase 3 house [exact property to confirm]

Staff involved: Douglas Roberto

Clients involved: Client asked to sweep the house [name to confirm]

Type: Secondhand allegation; house safety; intruder incident; staff judgment; failure to report / secrecy concern

I heard from multiple people that Douglas Roberto allegedly left a Phase 3 house open, and that a man in a ski mask

came into the house. According to the allegation, once Douglas realized someone was in the house, he grabbed a knife

and brought a client with him to sweep the house. He allegedly told the client not to tell anybody. I also heard that

Douglas was fired shortly after this. I did not personally witness this incident. I am preserving it because I heard the

rumor from multiple people, and because, if true, it would raise serious questions about house security, staff judgment,

the use of clients in a potentially dangerous situation, incident reporting, and whether staff attempted to suppress

reporting. This should not be stated as proven unless corroborated through witnesses, house logs, police reports, staff

records, or internal communications.

Potential corroboration:

- Client who was allegedly asked to sweep the house
- Other clients who heard about the incident at the time
- House roster and address for the Phase 3 property
- Staff schedules showing Douglas Roberto assigned to the house
- Police report / 911 call / incident report concerning an intruder or suspicious person in a ski mask
- Internal Turnbridge communications about the incident
- HR / termination records showing whether Douglas Roberto was fired and when
- Contemporaneous texts, group chats, or client disclosures about the alleged intruder incident

Archive classification: Secondhand allegation heard from multiple people; serious safety / staff-judgment lead requiring corroboration.

7. Steve Tobey sexual-boundary / inappropriate self-disclosure concern involving

C.R. Approx. date: February 2022

Program/location: Phase I; Structured Group / Carriage House context [exact property / group location to confirm]

Staff involved: Steve Tobey, Phase I case manager

Clients involved: C.R.; myself

Type: Secondhand allegation; sexual-boundary concern; inappropriate staff self-disclosure; inappropriate sexualized pressure

toward client In February 2022, client C.R. told me that Phase I case manager Steve Tobey had told the Structured

Group / Carriage House group that his marriage had recently fallen apart because of his sex addiction and cheating.

C.R. further relayed to me that Tobey was frustrated that C.R. was masturbating and verbally pressured him to stop

masturbating, after identifying C.R. as "another sex addict." I did not personally witness the group disclosure or the

private interaction between Tobey and C.R. This item is included because it was relayed to me by C.R. and because, if

accurate, it would raise staff-boundary concerns involving sexualized self-disclosure, staff projection onto a client, and

inappropriate pressure around a client's sexual behavior in a treatment setting.

Potential corroboration:

- C.R.'s direct account
- Other Structured Group / Carriage House clients present for Tobey's alleged self-disclosure
- Phase I group schedules from February 2022
- Case-management records involving Tobey and C.R.
- Contemporaneous texts, journal entries, client conversations, therapist disclosures, or family disclosures

- Turnbridge employment / staff records confirming Tobey's Phase I case-manager role during that period

Archive classification: Secondhand allegation involving staff sexual-boundary / self-disclosure concerns; requires corroboration.

8. Allegation involving adolescent-program client J. and Matt Fields / Matthew

Fields, LMFT during walk near 189 Orange Approx. date: Late 2021 / early 2022

Program/location: Turnbridge clinical building at 189 Orange / surrounding area

Staff involved: Matt Fields / Matthew Fields, LMFT

Client involved: J., former adolescent-program client [identity to distinguish from other J. entries if needed]

Type: Secondhand allegation; therapist boundary concern; adolescent-program concern; cruelty / humiliation; inappropriate

joke involving client safety; alleged request not to disclose In late 2021 or early 2022, J., an old adolescent-program

client, told me about an incident involving therapist Matt Fields / Matthew Fields, LMFT, whom J. described as a bald

therapist and recovered Xanax addict. According to J., Matt Fields took him for a walk around the clinical building at 189

Orange. During that walk, Matt Fields allegedly saw a homeless man and joked that he should sell J. to the homeless

man, and that he could buy a lot of crack with the money.

J. further said that Matt Fields panicked after making the comment and pleaded

with J. not to disclose it to anyone. I did not personally witness the walk or the alleged comment. This item is included

because it was relayed to me by J., because it involved an adolescent-program client, and because, if accurate, it would

raise concerns about therapist judgment, cruelty / humiliation, client safety, professional boundaries,

and alleged
discouragement of reporting.

Potential corroboration:

- J.'s direct account
- Other adolescent-program clients who may have heard J. describe the incident
- Employment records confirming Matt Fields / Matthew Fields, LMFT's adolescent-program role, dates, and assignment to 189 Orange
- Staff schedules showing Matt Fields assigned to 189 Orange during late 2021 / early 2022
- Clinical-building records or appointment schedules involving J. and Matt Fields
- Contemporaneous texts, journal entries, therapist disclosures, family disclosures, or client conversations
- Records showing walks or off-building movement around 189 Orange
- Prior complaints or reports involving Matt Fields' conduct with adolescent clients

Archive classification: Secondhand allegation from former adolescent-program client J. involving therapist-boundary / cruelty
concern and alleged request not to disclose.

D. Client Culture / Identity-Based Hostility / Peer Humiliation / Staff-Modeled

Humiliation Concerns

Approx. date range: Late 2021-2024

Program/location: Phase I, Phase II, 520 Whitney Avenue, 90 Ford Street, 1212 Quinncipiac Avenue, 189 Orange Street clinical building, adolescent-program context, and broader Turnbridge / Turning Point client culture

Type: Client culture; identity-based harassment; sexual shaming; anti-gay slurs; racialized harassment; peer

violence; peer humiliation; cyberbullying; staff-witnessed hostility; staff-modeled contempt; trauma-disclosure dismissal; clinical-response concern

I. Core Issue

This section does not argue that Turnbridge / Turning Point created every harmful statement or action made by a client.

Residential treatment programs cannot control every word spoken by every client. The institutional question is

different: What did Turnbridge know, witness, tolerate, document, interrupt, ignore, model, or clinically process when

clients and staff humiliated, shamed, slurred, mocked, threatened, or assaulted vulnerable clients? A residential

treatment program controls housing, supervision, group structure, clinical framing, staff response, documentation,

separation decisions, and family communication. If a hostile client culture is allowed to become ordinary, then

identity-based humiliation and peer violence become part of the treatment environment. The question is not only

whether individual clients behaved badly. The question is whether Turnbridge adequately protected vulnerable clients

from a culture of sexual shame, anti-gay hostility, racialized humiliation, retaliation, group-chat mockery, staff

contempt, and peer violence.

II. Summary of Accounts Preserved

The accounts preserved here include:

- a 2021 secondhand / client-culture legal-proceeding lead involving a client known as "Scarface Adam," whom multiple

clients reportedly understood to be facing legal proceedings related to the alleged rape of female Turnbridge client T.K.;

- an early-2023 L.M. pants-pulling / forced-exposure allegation at a Turnbridge house near 189 Orange / Fair Haven, in which

I allege L.M. pulled down my pants and underwear and exposed my bare penis to B.H., A., and another client after the earlier 1212 Quinipiac disclosure;

- an early-2023 Dave Murphy sexual-rumor / pronoun-interrogation concern after untrue rumors involving me and L.M., in which Murphy allegedly discussed his discomfort with the rumors, said sexuality between clients was not allowed, and asked whether my use of they/them pronouns was a "plea for attention";

- a firsthand-corroborated J.E. / D.A. sexual-privacy incident lead from early 2022 at a Turnbridge house near Foxon Boulevard / Hobby

Lobby, involving alleged nonconsensual recording and distribution of an intimate video, direct former-client disclosure, my firsthand

memory of seeing the video circulating, and questions about Douglas Roberto, staff knowledge, internal handling, police involvement, and documentation;

- a client sexually shaming me in early 2023 over a false claim involving L.M., saying I "sucked L.M.'s dick," with same-sex

sexual

contact as the focal point of ridicule, allegedly witnessed by clinical staff including Chris Rush;

- H.V. allegedly calling adolescent client J. an anti-gay slur after J. accused H.V. of beating women in late 2021;

- K.G. recounting in 2024 that he and W.H. had beaten and kicked an adolescent client while the client was on the ground

at an

adolescent house;

- D.W. allegedly calling Q.R. an anti-gay slur after disagreements during C.M.'s group at 520 Whitney Avenue around

December

2021;

- L.B. allegedly calling D.W. a racial slur and throwing fried chicken at him, leading to a fistfight, in late 2021;

- an unattributed / deleted Reddit comment defending old Turnbridge / Ford Street staff culture, praising "Chris,"

attacking critics,

and using anti-"woke" / anti-client framing;

- a staff member allegedly telling me around 2023 that a trans woman placed in the men's young-adult program around

early 2021

had been "emotionally terrorized" while attending;

- Q.R. allegedly creating a group chat using D.W.'s mugshot and arrest article, which was widely shared and mocked

around

December 2021;

- a relayed allegation from early 2023 that a client who had "snitched" was "knocked out" by another client on the first

floor of the

clinical building at 189 Orange Street;

- client T.J. alleging to me in late 2021 that shortly before September 2021, David Vieau arrived at Phase 1 and began

verbally

berating Phase 1 program director John Stewart, calling him a "fucking idiot" in front of clients and staff;

- a late-2021 incident at 90 Ford Street in which, after I recounted a traumatic story involving selling crack in Harlem's

Central

Park North area as a teenager, a staff member laughed dismissively, said it never happened / that I was

making it up,
and exited the conversation in front of J.B. Together, these accounts suggest a broader culture concern:
Turnbridge
clients could be targeted through sexuality, race, gender identity, criminal-record humiliation,
"snitching" accusations,
traumatic-history disbelief, and physical intimidation, while staff behavior could model contempt,
dismissal,
humiliation, or verbal degradation.

III. Specific Accounts

1. Sexual shaming involving false claim about L.M.; witnessed by clinical staff and

clients

Approx. date: Early 2023 Location/program: Turnbridge / Turning Point clinical or program setting; exact location to confirm

People involved: D.; L.M.; myself; Chris Rush; other clinical staff and clients present

Type: Sexual shaming; false sexual claim; same-sex sexual stigma; staff-witnessed peer humiliation

In early 2023, a client, D., told me in a condemnatory and mocking manner that it was shameful that I had "sucked

L.M.'s dick." I had never engaged in sexual relations with L.M. My recollection is that same-sex sexual contact was the

focal point of the ridicule. D. laughed while making the comment. My memory is that clinical staff present, including

Chris Rush, and other clients witnessed this. This belongs in the client-culture record because it raises questions about

sexual shaming, false sexual allegations, anti-gay stigma, peer humiliation, and staff response. If clinical staff were

present, the issue becomes whether the comment was interrupted, documented, clinically processed, or ignored.

Potential corroboration:

- Chris Rush's account
- Other clinical staff present
- Other clients present
- Group schedule / clinical schedule for early 2023
- Any clinical notes or incident notes
- Any contemporaneous disclosures to therapist, family, or peers

Classification: Firsthand experience of sexual shaming / false sexual claim; staff-witnessed response concern.

2. H.V. allegedly called adolescent client J. an anti-gay slur after J. accused him of

beating

women Approx. date: Late 2021

People involved: H.V.; J.; other witnesses to confirm

Type: Anti-gay slur; peer hostility; adolescent-program concern; violence-accusation context

In late 2021, I remember H.V. calling adolescent client J. an anti-gay slur after J. accused H.V. of beating women. This

belongs in the client-culture record because it reflects anti-gay language in a hostile peer conflict, involving an

adolescent client and an allegation of violence against women.

Potential corroboration:

- J.'s account
- H.V.'s account

- Other clients present
- Staff present, if any
- House logs or incident notes
- Contemporaneous messages or disclosures

Classification: Remembered client-culture concern; exact setting and witnesses to confirm.

3. K.G. recounted beating an adolescent client with W.H. at an adolescent house

Approx. date recounted: 2024 Underlying incident date: To confirm

Location: Adolescent house; exact house to confirm

People involved: K.G.; W.H.; adolescent client; other witnesses to confirm

Type: Relayed client-on-client violence; adolescent-program safety; peer assault; supervision concern

In 2024, K.G. recounted a story of "beating the shit out of" and kicking an adolescent client while the client was on the ground, allegedly with W.H., at an adolescent house. This is preserved as a serious relayed allegation. If accurate, it raises questions about adolescent-program supervision, staff awareness, peer violence, injury documentation, separation, discipline, incident reporting, and whether the assaulted adolescent client was protected.

Potential corroboration:

- K.G.'s account
- W.H.'s account
- The adolescent client's account, if legally and ethically obtainable
- Other adolescent clients present
- Adolescent house rosters
- Staff schedules
- Incident reports / house logs
- Medical records or injury documentation, if any
- Contemporaneous texts or disclosures

Classification: Relayed allegation / adolescent-program violence lead requiring corroboration.

4. D.W. allegedly called Q.R. an anti-gay slur during or after C.M.'s group at 520

Whitney

Avenue Approx. date: Approximately December 2021

Location: 520 Whitney Avenue

People involved: D.W.; Q.R.; C.M.; other group participants

Type: Anti-gay slur; group-setting hostility; peer conflict; staff-supervision concern

In approximately December 2021, client D.W. called client Q.R. an anti-gay slur after they had disagreements during C.M.'s group at 520 Whitney Avenue. This belongs in the client-culture record because the alleged slur occurred in a group or group-adjacent setting. If staff were present or became aware, the issue is whether anti-gay hostility was interrupted, documented, or clinically addressed.

Potential corroboration:

- Q.R.'s account
- D.W.'s account
- C.M.'s account
- Other clients present in the group
- Group schedule / 520 Whitney Avenue records
- Clinical notes, incident reports, or staff notes

Classification: Client-culture / group-setting hostility concern; witnesses and staff response to confirm.

5. L.B. allegedly used a racial slur toward D.W. and threw fried chicken at him,

leading to a

fistfight Approx. date: Late 2021

People involved: L.B.; D.W.; other clients who related the incident

Type: Racialized harassment; peer violence; client-on-client fight; supervision concern

In late 2021, I heard that client L.B. called client D.W. a racial slur and threw fried chicken at D.W., leading to a fistfight.

It was related by other clients that L.B. had no previous issues with D.W. before the incident. This is preserved because

it raises questions about racialized provocation, peer violence, supervision, staff response, and whether Turnbridge

documented or addressed racist conduct and the resulting fight.

Potential corroboration:

- D.W.'s account
- L.B.'s account
- Clients who witnessed or heard about the incident
- Staff present or responding
- House logs
- Incident reports
- Medical records, if any
- Disciplinary or separation records

Classification:elayed racialized-harassment / peer-violence allegation requiring corroboration.

6. Deleted Reddit comment defending old Turnbridge staff culture and disparaging

clients

Approx. date: Public Reddit thread date to preserve

Platform: Reddit / r/troubledteens

People referenced: "Chris" / Chris Meyer context; authorship unverified

Type: Public-comment lead; staff-culture discourse; anti-client rhetoric; anti-"woke" framing

A deleted Reddit commenter in r/troubledteens defended older Turnbridge / Ford Street staff culture, disparaged clients

criticizing Turnbridge, used anti-"woke" language, and singled out "a guy named Chris" as "by far the best SS and

employee," adding that clients got him in trouble. I suspect the commenter may have been Chris Meyer, given the

tone, the unusually personal defense of "Chris," the surrounding Chris Meyer discussion, and my own prior experiences

with Meyer. However, authorship is unverified. This should be treated only as an unattributed public Reddit lead

relevant to Turnbridge staff culture and the Chris Meyer discussion cluster. It should not be presented as proof of

authorship or proof that Chris Meyer made the comment unless additional evidence is located. The significance for this

section is that the comment reflects a broader anti-client framing: critics are cast as weak, soft, "woke," or deserving of

harsh treatment, while older support-staff culture is defended as more "real." That rhetoric matters because it mirrors

the question at the center of this section: whether client humiliation and aggression were treated as part of the culture

rather than as clinical safety issues.

Potential corroboration:

- Reddit thread screenshot
- Wayback or archive capture
- Anyone who saw the username before deletion
- Account metadata, if obtainable
- Other Reddit discussion around Chris Meyer and Turnbridge staff culture

Classification: Public Reddit lead; authorship unverified.

7. Staff member allegedly said a trans woman placed in the men's young-adult

program was

"emotionally terrorized" Approx. date heard: Circa 2023 Underlying placement date: Circa early 2021

People involved: Trans woman client; staff member to identify; other clients to confirm

Type: Gender-identity safety concern; placement concern; peer culture; staff-relayed concern

Circa 2023, I heard from a staff member that a trans woman who had been placed in the men's young-adult program

around early 2021 was "emotionally terrorized" while attending. This is a serious gender-identity safety and placement

concern. If accurate, it raises questions about whether Turnbridge safely placed transgender clients, whether peer

harassment was anticipated or addressed, whether staff documented identity-based harm, and whether the client was

protected from an unsafe environment. The issue is not only whether individual peers behaved abusively.

The

institutional question is whether a gendered young-adult program placed a transgender client into a setting where

predictable harassment could occur, and then failed to adequately protect her.

Potential corroboration:

- The staff member's account
- The trans woman client's account, if legally and ethically obtainable
- Program placement records
- Clinical notes
- Incident reports
- Staff communications
- Other clients present during the relevant period
- Policies on transgender client placement and safety

Classification: Staff-relayed gender-identity safety concern requiring corroboration.

8. Q.R. allegedly made and circulated a group chat using D.W.'s mugshot / arrest

article

Approx. date: Approximately December 2021

People involved: Q.R.; D.W.; clients who received or saw the group chat

Type: Peer humiliation; criminal-record mockery; cyberbullying / group-chat harassment; client privacy; staff-response concern

In approximately December 2021, Q.R. allegedly made a group chat using D.W.'s mugshot and arrest article.

My

recollection is that this was widely shared around and mocked.

This belongs in the client-culture record because it raises questions about peer humiliation, cyberbullying, mocking of

arrest history, client privacy, and whether Turnbridge staff monitored or intervened when clients used another client's

public-record material for group humiliation. In a treatment setting, clients often arrive with criminal records, addiction

histories, psychiatric histories, family crises, sexual histories, and public humiliations already attached to them. A

program that allows those vulnerabilities to become peer entertainment is not merely failing socially; it is failing

clinically.

Potential corroboration:

- Screenshots of the group chat, if preserved
- D.W.'s account
- Q.R.'s account
- Other clients who received or saw the group chat
- Staff who became aware of it

- Incident reports, clinical notes, or group discussions addressing it
- Contemporaneous messages or disclosures

Classification: Client-culture / cyber-humiliation concern requiring corroboration.

9. Allegation that a client who "snitched" was knocked out on the first floor of 189

Orange

Street Approx. date heard: Early 2023 Underlying incident date: To confirm

Location: First floor of 189 Orange Street clinical building

People involved: Client who allegedly "snitched"; client who allegedly knocked him out; witnesses to confirm

Type: Retaliatory peer violence; "snitching" culture; clinical-building safety; supervision concern; incident-reporting concern

In early 2023, I heard that a client who had "snitched" was "knocked out" by another client on the first floor of the

clinical building at 189 Orange Street. I did not personally witness this incident. It is preserved as a relayed allegation

because, if accurate, it raises serious questions about retaliation culture, client-on-client violence, supervision inside

the clinical building, incident documentation, and whether clients were protected from violence after reporting or

disclosing information. This allegation is especially important because treatment programs depend on disclosure. If

clients believe that "snitching" can lead to violence, then the reporting system collapses. Clients will not safely disclose

threats, abuse, contraband, sexual harm, staff misconduct, or peer violence if the culture punishes disclosure.

Potential corroboration:

- Identity and account of the client allegedly knocked out
- Identity and account of the client who allegedly assaulted him
- Witnesses who saw or heard about the incident
- 189 Orange Street staff present that day
- CCTV footage, if available
- Incident reports
- Clinical notes
- Medical records or injury documentation
- Staff communications concerning retaliation, "snitching," or peer violence
- Contemporaneous texts, messages, or client disclosures

Classification: Relayed allegation of retaliatory peer violence / clinical-building safety concern requiring corroboration.

10. T.J. allegation that David Vieau verbally berated Phase 1 program director John

Stewart in

front of clients and staff Approx. date heard: Late 2021 Underlying incident date: Shortly before September 2021, according to T.J.

Program/location: Phase 1

People involved: T.J.; David Vieau; John Stewart; clients and staff present

Type: Staff-modeled contempt; staff-on-staff verbal degradation; leadership culture; client-facing staff conflict; supervision

concern In late 2021, client T.J. alleged to me that shortly before September 2021, David Vieau arrived at Phase 1 and

began verbally berating Phase 1 program director John Stewart in front of clients and staff. According to T.J., Vieau

called John Stewart a "fucking idiot" in front of clients and staff. I did not personally witness this incident. It is preserved

as T.J.'s allegation. If accurate, it raises questions about staff-modeled contempt, leadership culture, staff-on-staff degradation, and what clients were taught by the behavior of authority figures. In a treatment setting, staff conflict performed in front of clients can shape the whole peer culture. If senior or authority figures model humiliation, clients learn that humiliation is part of how power works. This item also matters because John Stewart appears elsewhere in the archive in connection with a separate firsthand allegation involving client money. The David Vieau / John Stewart allegation should not be used to prove that separate allegation. It is included for the narrower client-culture and staff-culture question: whether clients witnessed staff degrading staff in a way that normalized contempt.

Potential corroboration:

- T.J.'s direct account
- John Stewart's account
- David Vieau's account
- Clients present during the alleged incident
- Staff present during the alleged incident
- Phase 1 staff schedules from the period shortly before September 2021
- House logs, shift notes, or internal communications concerning the alleged staff conflict
- Any contemporaneous texts, client discussions, or disclosures about the incident

Classification: Relayed allegation from T.J.; staff-modeled contempt / leadership-culture concern requiring corroboration.

11. Staff member allegedly laughed at and dismissed traumatic Harlem / Central Park

North

crack-selling story at 90 Ford Street Approx. date: Late 2021

Program/location: 90 Ford Street

People involved: Unidentified staff member; myself; J.B. present

Type: Staff dismissal of trauma disclosure; humiliation; disbelief; staff contempt; clinical-safety concern

In late 2021, at 90 Ford Street, I recounted a traumatic story involving selling crack as a teenager in Harlem's Central

Park North area. After I recounted the story, a staff member laughed dismissively, said words to the effect that this

never happened and that I was making it up, and then exited the conversation. This was said in front of J.B. This is

included because clients in treatment are often disclosing humiliating, frightening, legally risky, traumatic, or

shame-laden material. When a staff member laughs at a trauma disclosure and says the client is making it up, the

harm is not only interpersonal. It teaches clients that disclosure is unsafe, that their histories will be mocked, and that

staff can humiliate them without consequence. This also belongs in the broader client-culture record because staff

behavior models what counts as acceptable. If staff dismiss trauma disclosures as fake or ridiculous, clients may learn

to do the same to each other.

Potential corroboration:

- J.B.'s account
- Identity of the staff member
- Other clients or staff present at 90 Ford Street
- Contemporaneous disclosures to therapist, family, or peers

- Any clinical notes or staff notes from the relevant period
- 90 Ford Street house schedule or staff assignments from late 2021
- Pattern accounts from other clients whose disclosures were mocked or dismissed

Classification: Firsthand staff-dismissal / trauma-disclosure humiliation concern at 90 Ford Street; witness

J.B. present.

IV. Pattern Analysis

1. Anti-gay hostility and sexual shaming

Several accounts involve anti-gay slurs, same-sex sexual shaming, or ridicule based on perceived same-sex sexual

conduct. The early-2023 D. / L.M. comment is particularly significant because it allegedly occurred in front of clinical

staff, including Chris Rush. It was not merely a private insult between peers. If clinical staff witnessed it, the issue

becomes whether staff intervened or allowed the humiliation to stand.

The H.V. / J. incident and D.W. / Q.R. incident also suggest anti-gay slurs were part of client conflict.

This matters

because Turnbridge treated young men, adolescents, queer clients, sexually vulnerable clients, and clients with shame

histories. Anti-gay hostility in that setting is not harmless banter. It can intensify fear, silence disclosure, and turn

sexual vulnerability into peer ammunition.

Updated sexual-boundary / sexual-safety pattern note:

The sexual-boundary record now includes multiple layers of concern across 2021, 2022, and 2023: the 2021 secondhand / client-culture legal-proceeding lead involving a client known as "Scarface Adam," whom multiple clients reportedly understood to be facing legal proceedings related to the alleged rape of female Turnbridge client T.K.; the late-2022 L.M. / 1212 Quinipiac incident in which I allege L.M. got on top of me, grabbed my penis, and refused to get off, followed by Mark David Grasso / Mark Grasso allegedly overhearing my disclosure without meaningful protective action; the early-2023 L.M. pants-pulling / forced-exposure incident at the house near 189 Orange / Fair Haven, in which I allege L.M. pulled down my pants and underwear, exposing my bare penis to B.H., A., and another client; and the early-2023 Dave Murphy sexual-rumor / pronoun-interrogation incident, in which Murphy allegedly called me into his office after hearing untrue sexual rumors about me and L.M., described discomfort with the rumors, said sexuality between clients was not allowed, and then questioned whether my use of they/them pronouns was a "plea for attention."

These items should not be collapsed into one proven finding. Some are firsthand allegations, some are direct former-client disclosures, some are relayed allegations, and some are public-review allegations. But together they create a serious due-diligence question: whether Turnbridge maintained adequate systems for preventing, documenting, reporting, separating, and clinically responding to sexual-assault allegations, sexual-boundary violations, forced exposure, nonconsensual intimate-image distribution, outing threats, sexual shaming, queer-coded sexual rumors, and gender-identity-related staff questioning.

2. Racialized humiliation and peer violence

The L.B. / D.W. allegation involves a racial slur, fried chicken being thrown, and a resulting fistfight.

If accurate, that is

not ordinary peer conflict. It is racialized humiliation escalating into violence. The fact that other clients allegedly

related that L.B. had no previous issues with D.W. matters because it suggests the incident may not have been a

long-running personal dispute, but a targeted or opportunistic racialized provocation. A treatment program should have

clear procedures for documenting racist conduct, separating clients after racialized violence, and clinically addressing

the harm.

Supplement to Updated Sexual-Boundary / Sexual-Safety Pattern Note

- E.A.

The sexual-safety record now also includes E.A.'s preliminary direct former-client testimony that, during her final months in the women's residential program and while she was sixteen, a male staff member sent her explicit photographs and, in her words, "practically groomed" her. E.A. further states that she had warned her case manager and parents about other clients' testimony before similar conduct happened to her, and that male clients alleged the staff member was actively getting high. She expects that historical Instagram messages may still exist but has not yet supplied them.

This account must remain distinct from other sexual-safety entries. It is a preliminary direct source allegation involving alleged staff-to-minor grooming and electronic communications; the staff-drug-use component is presently relayed information; and the anticipated Instagram records remain an unresolved preservation lead. It should not be treated as a proven institutional finding or merged with client-on-client incidents.

Additional institutional questions generated:

- What controls governed staff electronic and social-media contact with minor clients?
- What monitoring, supervision, reporting, and evidence-preservation systems existed for alleged staff grooming or explicit communications?
- Did Turnbridge receive prior complaints, warnings, or concerns about the same staff member?
- What happened when E.A. warned her case manager about other clients' accounts?
- Were parents, guardians, DCF, DPH, police, or other authorities notified?
- Did Turnbridge investigate allegations that the staff member was impaired or using substances while employed?
- Were E.A. and other potentially affected clients offered protection, independent support, or a non-retaliatory reporting route?

Pattern-use rule. E.A.'s testimony strengthens the need for a records-based review of Turnbridge's systems for preventing, identifying, reporting, investigating, and responding to alleged sexual misconduct involving minors and staff. It does not independently prove the truth of other accounts, and other accounts do not independently prove E.A.'s allegation.

Turnbridge / Turning Point Due-Diligence Memo

INTEGRATED PATTERN SUPPLEMENT - A. - July 28, 2026

Placement. Insert after the existing E.A. supplement to the sexual-boundary / sexual-safety pattern note. This supplement integrates A.'s testimony without collapsing it into other accounts.

Supplement to sexual-boundary / sexual-safety pattern note - A.

The sexual-safety record now includes A.'s detailed former-client testimony concerning multiple distinct categories: a senior program director allegedly screaming a graphic sexual question at a seventeen-year-old client; an alleged sexual relationship between Tom Marzilli and a recently graduated former client who became support staff; an alleged resulting restriction barring Marzilli from the women's house; coercive sexual pathologization of A. through a "sex contract" and forced referral; institutional predator labeling; and a separate allegation that a twenty-six-year-old former client turned employee became sexually involved with a sixteen-year-old client, followed by DCF interviews and the minor allegedly running away with the employee.

These allegations are not interchangeable. The Marzilli allegation concerns senior leadership, a former client / employee boundary, and an alleged housing-access restriction. The sixteen-year-old allegation concerns an employee-minor relationship and reported DCF involvement. The "sex contract" concerns pathologization and differential treatment of consensual client sexuality. Each requires a separate incident, witness, HR, clinical, and mandated-reporting record trail.

Supplement to confidentiality / privacy / rumor-spreading pattern

A. alleges that Turnbridge personnel stated that housing lacked HIPAA privacy protections, searched and seized her phone, spread personal information, labeled her a predator, warned current clients about her after graduation, and contacted friends' and family members with a false narrative. Her account overlaps other archive material involving staff gossip, intimate information circulating across houses, phone searches, staff discussion of personal photographs, and public-review allegations of confidentiality breach.

The supplied text screenshots materially strengthen the narrower post-discharge-contact component: Turnbridge-affiliated responders acknowledged that staff checked whether a missing client was with A. and also acknowledged that A. had not been engaging with clients for a long time. The texts do not prove every alleged rumor or surveillance claim, but they show that former-client monitoring and outreach continued after graduation.

Supplement to admissions / program-length pattern

A.'s early-2017 account adds another direct source who says she was told she could leave after approximately one month and then learned after arrival that the program was understood to last approximately a year. This account predates the memorandum author's 2021 Joseph Moura account and the later public and direct-source reports, supporting investigation of a longstanding admissions practice rather than a single misunderstanding.

Supplement to retaliation / scapegoating / post-discharge interference pattern

A. describes a progression from being celebrated at graduation as a miracle story to being treated after discharge as a standing suspect whenever clients left, ran away, or became involved in community conflict. She alleges that this stigma affected her employment, family relationships, local recovery access, and sobriety. The key institutional question is whether Turnbridge maintained informal blacklists, danger labels, former-client watch practices, or cross-family warning networks without a fair process for correction.

Supplement to staff-vetting and leadership-accountability pattern

A.'s testimony and attachments materially expand the Thomas Marzilli staff-vetting record. The earlier entry correctly noted the 2016 voluntary surrender, but the supplied Colorado order identifies formal Board allegations under subsections including professional-standard, mandatory-disclosure, and sexual-contact provisions. A. also supplies a direct program account involving graphic sexual questioning of a minor, an alleged relationship with a recently graduated client / employee, and an alleged restriction from the women's house. The memorandum author independently recalls hearing of the restriction while at Turnbridge. These materials do not prove the alleged relationship, but they create a high-priority question: what did Turnbridge know about Marzilli's licensing history and internal boundary concerns before or while elevating him into senior residential leadership?

3. Criminal-record humiliation and public shaming

The Q.R. / D.W. group-chat allegation belongs in the archive because clients in treatment are uniquely vulnerable to public-record humiliation. Mugshots and arrest articles can be used to socially degrade someone, especially in a closed residential environment. If a client's mugshot or arrest article was widely shared and mocked, the issue is not only peer cruelty. It is whether Turnbridge recognized the humiliation as a clinical and safety problem.

4. Gender-identity placement and trans-client safety

The staff-relayed account that a trans woman placed in the men's young-adult program was "emotionally terrorized" raises one of the clearest institutional questions in this section. A program placing a transgender woman in a men's young-adult treatment environment should anticipate identity-based risk. If the client was emotionally terrorized, the due-diligence questions are:

- Who approved the placement?
- What safety plan existed?
- What did staff know?
- Were incidents documented?
- Was the client moved, protected, or ignored?
- Did Turnbridge have a trans-client placement policy?

This issue connects directly to public review concerns about Turnbridge's suitability for LGBTQ, trans, non-binary, and BIPOC clients.

5. Adolescent-program violence

The K.G. / W.H. account involving an adolescent client being beaten and kicked while on the ground raises adolescent-program safety questions. Adolescent clients require heightened protection. If older, stronger, or more socially dominant peers were able to assault an adolescent client, the issue is supervision, staffing, incident reporting, and protection afterward. This account is relayed and requires corroboration, but its seriousness justifies preservation.

6. Retaliation and "snitching" culture

The 189 Orange allegation - that a client who "snitched" was knocked out - raises a critical safety issue. Treatment programs rely on reporting. Clients are supposed to disclose threats, contraband, assaults, sexual misconduct, relapse risk, self-harm risk, staff misconduct, and peer intimidation. If a client culture punishes "snitching" with violence, then the program's safety infrastructure is compromised. The location matters too: the alleged incident occurred on the first floor of the clinical building at 189 Orange Street, not in an unsupervised offsite location. If accurate, that raises questions about supervision inside the clinical building itself.

7. Anti-client rhetoric and old support-staff culture

The deleted Reddit comment defending older Turnbridge / Ford Street staff culture and praising "Chris" is not proof of authorship. But it is relevant as a cultural artifact. It frames critical clients as weak, "woke," soft, or destined to be "bums." It praises old support-staff culture as more real or effective. It implies that clients got "Chris" in trouble. That

rhetoric is relevant because it suggests a worldview in which harshness, humiliation, and anti-client contempt could be rationalized as toughness or maturity. That worldview overlaps with many of the concerns in this section.

8. Staff-modeled humiliation and institutional contempt

The David Vieau / John Stewart allegation and the staff member's dismissal of the Harlem / Central Park North trauma disclosure at 90 Ford Street both show why client culture cannot be separated from staff culture. If staff or leadership figures degrade each other in front of clients, clients learn that contempt is a legitimate form of authority. If staff laugh at traumatic disclosures and accuse clients of making them up, clients learn that vulnerability is unsafe and that humiliation is institutionally permitted. This matters because a hostile client culture does not develop in isolation. It is shaped by what staff model, what staff ignore, and what staff reward.

9. Trauma-disclosure safety

The late-2021 Harlem / Central Park North incident at 90 Ford Street raises a specific clinical question: what happens when a client discloses trauma involving crime, survival behavior, shame, or violence? A treatment environment should be able to receive complex disclosures without reflexive mockery. Staff do not have to accept every recollection uncritically as a verified legal fact. But laughing, calling it fake, and leaving the conversation is not clinical skepticism. It is humiliation. That kind of response can make clients less likely to disclose sexual harm, criminal exploitation, drug-world violence, family abuse, self-harm risk, or staff misconduct.

V. Why This Matters Clinically

The client-culture and staff-modeled-culture material matters because Turnbridge was not an ordinary apartment building, dorm, or peer hangout. It was a treatment environment. Clients were there because they were vulnerable, dependent, and often unable to freely leave without family, clinical, financial, or program consequences. In that context, peer culture and staff behavior become part of the treatment environment. A harmful culture can:

- silence clients from reporting;
- intensify sexual shame;
- punish disclosure;
- make LGBTQ clients unsafe;
- make transgender clients unsafe;
- expose BIPOC clients to racialized humiliation;
- turn criminal records into weapons;
- normalize violence;
- allow stronger clients to dominate weaker clients;
- make clinical groups unsafe;
- teach clients that humiliation is part of recovery;
- let staff dismiss cruelty as ordinary peer conflict;
- teach clients that trauma disclosures will be mocked;
- teach clients that staff contempt is part of institutional authority.

If Turnbridge staff witnessed or knew about these dynamics and failed to intervene, then the issue becomes institutional.

VI. Due-Diligence Questions

Turnbridge should be able to answer the following:

- 1. How did Turnbridge document anti-gay slurs, racial slurs, sexual shaming, identity-based harassment, staff humiliation, and retaliatory violence?**
- 2. What happened when clinical staff witnessed or learned of sexual humiliation or false sexual allegations?**
- 3. What policies protected LGBTQ clients, transgender clients, BIPOC clients, adolescent clients, and clients with publicly available arrest histories?**
- 4. Were clients disciplined, separated, or clinically addressed after identity-based harassment, peer humiliation, or retaliatory violence?**
- 5. Were families informed when clients were targeted by slurs, harassment, humiliation, or violence?**
- 6. Did Turnbridge treat group-chat harassment and mugshot / arrest-article sharing as safety issues?**
- 7. What safeguards existed when transgender clients were placed in gendered young-adult housing?**
- 8. Were adolescent clients protected from stronger peers who allegedly assaulted or humiliated them?**
- 9. Were clients protected from retaliation after being perceived as having "snitched"?**
- 10. What supervision and incident-reporting procedures existed on the first floor of 189 Orange Street?**
- 11. What clinical response was required when identity-based humiliation occurred in group settings?**
- 12. Were staff trained to interrupt anti-gay, racist, transphobic, or sexually shaming peer behavior?**
- 13. Were clients ever removed, separated, or given safety plans after identity-based incidents?**
- 14. Did Turnbridge track patterns of peer harassment by specific clients?**
- 15. Were staff trained to receive traumatic disclosures without mocking, dismissing, or humiliating clients?**
- 16. What staff-conduct standards governed staff speaking to or about each other in front of clients?**

17. Were staff ever disciplined for degrading other staff in front of clients?

18. Were staff ever disciplined for laughing at or dismissing client trauma disclosures?

19. Were any of these incidents documented in clinical notes, incident reports, house logs, HR records, or family communications?

VII. Evidence and Records To Preserve / Request

Witnesses and accounts

- Chris Rush's account of the early-2023 D. / L.M. sexual-shaming incident
- Other clinical staff present during the early-2023 D. / L.M. incident
- Other clients present during the early-2023 D. / L.M. incident
- D.'s account of the early-2023 D. / L.M. comment
- H.V.'s account of the late-2021 H.V. / J. incident
- J.'s account of being called an anti-gay slur after accusing H.V. of beating women
- Witnesses to the H.V. / J. incident
- K.G.'s account of the alleged adolescent-house beating
- W.H.'s account of the alleged adolescent-house beating
- The adolescent client's account, if legally and ethically obtainable
- D.W.'s account of calling Q.R. an anti-gay slur
- Q.R.'s account of the December 2021 520 Whitney group conflict
- C.M.'s account and group records from the 520 Whitney Avenue group
- D.W.'s account of the racial-slur / fried-chicken incident involving L.B.
- L.B.'s account of the racial-slur / fried-chicken incident
- Witnesses to the L.B. / D.W. fistfight
- Staff member's account concerning the trans woman allegedly "emotionally terrorized" in the men's young-

adult

program

- The trans woman client's account, if legally and ethically obtainable
- D.W.'s account of the mugshot / arrest-article group chat
- Q.R.'s account of the mugshot / arrest-article group chat
- Other clients who received, saw, or mocked the group chat
- Identity and account of the client allegedly knocked out at 189 Orange after being labeled a "snitch"
- Identity and account of the client who allegedly knocked him out
- Witnesses to the alleged 189 Orange first-floor incident
- T.J.'s direct account of the David Vieau / John Stewart incident
- John Stewart's account of the David Vieau incident
- David Vieau's account of the alleged Phase 1 verbal berating incident
- Clients present for the alleged David Vieau / John Stewart incident
- Staff present for the alleged David Vieau / John Stewart incident
- J.B.'s account of the staff member allegedly laughing at and dismissing my Harlem / Central Park North

trauma

disclosure at 90

Ford Street

- Identity and account of the staff member who allegedly dismissed the Harlem / Central Park North

disclosure at 90 Ford

Street

- Other clients or staff present during the Harlem / Central Park North disclosure incident at 90 Ford Street

Program records

- Clinical/group schedule for the early-2023 D. / L.M. incident
- Any clinical notes or incident notes concerning the false L.M. sexual allegation / sexual shaming
- House logs or incident notes concerning the H.V. / J. incident
- Adolescent house rosters, staff schedules, incident reports, and medical records connected to the K.G. /

W.H. allegation

- 520 Whitney Avenue group schedules and participant records around December 2021
- C.M.'s group records, staff notes, or participant records from 520 Whitney Avenue

- House logs, incident reports, or staff notes concerning the L.B. / D.W. fight
- Placement records concerning the trans woman placed in the men's young-adult program circa early 2021
- Any clinical notes, incident reports, or staff communications concerning gender-identity harassment or emotional terrorization
- Policies on transgender client placement and safety
- Screenshots of the Q.R. group chat using D.W.'s mugshot / arrest article, if preserved
- Staff notes or clinical interventions concerning the mugshot / arrest-article group chat
- 189 Orange Street first-floor CCTV footage, if available
- Incident reports, clinical notes, medical documentation, or staff communications concerning the alleged 189 Orange "snitch" retaliation incident
- Staff communications concerning retaliation, "snitching," peer violence, identity-based harassment, group safety, client humiliation, or staff-modeled contempt
- Phase 1 staff schedules from the period shortly before September 2021
- House logs, shift notes, or internal communications concerning the alleged David Vieau / John Stewart confrontation
- HR records, supervision notes, or staff-conduct records concerning David Vieau's alleged verbal berating of John Stewart
- 90 Ford Street house schedule, staff assignments, or shift logs for the late-2021 Harlem / Central Park North trauma-disclosure incident
- Clinical notes, staff notes, or incident notes concerning the Harlem / Central Park North disclosure at 90 Ford Street, if any exist
- Staff-training materials concerning trauma-informed response to client disclosures
- Staff code-of-conduct policies about mocking, dismissing, or accusing clients of lying about trauma disclosures
- Public / external preservation
- Reddit thread screenshots / Wayback captures involving the deleted commenter defending "Chris" and old Turnbridge / Ford Street staff culture
- Any evidence identifying the deleted Reddit commenter before deletion
- Other Reddit discussion around Chris Meyer and Turnbridge staff culture
- Any contemporaneous texts, journal entries, therapy disclosures, family disclosures, or client communications about the incidents listed above

VIII. Recommended Public Framing

The safest public framing is: This section does not claim that every harmful peer interaction was created by Turnbridge.

It asks whether Turnbridge adequately supervised, interrupted, documented, and clinically addressed a culture where sexual shaming, anti-gay slurs, racialized humiliation, trans-client vulnerability, mugshot mockery, adolescent violence, retaliation after "snitching," staff-modeled contempt, and mockery of traumatic disclosures could occur inside a residential treatment environment. A shorter version: The issue is not only what clients said or did to each other. The issue is what Turnbridge witnessed, tolerated, documented, ignored, modeled, or failed to interrupt.

IX. Conclusion

The accounts preserved here suggest a treatment environment in which vulnerable clients could be sexually shamed, mocked for perceived same-sex sexuality, called anti-gay slurs, racially targeted, physically attacked, humiliated through mugshot and arrest-article sharing, emotionally terrorized because of gender identity, retaliated against after being labeled a "snitch," or dismissed by staff when recounting traumatic histories. Some accounts are firsthand. Some are relayed and require corroboration. But the pattern is serious enough to warrant records preservation and institutional due diligence. The central question is not whether every allegation can be proven from memory alone. The question is whether Turnbridge maintained adequate systems to prevent, document, interrupt, and respond to identity-based hostility, peer humiliation, adolescent violence, retaliatory violence, staff-modeled contempt, client-on-client intimidation, and staff dismissal of trauma disclosures. If these incidents were documented, Turnbridge should be able to produce the records. If they were not documented, that itself raises a separate question.

VI. Publicly Available Records / Staff-Vetting Relevance

The staff-vetting portion of the archive should remain focused on six names currently intended for that section:

- Peter McConnell
- Tom Marzili / Tom Marzilli
- Mark Grasso / Mark David Grasso
- Dayton Kingery
- Ian Parker
- Chris Meyer / Chris Myer

Additional names should not be inserted without specific verification and a clear reason for inclusion.

These items

should be framed as staff-vetting questions, not as final findings of unfitness. The correct question is whether

Turnbridge checked public records, licensing histories, public posts, prior-conduct concerns, transportation concerns, and rehiring records before placing staff in authority over vulnerable clients.

1. Peter McConnell

Turnbridge role: Publicly identified by Turnbridge as a former case manager, former Young Men's Program director, and later

professional-development staff member.

Public-record concern: Public-indexed police results surfaced a possible Peter McConnell arrest trail involving Harassment 2nd

Degree and Threatening 2nd Degree in 2017.

Type: Public-record vetting concern; harassment / threatening-related charges; leadership-level staff-vetting concern.

Peter McConnell should be treated as a priority public-record vetting item because the institutional role is more

significant than ordinary support staff. He was publicly presented by Turnbridge as someone who moved from case

management into Young Men's Program leadership and later professional development. The available indexed material

requires final verification through original police posts, court dockets, archived pages, or official records showing full

name, age/location, docket information, and disposition. The current record should therefore be phrased cautiously:

public-indexed police results surfaced possible matching arrest/charge material, but final identity and disposition

verification are still needed before using stronger language. Correction / exclusion note: A later 2023 Coventry / CT

Insider item previously considered in this archive appears to involve a different McConnell and should not be used as

Peter McConnell evidence.

Archive classification: Serious possible public-record vetting issue involving a higher-level Turnbridge figure.

Identity/disposition verification required before stating as confirmed.

2. Chris Meyer / Chris Myer

Turnbridge role: Publicly identified by Turnbridge as Phase I Support Staff / "Unsung Hero" material, and separately preserved

in prior archive material.

Public-record concern: Public police-log reporting names Christopher William Meyer, age 35, of Ford Street,

Hamden, and lists

charges of second-degree breach of peace, first-degree stalking, second-degree harassment, and voyeurism with

malice. Prior archive / Reddit context: In a prior Turnbridge Reddit post, I wrote that Turnbridge employed Chris Meyer

of Hamden, that he assaulted a client and was subsequently rehired, and that he was later arrested for criminal

stalking. In an earlier comment, I described the same memory as: "I remember him beating up a client and then getting

rehired the next day," followed by the later stalking-related arrest.

Deleted Reddit lead: A deleted Reddit commenter defended older Turnbridge / Ford Street staff culture, disparaged critical

clients, used anti-"woke" language, and singled out "a guy named Chris" as "by far the best SS and employee," adding

that clients got him in trouble. I suspect the commenter may have been Chris Meyer, but authorship is unverified.

Additional firsthand context: During a late-2022 client transport to New York City, I remember Meyer discussing the Fair Haven

/ "Fast Eddie" murder and saying, as I remember it, that he was the person who was supposed to be killed by the

person later charged in that case.

Type: Public-record vetting concern; stalking / harassment / voyeurism-related charges; alleged client assault / rehiring

concern; support-staff vetting concern; staff-culture lead; transportation / judgment concern; local-crime-story

boundary concern. Chris Meyer should be treated as a major public-record, staff-retention, transportation, and

staff-culture item. Turnbridge publicly presented Chris Meyer as Phase I support staff whose duties included safety,

transportation, medication-adherence observation, and daily contact with residents. Prior archive / Reddit material

preserves my recollection that Chris Meyer assaulted or beat up a client and was then rehired or allowed to return to

work shortly afterward. That allegation should be treated as a recollection requiring corroboration through witnesses,

employment records, incident reports, shift logs, client accounts, or internal communications. Separate from that

recollection, public police-log reporting later listed charges against Christopher William Meyer including second-degree breach of peace, first-degree stalking, second-degree harassment, and voyeurism with malice. Arrests and charges should not be described as convictions unless final court disposition is verified. However, the public charges are relevant to the institutional question of whether Turnbridge adequately screened, supervised, retained, rehired, or protected staff placed in direct authority over vulnerable clients. The late-2022 NYC transportation account is also relevant to the Chris Meyer staff-vetting record. I personally remember Meyer being hired to drive me into New York City for a film-related obligation. During that ride, he allegedly ran red lights, spoke on the phone with multiple women about ways he was lying to them, told me how much my parents were paying him, recounted a Fairhaven drug-buying story involving his girlfriend, a large Black man, and a dog, told me about the Fair Haven / "Fast Eddie" murder, and said, as I remember it, that he was the person who was supposed to be killed by the person later charged in the "Fast Eddie" case. This should not be treated as a criminal allegation against Meyer. It is a staff-conduct, transportation-safety, confidentiality, professional-boundary, and judgment concern. Public reporting separately anchors that Edward Andrew "Fast Eddie" Thompson was killed in Fair Haven in 2011, that Larry Johnson was arrested on a warrant for murder, that police said Thompson was not the intended target, and that Johnson was later found not guilty. That public reporting does not verify Meyer's statement and does not establish any involvement by Meyer. It is included only because Meyer's alleged statement about being the intended target may be relevant to staff judgment, boundaries, and the appropriateness of discussing local violence during a client transport. The deleted Reddit comment should also be preserved carefully. The comment defended older Turnbridge / Ford Street culture, disparaged critical clients, used anti-"woke" language, and singled out "a guy named Chris" as "by far the best SS and employee," adding that clients got him in trouble. I suspect the commenter may have been Chris Meyer, given the tone, the unusually personal defense of "Chris," the surrounding Turnbridge / Chris Meyer discussion, and my own prior experiences with Meyer. However, authorship is unverified, and the comment does not identify the commenter or specify Chris Meyer by full name. It should be treated only as an unattributed public Reddit lead relevant to Turnbridge staff culture and the Chris Meyer discussion cluster. Any stronger attribution would require additional evidence, such as screenshots showing the account before deletion, account metadata, admissions by the commenter, or corroboration from someone who saw the account before it was deleted.

Potential corroboration:

- Turnbridge "Unsung Hero" page / archived copy
- Staff rosters
- Employment records
- Transportation records

- Family payment records
- Staff code of conduct / transportation policies
- HR records
- Incident reports
- Rehiring / discipline records
- Patch / Southington police-log clipping
- Court disposition records for Christopher William Meyer
- Reddit thread screenshots / Wayback captures
- Witness accounts about the alleged client assault / rehiring
- Witness accounts about Meyer's staff conduct
- Communications arranging the NYC ride
- My parents' recollection of the transportation arrangement
- Contemporaneous texts, therapist disclosures, or family disclosures about the ride
- Public reporting on the Fair Haven / "Fast Eddie" murder case
- Any witness, text, or prior disclosure confirming Meyer stated he was the intended target

Archive classification: Public-record vetting issue + alleged client-assault / rehiring concern + firsthand

transportation /

staff-conduct concern + unattributed Reddit staff-culture lead. Final disposition should be verified

before using any

stronger language than "charged." Authorship of the deleted Reddit comment remains unverified. Meyer's alleged

statement about being the intended target in the "Fast Eddie" case is preserved as a firsthand recollection of what he

said during a client transport, not as a verified fact.

3. Thomas Marzili / Tom Marzilli

Turnbridge role: Publicly identified by Turnbridge as Executive Director of Residential Services / senior men's and adolescent residential-services figure.

Public-record concern: Colorado Division of Professions and Occupations primary-source lookup lists Thomas Paul Marzilli's

credential as "Unlicensed Psychotherapist" with license status "Voluntary Surrender." The board/program action lists

voluntary surrender/relinquishment effective May 23, 2016.

Type: Public-record vetting concern; licensing / professional-credential concern; leadership-level concern.

Thomas Marzili / Tom Marzilli should be treated as a leadership-level licensing item. Turnbridge publicly presents him

as a senior residential-services figure. Colorado primary-source licensing records list a Thomas Paul Marzilli credential

as an Unlicensed Psychotherapist with a voluntary surrender / relinquishment action in 2016. This item should be

phrased carefully. The record should not be overstated beyond what the licensing source shows. The current public-record language is: Colorado licensing records list voluntary surrender / relinquishment of an Unlicensed

Psychotherapist credential. Any stronger claim about misconduct, discipline, or underlying facts should require the

underlying board documents or additional official records.

Archive classification: Public-record licensing / leadership-vetting issue. Underlying board documents should

be preserved if

available.

4. Dayton Kingery

Turnbridge role: Later employed at Turnbridge as support staff / support staff manager, according to public

employment

Turnbridge / Turning Point Due-Diligence Memo

COMPLETE REPLACEMENT STAFF-VETTING ENTRY - THOMAS PAUL MARZILLI - July 28, 2026

Controlling replacement rule. This entry supersedes the shorter Thomas Marzili / Tom Marzilli staff-vetting entry that described only voluntary surrender. The earlier text may remain in the PDF for historical continuity, but this full entry controls all future use.

3. Thomas Marzili / Tom Marzilli / Thomas Paul Marzilli

Turnbridge role. Publicly identified by Turnbridge as Executive Director of Residential Services and as a senior residential-services figure connected to men's and adolescent programming. A. identifies him as program director in the women's-program environment during 2017.

Primary-source licensing record. Colorado licensing materials identify Thomas Paul Marzilli as an Unlicensed Psychotherapist and reflect a voluntary surrender / relinquishment effective May 23, 2016 in case number 2015-1632.

Underlying allegation categories now located. The supplied final agency order states that the Colorado Board alleged violations of former § 12-43-222(1)(f)(I), (g)(I), (i), (p), and (r). The accompanying statutory material indicates that (g)(I) addressed conduct below generally accepted professional standards; (p) addressed failure to comply with mandatory disclosure requirements under § 12-43-214; and (r) addressed sexual contact, sexual intrusion, or sexual penetration with a client during the therapeutic relationship or within two years afterward. The mandatory-disclosure statute included information about method, duration, fees, termination rights, confidentiality, and the rule that sexual intimacy in a professional relationship is never appropriate.

Disposition and limitation. The order states that Marzilli denied the Board's allegations. The matter was resolved through a final order and voluntary surrender rather than a contested hearing establishing every allegation as proven. Public language must therefore say that regulators formally alleged these categories and that Marzilli denied them and surrendered the credential; it must not state that sexual misconduct was judicially or administratively proven after hearing.

A.'s Turnbridge testimony. A. alleges that Marzilli screamed a graphic sexual question at a seventeen-year-old client, asking whether a man had ejaculated inside her after a sexual encounter. A. separately alleges that Marzilli became barred from the women's house after sexual involvement with a recently graduated former client who had become support staff. The memorandum author independently recalls hearing while enrolled at Turnbridge that Marzilli was banned from the women's house. That independent memory supports the existence of a discussed restriction but not its cause.

Gambling context. A. alleges that Marzilli had a compulsive gambling problem and named a Turnbridge softball team "Minus 160." A February 13, 2016 Foxwoods Poker post identifies Thomas Marzilli as chip leader in Event #12, Flight A, with 265,100 chips. The poker record corroborates participation and the public gambling context, not a clinical diagnosis or compulsive gambling by itself.

Institutional significance. The combined record creates a serious leadership-vetting question. Turnbridge should be able to show whether it obtained and reviewed the complete Colorado order; how it evaluated the alleged sexual-contact category and mandatory-disclosure allegations; what disclosures Marzilli made; whether he was restricted from women's facilities; why; what complaints or internal investigations existed; and why he remained or advanced in senior residential leadership.

Priority records and witnesses

- Complete Colorado DORA credential file, final order, stipulation, complaint, public investigative records, and credential-history printouts.
- Turnbridge pre-employment and promotion background checks, licensing checks, applications, disclosures, credential-verification records, supervision, and board / leadership review.
- All HR, complaint, incident, supervision, access-control, house-assignment, restriction, and internal communication records concerning Marzilli and the women's program.
- A.'s direct account; the seventeen-year-old former client if she consents; the recently graduated former client / staff member; Audrey Bell; Lila Sussman; other women's-program staff and clients; and the memorandum author's limited independent recollection of the ban discussion.
- Foxwoods Poker page, archive capture, metadata, and any additional public tournament records, used only as gambling-context evidence.

Archive classification. Leadership-level public-record licensing concern + direct former-client allegations concerning sexualized treatment of a minor and an alleged former-client / staff boundary violation + independent contemporaneous recollection that a women's-house restriction was discussed + dated public poker context. Stronger claims require record and witness corroboration.

Exhibit TM-1 - Colorado final agency order excerpt

ISTRATION NO. RP 13556,

by and between the State Board of Registered
Thomas Paul Marzilli ("Respondent") as follows:

tion over the person of Respondent and the
Final Agency Order ("Order").

ed to practice as a Registered Psychotherapist
October 17, 2011, and has been so registered at

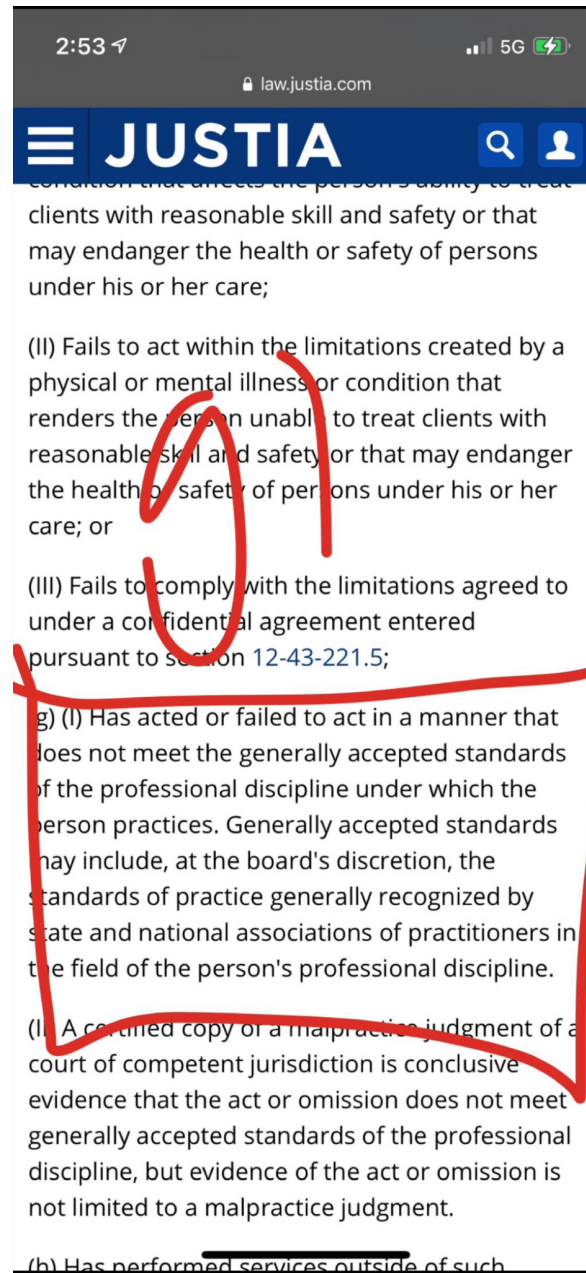
ties and the purpose of this Order to provide a
arising out of case number 2015-1632 without
ring. This Order is a full and final resolution
r does not resolve any other cases, complaints,
Board or Respondent, as of the effective date
te that to the best of their knowledge no other

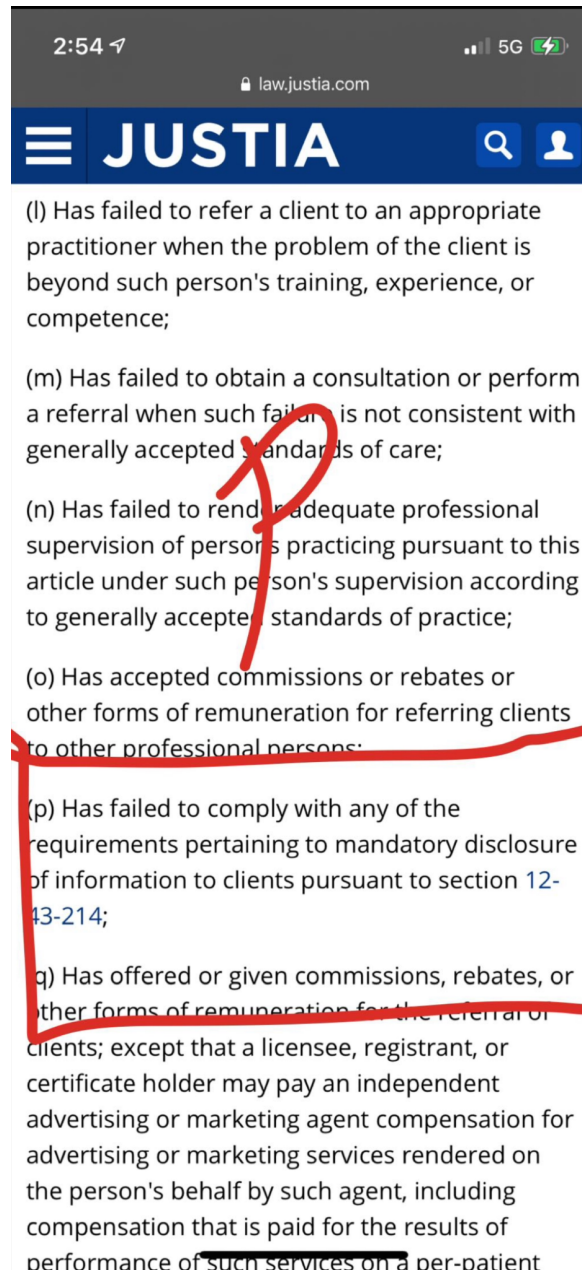
se number 2015-1632, the Board alleges that
nd 12-43-222(1)(f)(I), (g)(I), (i), (p), and (r),
allegations.

denies the Board's allegations, Respondent
proven by the Board at hearing, Respondent
2-43-214 and 12-43-222(1)(f)(I), (g)(I), (i), (p),

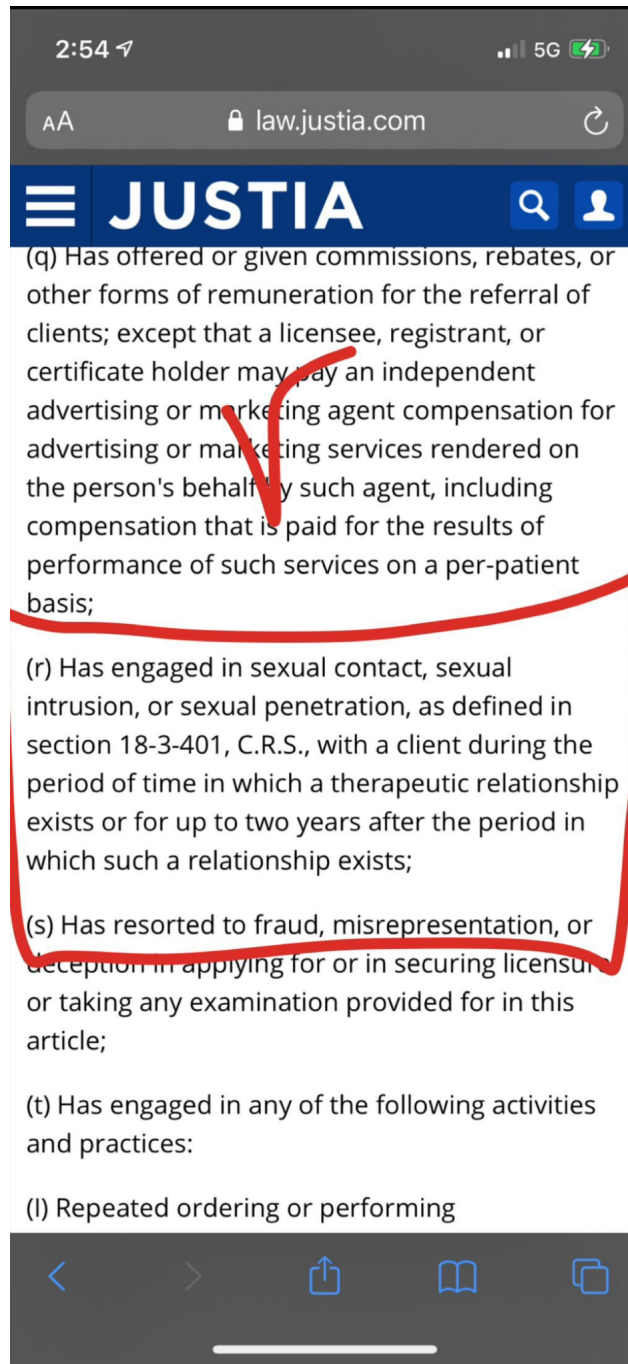
The excerpt identifies case number 2015-1632, lists the Board's alleged statutory violations, states that Marzilli denied the allegations, and forms part of the final resolution. The complete official order should be preserved.

Exhibit TM-2 - Statutory provisions corresponding to alleged violations





Selected supplied screenshots show the professional-standards and mandatory-disclosure provisions. The complete historical statute should be obtained from an official source.



The supplied screenshot shows the former subsection addressing sexual contact, intrusion, or penetration with a client during the therapeutic relationship or within two years afterward. This was an allegation category, not a proven finding after hearing.

Exhibit TM-3 - February 13, 2016 Foxwoods Poker post

Saturday, February 13, 2016

Notables and Chip Leader - Event #12, Flight A

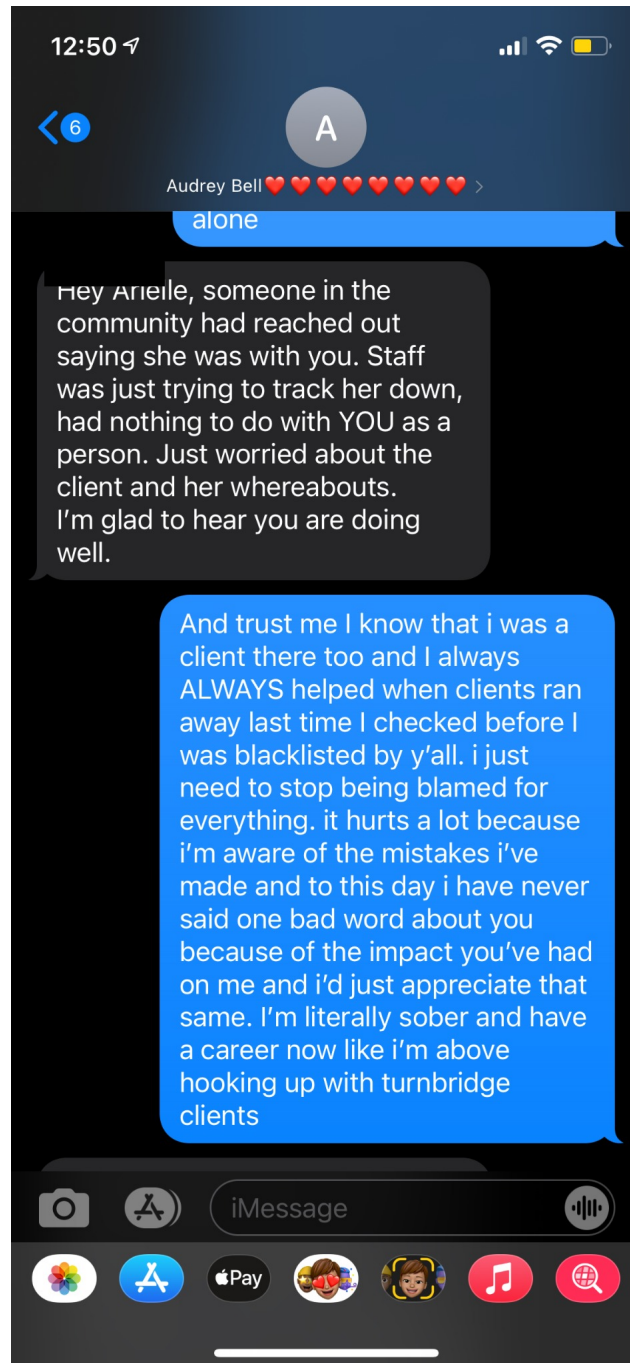


Thomas Marzilli - Chip Leader - 265,100

Flight A has concluded, and the chip leader from this flight is Thomas Marzilli with 265,100. Coming in a close second is Justin Higgins with 261,900.

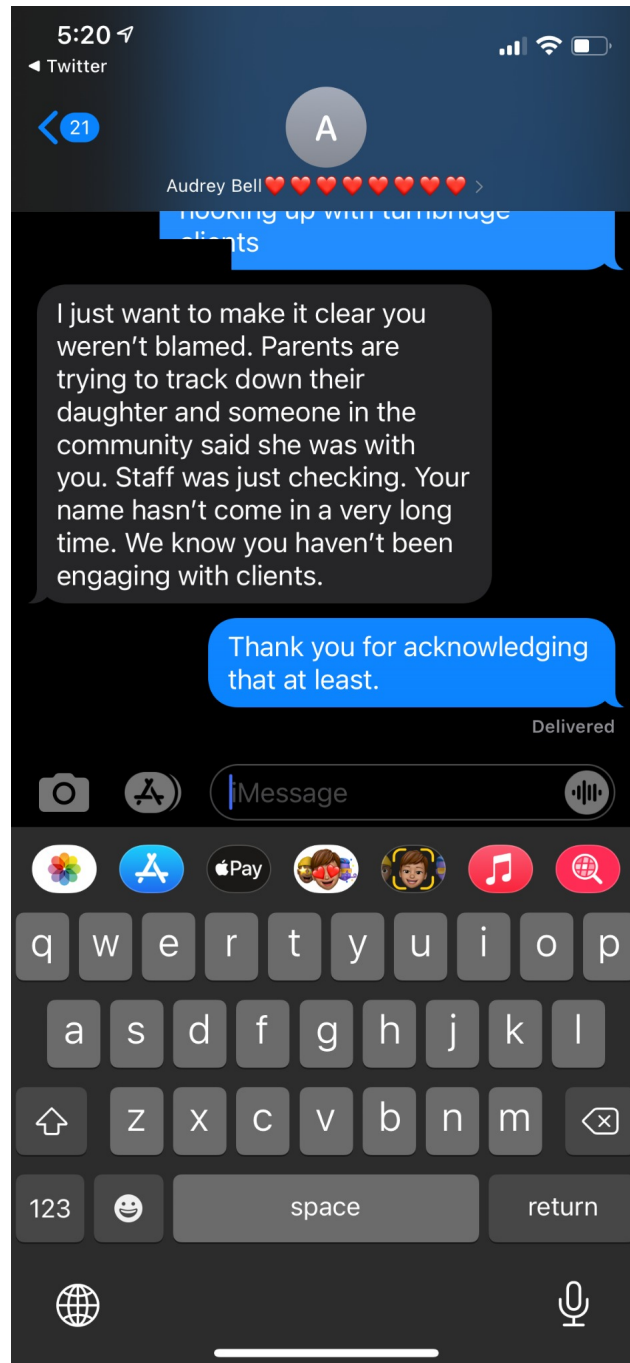
The public post identifies Thomas Marzilli as Event #12 Flight A chip leader with 265,100 chips. It supports public gambling context only and does not by itself establish compulsive gambling.

Exhibit A-1 - Post-discharge contact / missing-client inquiry



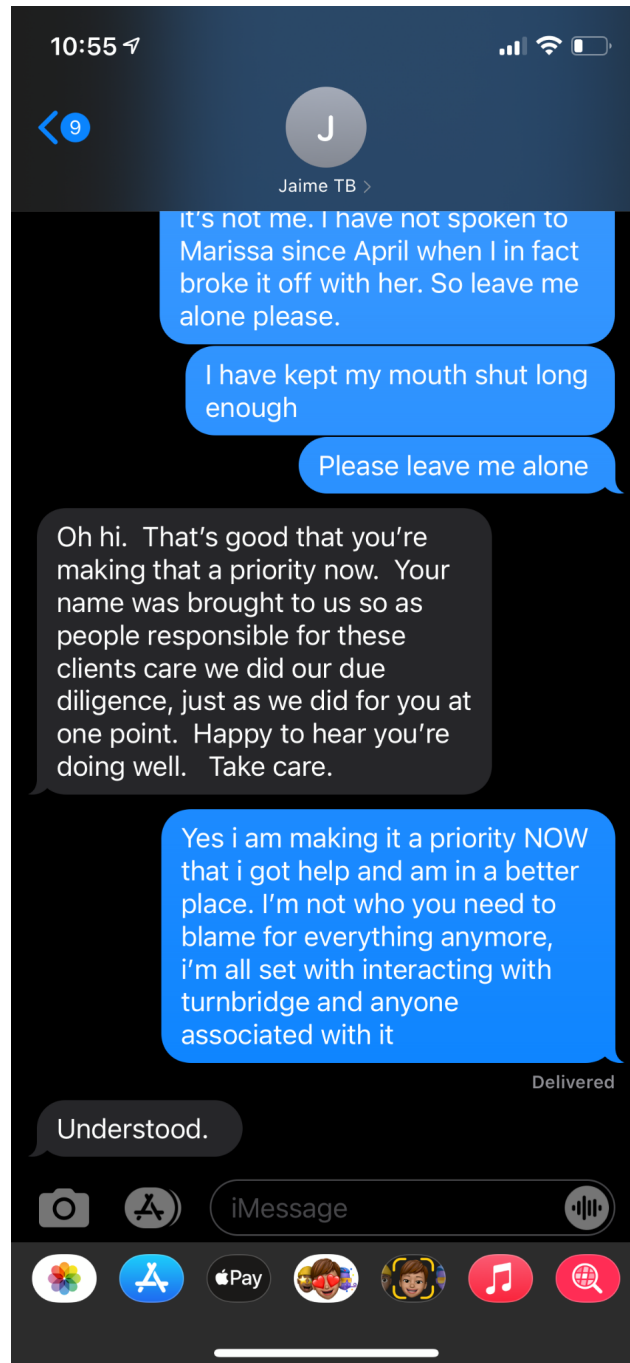
Redacted screenshot supplied by A. Turnbridge-affiliated responder states that staff were trying to locate a client and says the inquiry had nothing to do with A. "as a person." A.'s identifying name is redacted.

Exhibit A-2 - Acknowledgment that A. was not recently engaging with clients



Redacted screenshot supplied by A. The responder states that A. was not blamed and that staff knew she had not been engaging with clients for a long time.

Exhibit A-3 - “Due diligence” framing and A.’s request to be left alone



Screenshot supplied by A. A Turnbridge-affiliated responder describes staff outreach as “due diligence” and references responsibility for client care. A. asks to be left alone and rejects continued institutional blame.

materials previously reviewed. Public record: Arrested and charged in California with felony vandalism, resisting arrest, making criminal threats, and elder-abuse-related conduct. Source context: Incident partially captured in publicly circulated video, including Reddit PublicFreakout post.

Type: Public-record vetting concern; out-of-state arrest/charge history.

Dayton Kingery was publicly reported as having been arrested and charged with felony vandalism, resisting arrest, making criminal threats, and elder-abuse-related conduct before later Turnbridge employment. Dayton is included here not as a claim about his character, but because his publicly reported arrest/charge history appears relevant to Turnbridge's staff-vetting practices. The institutional question is whether Turnbridge appropriately screened and supervised direct-access support staff, not whether any individual employee should be reduced to a public incident.

Archive classification: Public-record vetting issue. Final disposition should be verified before using any stronger language than "arrested/charged."

5. Ian Parker

Turnbridge role: Publicly indexed as Turnbridge case manager, 2021-2023.

Public record: WestportNow and Patch reported that Ian Parker, age 25, of Westport, was arrested on December 16, 2016 and charged with second-degree assault and disorderly conduct after police found a male party bleeding from the head. The articles also referenced a prior August 2016 narcotics/paraphernalia arrest and an outstanding failure-to-appear warrant. Additional identity anchor: Public recovery testimonial by Ian Parker describes Westport background, recovery timeline, and later work as a case manager in a long-term treatment center.

Type: Public-record vetting concern; criminal-charge history; warrant/disposition issue.

Ian Parker was publicly indexed as a Turnbridge case manager during the 2021-2023 period. Public reporting from 2016 described an Ian Parker, age 25, of Westport, charged with second-degree assault and disorderly conduct, with prior narcotics/paraphernalia arrest history and an outstanding failure-to-appear warrant referenced in the reporting. A later recovery testimonial provides additional identity anchors connecting the Westport Ian Parker profile to a long-term-treatment case-management role. I personally observed that Ian Parker appeared very eager to restrain me on his first day on the job during a violent incident.

Archive classification: Public-record vetting issue + firsthand observation of staff behavior. Final court disposition should be verified.

6. Mark David Grasso / Mark Grasso

Turnbridge role: Staff member present at / associated with 1212 Quinnipiac Avenue during the late-2022 L.M. disclosure incident, based on my firsthand identification. Archive incident connection: Mark David Grasso is the staff member I identify as having overheard my late-2022 disclosure to E.O. that L.M. had gotten on top of me, grabbed my penis, and refused to get off. Public-record / public-material concern: Public materials identify a Mark Grasso of Bridgeport as a Family ReEntry recovery coach and quote him saying addiction "landed me in prison" before recovery. A

public

Instagram profile using the handle @markdgrassoct22 and display name "Mark David Grasso" matches the staff member I remember as Mark. Specific charge history, docket details, conviction status, or disposition should not be stated unless official records are located and confirmed.

Type: Staff identity anchor; staff-vetting / reentry-background context; sexual-boundary disclosure response; alleged failure to initiate meaningful protective action. Mark David Grasso should be treated as both a staff-response item and a staff-vetting context item. In late 2022, at 1212 Quinnipiac Avenue, I told E.O. that L.M. had gotten on top of me, grabbed my penis, and refused to get off. Mark David Grasso / Mark Grasso overheard me relay this disclosure. My memory is that Mark said words to the effect that it sounded crazy and that I should "feel free" to report it to higher-ups if I felt like it. To my knowledge, no meaningful protective action followed, and L.M. continued to harass me afterward. I

identify this staff member as Mark David Grasso. A public Instagram profile using the handle @markdgrassoct22 and display name "Mark David Grasso" matches the person I remember as Mark. Public materials also identify a Mark Grasso of Bridgeport in recovery / reentry work, including Family ReEntry, and quote him saying addiction "landed me in prison" before he turned his life around. This material is included for staff-vetting and institutional-response context.

The issue is not whether a person with a recovery or reentry history should be categorically excluded from direct-care work. The institutional questions are whether Turnbridge adequately vetted, trained, supervised, and documented staff placed around vulnerable clients, and whether staff responded appropriately when a sexual-boundary disclosure was made in their presence. This entry should not state any specific criminal charge, conviction, docket, or disposition unless official records are located and confirmed. The current public-record language should remain limited to: public materials identify Mark Grasso of Bridgeport in recovery / reentry work and quote him saying addiction "landed me in prison"; specific charge / docket / disposition details remain unconfirmed.

Potential corroboration:

- Turnbridge employment records confirming Mark David Grasso / Mark Grasso's role and dates
 - Staff schedules or shift logs for 1212 Quinnipiac Avenue in late 2022
 - E.O.'s account of my disclosure and Mark's response
 - Incident reports, clinical notes, or house logs concerning the L.M. disclosure
 - Other clients aware of L.M.'s later harassment
 - Screenshot / archive of @markdgrassoct22 showing display name Mark David Grasso
 - Public Family ReEntry / recovery-coach materials identifying Mark Grasso
 - Official Connecticut docket records, if any, confirming charge history, disposition, incarceration history, or dropped charges
 - Contemporaneous texts, journal entries, therapist disclosures, or family disclosures from the time
- Archive classification: Firsthand disclosure + staff overhearing + alleged failure to respond, with later staff-identity anchor and public staff-vetting / reentry-background context requiring official-record verification.

7. Mason Edwards

Integration correction. This inserted entry expands the staff-vetting cluster from six names to seven. Wherever earlier pages refer to a six-name staff-vetting cluster, the controlling list should now include Mason Edwards together with Peter McConnell, Chris Meyer / Chris Myer, Thomas Marzili / Tom Marzilli, Dayton Kingery, Ian Parker, and Mark David Grasso / Mark Grasso.

Turnbridge role / employment lead: A public LinkedIn profile under the name Mason Edwards lists Turnbridge employment beginning in June 2017 and continuing to "Present." Because LinkedIn entries are self-reported and may be stale, the profile does not independently establish his exact title, worksite, duties, or actual end date. A former Turnbridge client posting under the Reddit username fiend_jpeg separately identified Mason Edwards as a Turnbridge staff member during the commenter's time in the program.

Former-client allegation: The commenter alleged that Edwards was reported numerous times for engaging with clients in an inappropriate manner and stated that the majority of the clients involved were minors. The commenter further stated that this occurred before Turnbridge built its formal adolescent program, during a period when the youngest clients accepted could be sixteen under certain conditions. The present record does not yet establish the dates of the alleged reports, the precise conduct alleged, the identities or ages of the clients, who received the reports, or how Turnbridge responded.

Public-source video concern: The commenter attached a video that appears to show a man identified as Mason Edwards being confronted by a predator-catching group concerning alleged communications and an intended sexual meeting with a person presented to him as fourteen years old. In the footage, the man appears to make statements acknowledging the alleged conduct and repeatedly asks for forgiveness. The video should be preserved in full and reviewed by exact quotation. The memorandum does not treat the footage as a court finding, and the identity of the person in the video, the completeness of the recording, the circumstances of the exchange, and any criminal investigation or disposition require independent verification.

Type: Staff-vetting concern; alleged sexual-boundary and minor-safety concern; former-client report; public-source video; employment-history and institutional-response question.

Why this matters

- If Edwards worked in direct-care or residential roles while Turnbridge accepted minors, the organization should be able to identify every program, house, shift assignment, and age group with which he had contact.
- If clients or staff reported inappropriate conduct, Turnbridge should be able to produce complaint, supervision, incident, HR, mandated-reporting, suspension, transfer, termination, and law-enforcement records.
- The institutional question is not limited to whether the later video depicts misconduct. It is whether Turnbridge received earlier warnings, documented them, protected clients, restricted access to minors, and communicated with families or authorities.
- The LinkedIn entry creates a specific employment-timeline lead but should not be treated as proof that Edwards remained employed continuously through the present.

Priority records / corroboration

- Complete Turnbridge employment file for Mason Edwards, including hire date, titles, job descriptions, work locations, supervisors, direct-care duties, client-age groups, training, background checks, discipline, leave, separation, and rehire records.
- Staff rosters, schedules, shift logs, house assignments, transportation records, and client-contact records from June 2017 forward.
- All complaints, incident reports, clinical or house notes, supervision records, HR records, safeguarding reviews, mandated reports, police referrals, and internal communications involving Edwards.
- The complete original video file, URL, posting account, upload date, captions, description, comments, and any longer or unedited version.
- The fiend_jpeg account, including approximate dates, houses, names of supervisors, what was personally witnessed, what was reported by others, and how Turnbridge allegedly responded.
- Independent identity verification connecting the LinkedIn profile, the person in the video, and the former staff member identified by the source.
- Court, police, prosecutor, child-protection, or other official records, if any, concerning the conduct depicted or alleged in the video.

Archive classification: Mixed public-source and former-client lead. The LinkedIn profile is a public employment-history lead; the Reddit statement is a former-client allegation; and the video is public-source footage that appears to contain admissions but requires complete-context, identity, and official-record verification. Stronger claims about criminal liability, conviction, Turnbridge knowledge, or institutional concealment should not be made without additional evidence.

8. Kelly Elizabeth McCormack - staff-vetting, criminal-record, client-property, conduct, and separation concerns

Controlling integration correction. This entry is item 8 in the staff-vetting cluster and belongs immediately after item 7, Mason Edwards. Any earlier text describing a six-name or seven-name staff-vetting cluster is superseded. The controlling cluster now contains eight staff-vetting subjects, with Kelly Elizabeth McCormack added after Mason Edwards.

Turnbridge role / identity posture. I.S.C., a former women's-program client, identifies Kelly McCormack as her Turnbridge case manager. Turnbridge therapist Jeni, who knew McCormack through the program, separately identified McCormack in the April 2024 community-post images discussed below. Connecticut Judicial Branch conviction records supplied for this update identify **Kelly Elizabeth McCormack, birth year 1984**. The 2012 public news report described a Kelly McCormack as age 27, which is consistent with a 1984 birth year. The identity match should nevertheless remain records-based and should be confirmed through Turnbridge personnel records and date-of-birth information.

Core institutional issue. A criminal or recovery history does not, by itself, make a person unsuitable for treatment work. The due-diligence issue is whether Turnbridge knew or should have known of a repeated public criminal-record history, what screening and rehabilitation assessment it performed, what duties and access McCormack received, what complaints later arose, and what action Turnbridge took when concerns about her conduct, property handling, possible impairment, and client treatment were raised.

A. Confirmed Connecticut Judicial Branch conviction records supplied by the memorandum author

- **March 8, 2017 - Larceny 6th Degree**, docket N23N-CR17-0174532-S, New Haven GA 23 / East Haven Police. Guilty plea and guilty finding on June 15, 2017; sentence shown as unconditional discharge.
- **January 8, 2019 - Larceny 6th Degree**, docket F02B-CR19-0306337-S, Bridgeport GA 2 / Stratford Police. Guilty plea and guilty finding on May 15, 2019; sentence shown as 90 days jail, execution suspended, probation one year.
- **March 16, 2019 - Breach of Peace 2nd Degree**, docket F02B-CR19-0307345-S, Bridgeport GA 2 / Trumbull Police. Guilty plea and guilty finding on May 15, 2019; sentence shown as six months jail, execution suspended, probation two years.
- **March 16, 2019 - Threatening 2nd Degree**, same docket F02B-CR19-0307345-S. Guilty plea and guilty finding on May 15, 2019; sentence shown as one year jail, execution suspended, probation two years.
- **November 19, 2020 - Violation of Probation** shown on both 2019 dockets. The court records supplied for this update show guilty findings and probation continued.

These are official-court-record facts as shown in the Connecticut Judicial Branch screenshots supplied for this update. Exact certified copies should be preserved for regulator use.

B. 2012 public news-report lead

A February 20, 2012 Connecticut news article titled *Couple booked for disorderly conduct after dispute* identified Kelly McCormack, then 27, in a property dispute with a boyfriend. The article reported that both were charged with disorderly conduct; that McCormack told police the boyfriend had a knife and a gun in his vehicle; that officers reported finding no weapons; and that the boyfriend alleged McCormack punched him, while officers reported seeing no visible injury. This is an arrest / charge report, not a conviction finding. The age reported in 2012 is consistent with the 1984 birth year in the later court records.

C. Additional criminal-record leads requiring official docket confirmation

Additional search-result captures supplied by the memorandum author appear to show earlier sixth-degree larceny matters dated October 7, 2011 and May 15, 2013, both displayed as guilty, and a 2024 matter labeled Conspiracy to Commit Larceny 6th Degree dated April 21, 2024 with no disposition displayed in the supplied result card. Those items should remain **unconfirmed docket leads** until the underlying Connecticut Judicial Branch case-detail pages are obtained and preserved. They should not be merged with the confirmed convictions above merely because the name is the same.

D. April 2024 Concerned Citizens of Foxon post and later witness identification

A preserved screenshot from the Facebook group *Concerned Citizens of Foxon* shows a post stating that two pictured people had allegedly been arrested in West Haven after driving around in a white box truck and stealing property. A commenter asked whether they were the same people who stole a woman's luggage. The post is a community allegation, not an official police record.

I.S.C., who personally knew McCormack as her Turnbridge case manager, identified the woman pictured as Kelly. Jeni, a Turnbridge therapist who also personally knew McCormack, separately identified the same woman as Kelly and wrote, "That's the page I was talking about." Jeni further stated in contemporaneous messages that people had privately provided information to an alleged victim, that the woman contacted East Haven Police, and that there was reportedly an open investigation. Jeni also stated that a DCF report had been made in connection with concern for a child and that a family member had become involved in the child's care. The exact police report, investigation status, DCF basis, arrest history, charges, and disposition require official records.

I.S.C. separately described the alleged property victim as an autistic child. The preserved Facebook screenshot itself does not establish that detail; it should remain attributed to I.S.C. unless police, DCF, victim, or witness records corroborate it.

E. I.S.C. allegations concerning McCormack's conduct as case manager

I.S.C. alleges that McCormack exercised coercive and humiliating authority over her while acting as case manager. The current archive contains extensive contemporaneous and near-contemporaneous support for the broader relationship: approximately fifty-seven photographed journal pages written during treatment, more than twenty case-manager communications, a photographed behavioral contract, later complaint messages, and 2023 messages with therapist Jeni. The materials do not automatically prove each allegation below, but they make the account unusually records-rich.

- I.S.C. alleges repeated screaming, humiliation, favoritism, arbitrary restrictions, invasive searches, and gossip about clients.
- She alleges McCormack planted marijuana / weed among her belongings and planted or later claimed to find a condom in her bag or property, then used those items as grounds for accusation or punishment.
- She alleges McCormack accused her of "sucking dick for" a gift card to a vegan restaurant, which I.S.C. experienced as sexual humiliation.
- She alleges McCormack sent her back to Phase 1 for approximately eight weeks without a legitimate clinical basis.
- She alleges McCormack took or failed to return her Nintendo Switch. This should be tested through property inventories, electronics restrictions, staff sign-out records, family communications, and any reimbursement / missing-property records.
- Contemporaneous material already preserved documents extensive phone / laptop restrictions, review of private Discord and Venmo activity, behavioral-control measures, and later written complaints alleging searches, drug-related accusations, screaming, prolonged restrictions, humiliation, and gossip.
- Texts also document repeated work / family-therapy conflicts and I.S.C. warning that imposed scheduling could cost her employment; the case manager framed nonattendance as refusal.
- I.S.C. alleges that McCormack ultimately left Turnbridge, or was removed from her role, after refusing a drug test requested by Turnbridge. The precise employment classification - resignation, termination, administrative leave, or other separation - is not established and must be obtained from HR and drug-testing records.

F. 2023 Jeni communications relevant to contemporaneous notice and property / control concerns

In June 2023 messages to therapist Jeni, I.S.C. complained that weekend plans had again been taken after she had warned McCormack that a required UA / scheduling arrangement would not work, that McCormack had known about the conflict for weeks, and that the way McCormack spoke to her was unacceptable. I.S.C. wrote that the situation could not continue. In later messages, Jeni told I.S.C. that she deserved to feel supported and joked that she had tried to hide a gaming laptop so "Kelly and parents would forget." These messages do not prove every later property allegation, but they are contemporaneous evidence of conflict over McCormack's authority, electronics, scheduling, and I.S.C.'s complaints about how she was treated.

G. Staff-vetting and supervision questions

- What criminal-background check did Turnbridge perform before hiring or assigning McCormack, and on what date?
- Did the check disclose the 2017 and 2019 convictions or 2020 probation violation, and if so, who reviewed them and what written risk assessment was made?
- Did McCormack disclose her criminal history on any application, credentialing, onboarding, or annual disclosure form?

- What role, title, house access, client-property access, device-search authority, transportation authority, phase authority, and family-contact authority did she hold?
- What complaints, grievances, incident reports, HR notes, supervision notes, or quality-assurance reviews concerned McCormack?
- Did Turnbridge receive allegations of missing client property, planted contraband, sexual humiliation, screaming, arbitrary phase regression, or inappropriate searches? What action followed?
- Did Turnbridge request a drug test from McCormack? Why? Did she refuse? What policy governed refusal, and what was her actual separation date and reason?
- After her separation, did Turnbridge audit her case files, client-property decisions, phase decisions, behavioral contracts, searches, or complaints?
- What police / DCF / HR records exist concerning the April 2024 property-theft / white-box-truck allegations and any later criminal case?
- Were current or former clients and families notified of any substantiated concern that could have affected treatment decisions or property?

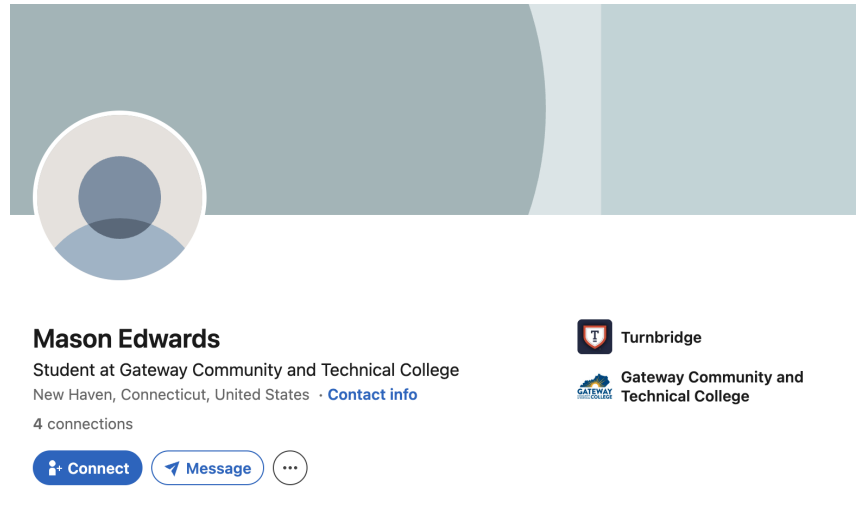
H. Evidentiary classification and safe use

This entry deliberately separates (1) official Connecticut Judicial Branch conviction records supplied for the update; (2) a 2012 public news report of charges; (3) additional criminal-result cards that remain unconfirmed docket leads; (4) a Facebook community allegation and witness identifications; (5) I.S.C.'s direct former-client allegations; and (6) Jeni's contemporaneous statements. Convictions should be stated as convictions only where the official court-detail record supports that language. Alleged thefts, planted items, drug-test refusal, and employment-separation circumstances must remain attributed unless independently confirmed.

Archive classification: **Public-record staff-vetting concern + direct former-client allegation with extensive contemporaneous documentary support + contemporaneous therapist communications + unresolved 2024 police / DCF / criminal-record leads.**

Exhibit ME-1 - Public-source captures concerning Mason Edwards

These exhibits preserve the current source trail. They are not, by themselves, adjudicated findings. The LinkedIn material is self-reported and may be stale. The Reddit statement is an allegation by a former client. The video still should be paired with the complete original recording and exact transcript.



LinkedIn profile capture under the name Mason Edwards, showing New Haven location and Turnbridge affiliation.

Experience



LinkedIn experience capture listing Turnbridge employment from June 2017 to "Present." This may be stale and does not establish the actual end date or role.

fiend_jpeg commented 28 min. ago



Mason Edward's who was a staff member during my time reported numerous times engaging with the clients in an inappropriate manner. Majority of the time it was the clients who were minors. This was before they built their adolescent program, 16 was the youngest they would accept and it was contingent on various things.

Reddit comment capture from fiend_jpeg identifying Mason Edwards as a Turnbridge staff member and alleging repeated inappropriate engagement with clients, many of them minors. The attached video still appears above the comment.

VII. Public Review Evidence and Archive Corroboration

Public reviews do not prove every specific archive allegation. Their value is that they independently raise overlapping risk categories from other vantage points: families, former clients, loved ones, neighbors, and employees. The public review record independently echoes several categories already present in the archive: peer-safety concerns, supervision failures, sexual-boundary and complaint-handling concerns, staff-quality concerns, money / retention concerns, admissions / marketing mismatch, and review-integrity concerns. The pattern warrants written questions and record requests. It does not, by itself, prove every specific allegation.

1. Google Review Capture: Public Pattern Evidence

The archived Google Reviews capture lists Turnbridge at 189 Orange Street, New Haven, Connecticut, with a 4.3

average rating from 246 reviews. The capture includes detailed positive reviews, detailed negative reviews, short one-line reviews, rating-only entries, and a recent cluster of positive entries around "2 months ago."

This mixed record

is more probative than a simple star average because the negative reviews allege concrete safety, staffing,

transparency, admissions, identity-related, medication, and money-related concerns. Because Google Maps reviews are

dynamic, this material should be preserved with dated screenshots, original image files, and, where possible, live

profile URLs or screen recordings showing the path from the Google listing to each review. Key negative Google entries

visible in the archived capture Sarah Glenn Leventis Former-client account alleging that only a few employees wanted

what was best for clients; manipulation of vulnerable parents and children; money motive; "not like the website"; and

review-management concerns, including the allegation that some reviews can be taken down and some five-star

reviews were requested from former staff and clients.

Memo significance: Important because it connects treatment experience, marketing mismatch, money motive, and

review-integrity concerns. Leighann Hutchinson / Margaret Doty Family review alleging that a suicidal child was not

adequately heard or checked on, obtained broken glass, cut himself, and "could have died."

Memo significance: Directly relevant to supervision, monitoring, self-harm-risk protocols, room safety, and

staff checks.

Aria Family review alleging weak package checks, weapons/drugs entering, ineffective pat-downs, dismissive workers,

and an unsafe facility despite safety marketing.

Memo significance: Directly relevant to contraband control, peer safety, facility safety, and marketing-vs-reality claims.

Eliza Taylor Former-client review alleging cash grab, little treatment, poor post-discharge sobriety, and later success at

a different program.

Memo significance: Relevant to money motive, treatment quality, outcomes, and family reliance on marketing.

David M Sibling review alleging an all-around awful family experience. The reviewer identifies his own recovery/program experience and recommends alternatives.

Memo significance: Relevant because it is not simply a client resentment review; it is a family / sibling perspective with comparative program context. Garland Alban Parent/family review alleging lack of transparency, poor communication, and non-individualized curriculum.

Memo significance: Relevant to family disclosure, informed consent, and marketing claims.

Tyler A Family review alleging claims on the website were not met and lack of meaningful challenge/development.

Memo significance: Relevant to marketing mismatch and treatment-expectation concerns.

Sabio Adelina Parent review alleging Phase II directors were condescending, rude, arrogant, and that promises were not fulfilled.

Memo significance: Relevant to staff conduct, family communication, and phase-specific concerns.

Coleen Huggins Hayback Parent review alleging emotional/verbal abuse by a therapist, dishonesty, and failed family therapy calls.

Memo significance: Relevant to staff conduct, clinical oversight, family communication, and complaint handling.

HP Identity-related review alleging Turnbridge was not good for trans, non-binary, LGBT, or BIPOC clients and lacked diversity/accountability.

Memo significance: Relevant to suitability for clients whose mental-health/substance issues intersect with identity and to staff/culture due diligence. Maria Griffin Review alleging acceptance for mental health followed by removal / ER transfer after an incident and lack of meaningful treatment.

Memo significance: Relevant to admissions fit, acuity screening, and response to mental-health incidents.

Jacob Lachman Former-client review alleging admissions misrepresented length of stay and program details.

Memo significance: Relevant to admissions representations and consent.

Riv g Former-client review alleging abuse / manipulation and being treated as unsafe when wanting to leave.

Memo significance: Relevant to autonomy, discharge pressure, complaint framing, and family relationship pressure.

Steven O Review alleging residential / non-medical framing, expensive billing, and difficulties leaving.

Memo significance: Relevant to marketing, billing, and autonomy concerns.

Leila Terry Adolescent-patient review alleging medication concerns and adverse side effects.

Memo significance: Relevant to medication oversight and psychiatric prescribing questions.

Lauren Killingsworth Neighborhood review alleging a Turnbridge SUV driver nearly hit pedestrians while looking at a phone with passengers.

Memo significance: Relevant to transportation safety and supervision outside residences.

Amanda Nelson / Chris Earhart / Kaden Harkins Admissions / deposit / phone interaction complaints.

Memo significance: Relevant to pre-admission conduct and family-facing process.

Joseph Camara / AP / Roman Rosales / Mart 456 / "Poop Fart" Short negative entries with limited detail.

Memo significance: Low probative individually, but still part of the negative review corpus.

2. Google Positive-Review Pattern and Review-Integrity Concerns

The archived Google capture also contains extensive positive material, including detailed parent reviews, alumni

reviews, professional/referrer reviews, family-member reviews, and very short positive entries. A rigorous memo should

not dismiss detailed positive family accounts merely because negative reviews exist. At the same time, not all positive

reviews carry equal due-diligence weight for client safety. Observed positive-review features

- A visible cluster of positive reviews appears around "2 months ago," including detailed parent reviews, short one-line

reviews, and several accounts with one to three total reviews. Clustering alone does not prove manipulation, but it warrants preservation and date/profile review.

- Several positive entries disclose professional, business, referral, or staff-adjacent relationships: examples include a reviewer who says they run a business and have worked with Turnbridge; a reviewer who had the privilege of touring campuses and collaborating with the team; a marketer describing the business side; and referring professionals or social workers praising particular staff or the program. These reviews may be genuine, but they are less probative of residential client safety than direct client/family incident accounts.
 - Several recent short positive entries are extremely thin: "Great place," "Amazing place," "Very nice place," "The staff has been great," and similar statements. These are not evidence of wrongdoing, but they do not answer safety questions about incident reporting, separation after threats, contraband control, or sexual-boundary complaint response.
 - Some adjacent family-member positive reviews warrant contextual review where timing, adjacency, sparse detail, single-reaction engagement, and archive context suggest the review may require additional verification. These features do not prove falsity; they reduce probative value as evidence of safety.
 - The strongest review-integrity lead is Sarah Glenn Leventis's review, which alleges that reviews can be taken down and that some five-star reviews were requested from former staff and clients. That allegation requires independent corroboration, but it belongs in the record because it is specific and directly tied to reputation management.
- Professional characterization The public review record contains review-integrity concerns, including a former-client allegation of solicited positive reviews; a recent cluster of positive reviews; some thin one-line reviews; relationship-based positive reviews; and adjacent or similarly engaged positive reviews that may warrant context. These patterns do not prove fraud, but they reduce the value of the star average as a safety proxy and justify requesting incident-level data.

3. Rehabs.com Evidence

Rehabs.com was checked during drafting. The visible Turnbridge page listed a 3.5 overall rating across 74 reviews and showed categories including accommodations/amenities, treatment effectiveness, and meals/nutrition. It also listed review keywords including staff, safe, room, clean, facility, group, admissions, insurance, detox, and counselor. The visible recent reviews included three negative entries and two positive entries. Jessica - 2.0 / Loved One Visible review allegations include lack of professionalism / expertise, no accountability, ineffective supervision, disorganization, and profit motive. Relevance: Staff quality, supervision, accountability, money motive. Samuel - 2.3 / Former Client Visible review concerns include client safety, staff supervision, staff conduct, complaint handling, incident reporting, staff vetting, and sexual-boundary complaint concerns. Relevance: Directly overlaps archive categories and

family

due-diligence questions. NunyaBizness - 2.3 / Loved One Visible review alleges unsafe phone contact involving a minor

client and a person connected to prior sexual harm, and later sexual assault by another patient.

Relevance: Sexual

safety, supervision, family wishes, outside contact, patient-on-patient harm. This item should be described carefully. It

is a public-review allegation, not a verified finding. Safe wording: One parent / loved-one review alleges that a minor

client was permitted to maintain unsafe outside contact with a person connected to prior sexual harm, despite family

concern, and that the client was later sexually assaulted while at Turnbridge. This review is preserved as a

public-review allegation raising questions about supervision, sexual-safety protocols, outside-contact boundaries,

family communication, documentation, and protection after disclosure. haleigh - 5.0 / Loved One Very short positive

review: "great, affective!!" Relevance: Low probative weight due to minimal detail; not evidence of falsity. Anne - 5.0

Detailed positive family account emphasizing long-term treatment, family support, and 14 months of care.

Relevance:

A detailed positive counterweight; should not be dismissed absent contrary evidence. Rehabs.com significance

Rehabs.com strengthens the archive not because every review is negative, but because its visible negative entries

independently raise the same categories: supervision, staff conduct, complaint handling, sexual safety, and money

motive. These are precisely the categories for which records should exist.

4. Glassdoor and Employee-Review Context

Glassdoor was checked during drafting. The public pages listed Turnbridge at 2.8/5 across 45 reviews, 41% recommending to a friend, 44% positive business outlook, and category ratings including 2.5 senior management and

2.5 compensation/benefits. Visible negative excerpts included allegations of poor management, poor pay, only people

who do not care lasting, management lying about raises/promotions, and upper staff being rude or judgmental. These

employee reviews do not prove client incidents, but they are relevant to the staff-retention and supervision

environment in which client safety is managed. Employee-review significance

- The overall employee score suggests mixed employee experience; it is not determinative of care quality but is relevant to culture.
- Senior-management and compensation / benefits concerns can matter where direct-care quality depends on staffing, retention, training, and supervision.
- Visible negative excerpts support asking how Turnbridge audits staff conduct, management response, training, and retention.
- Glassdoor also shows positive employee reviews and positive clinical-growth descriptions. The employee record is mixed and should be used cautiously, not as one-sided proof.

VII.A. Yelp Review Evidence and Corroboration Leads

Integrated subsection of VII. Public Review Evidence and Archive Corroboration | Prepared July 2026

1. Scope, Evidentiary Status, and Use

This subsection preserves seven detailed one-star Yelp reviews supplied as screenshots: Anon N. (Feb. 8, 2023), Autumn G. (Feb. 7, 2024), Janice M. (June 19, 2025), Christopher M. (June 15, 2025, with dated updates), Jessica B. (June 21, 2026), Ryan C. (Nov. 5, 2018), and Mo R. (Sept. 1, 2021). These are public-review allegations, not verified findings. Their value is that they preserve concrete, date-linked accounts from former clients, parents, and a nearby resident and independently echo categories already present elsewhere in this memorandum.

The reviews should be used as corroboration leads and records-request prompts, not as substitutes for incident reports, medication records, contracts, staffing logs, police records, or direct witness interviews.

2. Anon N. - former-client account (Feb. 8, 2023)

The reviewer alleges manipulation of parents, suppression of client voice, poor confidentiality, undisclosed program length, differential retention depending on payment status, restrictions on outside contact, phone searches, punishment for refusing medication, difficulty leaving AMA even as an adult, staff gossip about clients, and psychological deterioration inside the program.

- Program-length disclosure and informed consent
- Client autonomy and AMA barriers
- Outside-contact and device-control practices
- Medication refusal and coercion concerns
- Confidentiality and staff gossip
- Mental-health deterioration and institutional pressure

3. Autumn G. - parent account (Feb. 7, 2024)

The reviewer alleges that her daughter reported persistent verbal abuse by another patient; staff used mediation, but the bullying allegedly continued. The review states that medication changes made emotional regulation harder, the daughter was left alone with the alleged bully, and the daughter then became physically aggressive and was discharged. The reviewer further alleges there was no meaningful transition assistance after discharge and later outreach to leadership was ignored.

- Peer-bullying response and supervision
- Medication changes and emotional-regulation monitoring
- Separation and safety planning
- Discharge proportionality and fairness
- Transition planning and continuity of care
- Administrative nonresponse after family complaint

4. Janice M. - parent account (June 19, 2025)

The reviewer describes a sixteen-year-old allegedly being body-slammed shortly after arrival, not receiving prescribed medication on the first night, later receiving a sedating medication the parent says was not supplied or authorized, lacking basic orientation and hygiene supplies, and deteriorating rapidly over four days. The review also alleges attempts to prevent an AMA departure, poor clinical access, staff inattention, contraband including needles, missing belongings, and a cost of approximately \$4,000 per day.

- Immediate peer-safety response
- Medication reconciliation, consent, and administration
- Clinical access and staffing
- Basic orientation and hygiene support
- AMA / discharge rights
- Contraband controls and room supervision
- Property inventory and return
- Billing and marketing representations

5. Christopher M. - neighbor account (June 15, 2025, with updates)

The reviewer alleges repeated walk-offs from the Woodbury-area program, police and emergency-service involvement, clients entering private property, nighttime roadway exposure, proximity to active hunting areas, and a client later found in a swamp during single-digit temperatures. He states that he spoke with the CEO and perceived no workable prevention plan. The dated updates allege multiple later incidents requiring police intervention.

- Elopement / walk-off prevention protocols
- Emergency-service and police-call records
- Nighttime roadway and environmental safety
- Staffing and supervision during elopements
- Leadership knowledge and response
- Weather-risk and medical-response documentation
- Neighbor complaints and community-safety records

6. Jessica B. - parent account (June 21, 2026)

The reviewer alleges a sales-driven intake, lack of expertise with reactive attachment disorder, inadequate supervision, minimization of conduct, interference with family connectedness, medication reductions, an uncompleted promised neuropsychological evaluation, abrupt discharge immediately before the scheduled evaluation, and no transition planning.

- Admissions representations and clinical fit
- Diagnostic competence and supervision
- Family-communication practices
- Medication changes and informed decision-making
- Promised testing and follow-through
- Abrupt discharge and transition planning
- Treatment-content and value concerns

7. Ryan C. - former-client account (Nov. 5, 2018)

The reviewer alleges that admissions represented a three-month stay that became an expected one-year program after arrival. He states that an admissions director told him many clients would not come if they knew the true expected duration. He also alleges family estrangement, limited addiction treatment, incentives tied to filled beds, and efforts to retain paying clients.

- Program-length representation
- Consumer reliance and informed consent
- Family relationship interference
- Financial incentives and bed retention
- Treatment-content mismatch
- Longstanding pattern dating to at least 2018

8. Mo R. - former-client account (Sept. 1, 2021)

The reviewer states that they entered Turnbridge on June 8, 2020 and left on July 10, 2021 after arranging a sober-house placement they believed was appropriate for recovery. The reviewer alleges that Turnbridge disagreed with the departure and told the reviewer's parents that the reviewer was in danger and had to return. The review further alleges that only two staff members contacted the reviewer during the first three days after leaving to verify safety.

The reviewer also alleges worsening mental health after approximately thirteen months, inadequate eating-disorder support, staff telling the reviewer to eat less or lose weight, staff spreading rumors about drug dealing after relapse, and a serious confidentiality breach in which a friend's reported rape allegedly became known across multiple houses after a staff member shared the information.

- Client autonomy and alternate placement
- Family pressure after departure
- Post-departure safety follow-up
- Mental-health deterioration during long-term placement
- Eating-disorder competence and weight-related comments
- Staff rumor-spreading
- Sexual-assault confidentiality and need-to-know limits

Archive classification

Public former-client review allegation. The account is not independently verified, but it is unusually specific about dates, length of stay, attempted transition to another sober house, family communications, eating-disorder comments, staff rumor-spreading, and alleged disclosure of sexual-assault information. These details make it a priority witness and records lead.

9. Cross-Review Pattern Analysis

A. Program length, admissions representations, and informed consent

Anon N. and Ryan C. independently allege that expected program duration was not truthfully disclosed before admission. Their accounts directly overlap the memorandum's Joseph Moura / 28-day understanding and contract-signing concern. This strengthens the records-based question of what families and clients were told orally and in writing before intake.

B. Attempts to leave, AMA barriers, and outside-contact control

Anon N., Janice M., Ryan C., and Mo R. describe different forms of difficulty leaving, family pressure, outside-contact restriction, or institutional resistance to alternate placement. These reviews overlap the J., H., and March 2026 R. / Drew Behr autonomy leads and support requesting discharge, AMA, phone-access, and family-contact records.

C. Medication administration, consent, and clinical monitoring

Janice M. alleges missed prescribed medication followed by administration of another medication without parental consent. Autumn G. and Jessica B. describe medication changes tied to emotional regulation or treatment planning. These accounts reinforce the need for medication-reconciliation forms, administration logs, consent records, prescribing notes, and adverse-effect monitoring.

D. Peer violence, bullying, elopement, and supervision

Janice M. and Autumn G. describe alleged peer assault or persistent bullying, while Christopher M. describes repeated walk-offs and dangerous exposure in roads, woods, freezing conditions, and hunting areas. Together they raise broader questions about staffing, separation plans, elopement protocols, environmental risk assessment, and emergency response.

E. Confidentiality, gossip, and family manipulation

Anon N. and Mo R. allege staff disclosure of private client information or rumor-spreading. Ryan C., Anon N., and Mo R. also describe family pressure or wedge-driving. These claims overlap the memorandum's confidentiality, staff-culture, and family-contact concerns.

10. Records and Follow-Up Questions Generated by Yelp Evidence

- Admissions scripts, recorded calls, intake emails, program-length disclosures, contracts, and documents showing expected duration.
- Policies and logs governing client phones, outside contact, phone-number retention, device searches, and communication restrictions.
- AMA / discharge-request records, refusals, risk assessments, family communications, and legal or clinical rationales for delaying departure.
- Medication reconciliation forms, medication administration records, consent forms, prescribing records, adverse-effect monitoring, and medication-refusal policies.
- Incident reports, separation plans, bullying complaints, mediation notes, staff schedules, and room-assignment records.
- Elopement / walk-off policies, police and emergency-service call logs, internal incident reports, staffing plans, weather-risk protocols, and leadership communications.
- Neuropsychological-testing referrals, scheduling records, cancellation or discharge decisions, and transition-planning records.
- Confidentiality policies, role-based access controls, complaint records, and internal communications concerning alleged staff gossip or rumor-spreading.
- Eating-disorder screening, treatment plans, nutrition records, staff training, and documentation of weight-related guidance.
- Property inventories, packing records, missing-property reports, and return-of-belongings documentation.
- Billing records, daily-rate documentation, scholarship/payment status, and any incentives connected to occupancy, retention, or filled beds.
- Communications with parents following attempted departure or alternate placement, including assertions that a client was in danger and had to return.

11. Archive-Safe Public Framing

These Yelp reviews are not official findings, and each account requires corroboration. Their significance is that multiple reviewers, writing across 2018-2026 from different vantage points, independently describe overlapping concerns involving program-length disclosure, client autonomy, medication administration, peer safety, elopement, supervision, confidentiality, family pressure, discharge planning, and the gap between marketing and lived experience. The appropriate institutional question is what records Turnbridge maintained and what action it took when these concerns arose.

Exhibit Y-1: Anon N. Yelp review (Feb. 8, 2023)

User-supplied screenshot preserved as public-review evidence. The review is an allegation, not an official finding.



Jessica B.

San Francisco, CA

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     Jun 21, 2026

The lack of professionalism and expertise was stunning. I worried that we had been just given a sales pitch to get our child in the door, and in retrospect, that's clear that's all they could offer us. They showed no capacity to understand reactive attachment disorder and instead did the thing that we have seen all too often from inexperienced therapists: a lot of pussyfooting around and making endless excuses for the child's bad behaviors, while assuming the parents were really to blame and treating us as adversaries instead of partners. They refused to believe anything they didn't directly observe themselves even though the child was not at home, in a classroom, unsupervised, or asked much of anything, so if course they weren't going to see how he would show up in other contexts, but even when we shared evidence of a series of poor choices he made right under their noses, they still pretended as though it were nothing. They were entirely incapable of holding him accountable or providing proper supervision to keep him from feeding his technology addiction, and they minimized everything he did, from breaking their rules to harassing teenage girls. They showed their ignorance when they allowed their own hero complexes to get the better of them, genuinely believing that because he seemed charming and cooperative, it was because they were doing such a good job (or that he had no issues in the first place), when, in fact, that's a basic, textbook symptom of RAD -- and, incidentally, of sociopaths, who would take them right in and practice deceiving them as though they were the greenest therapists in suburbia. When they started actively interfering in family connectedness, we pushed back hard, and rightfully so: it's the worst thing to do to a child with RAD and is more likely to exacerbate the problem than anything else. They clearly had no real concern for him, despite their feigned care, since they took him off most of his meds, promising a new neuropsychology evaluation, but they couldn't be bothered to get that done even though he'd been there a month. They were disorganized from the start, and we had to keep pushing for them to even follow through on their most basic promises. When we came for a visit, they decided, just hours beforehand, to kick him out and send him home instead, a day before the scheduled neuropsych eval, probably because they didn't want to have to acknowledge his case as a total and utter failure on their parts. They provided no transition planning at all. They provided our kid nothing more than an expensive vacation. He learned nothing beneficial at all. Don't waste your effort or hope or your child's time at this place.



Helpful 1



Thanks 0



Love this 0



Oh no 1

Exhibit Y-2: Autumn G. Yelp review (Feb. 7, 2024)

User-supplied screenshot preserved as public-review evidence. The review is an allegation, not an official finding.



Ryan C.

Oakland, CA

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★☆☆☆☆ Nov 5, 2018

Please do not send your loved ones here if you really care about them. First off, admissions lies to kids about the length of stay, I was told 3 months and when I arrived learned it was 1 year, if you're lucky. I asked my case manager why this was and he told me that's how it works with every rehab in the country. I asked the admissions director why he lies to the kids and he told me to my face that 90% of kids would not come if they knew it was a year. So they're selling a product (a very very expensive product) that if 90% of people knew what it actually was, wouldn't want it. TB drove a wedge between me and my parents and completely destroyed our relationship. If you had a bad relationship with your parents before coming here, it's going to stay that way. And if you had a good relationship with them, you have to work insanely hard to keep it that way. The groups are a joke, and for being a addiction treatment program, there isn't a lot of addiction treatment. Most kids have no interest in being there because they were forced to come and lied to about the length, and many have absolutely no interest in being sober, and they're very open about it.

The phase directors and higher-ups get bonuses for the amount of beds that are filled, so they will find any excuse to keep you there as long as possible even though they know it's wrong. Basically, it's money first, and being helpful second. They will find any reason they can to convince parents that their kid needs to stay longer. After a certain point they are damaging kids by keeping them there as long as they do, and it's toxic for them and their families.

Do not listen to these people, this is the real experience of me being there and it really messed me up and messed my family up. If you really love your kids, please DO NOT SEND THEM HERE.



Helpful 14



Thanks 3



Love this 4



Oh no 3

Exhibit Y-3A: Janice M. Yelp review - first screenshot (June 19, 2025)

User-supplied screenshot preserved as public-review evidence. The review is an allegation, not an official finding.



Janice M.

Patchogue, NY

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Facts: recommended by Mather LI Social worker Kerrie as only and of course best option for my anxiety depressed sweet sad teen, 16 year old. Total smoke and mirror shit show. Admissions intake soooooooooo smooth !!!! IT IS smooth talking money grab with promise of professional clinical care in safe therapeutic calm environment. NOT safe at all but beautiful. There are not a small group of patients there are MULTIPLES of small houses that are driven to main house where the beautiful photos on website are. Total chaos, lack of care and complete lies within tour (8 min golf being whipped around and shown nothing while

Programmed robot lies through her teeth.

Total BULLSHIT!!!! My child was in hell

Hole for four days: my well cared for kid not cared for at all given no orientation or

This is how things work or schedule. Kid just dumped immediately into group which was kids just hanging out eating snacks and doing what they wanted in refusal room. Never told how phone calls worked or day at all seems crazy right ???? Wait for it. MY

Teen was wrestled and then body slammed in the first ten mins in "cottage" by another child who wasn't suppose to be in my child's room. Who then asked to take their stuff no staff member cared or intervened. Child was Never given medications first night which I supplied and never even given a towel or idea when to line up for phone or shower or hamper for clothes. Staff was on cellphones and laying about on couch not answering child's questions. My kid kept asking for help. How did we get the info BY getting our kid OUT on day four which they tried to prevent AMA doesn't work

That way when you

Don't give prescribed meds or means to wash yourself TURNBRIDGE!!!! Kid is doing just Fine my ass.

GOT child out after wasting 1000 on travel and losing 400 for "schooling"

third day my child was done with chaos and having panic attacks. And demanded to see therapist who was scheduled for FIRST meet following week. Therapist walked kid to a Nurse and left immediately had meetings to get too, or who knows lunch. NP who called me AFTER sedating attack without my permission for

Med I didn't supply or was prescribed not

How

That works by law. There is no data being collected or doctors around or clinicians monitoring children. There are camp like counselors herding kids from spot to spot. The website is total glossy BS and your child will not be safely monitored or cared for at all. No medication dispersed first day. Then medication given without consent that was not supplied by me and my child was not given a towel or time frames for showering no clocks so no idea what and when anything is happening. Trauma was kick started back to peak anxiety after waiting three weeks at Mather for this spot and

turn

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Get
189

Mes

Exhibit Y-3B: Janice M. Yelp review - continuation

User-supplied screenshot preserved as public-review evidence. The review is an allegation, not an official finding.

who was scheduled for FIRST meet following week. Therapist walked kid to a Nurse and left immediately had meetings to get too, or who knows lunch. NP who called me AFTER sedating attack without my permission for

Med I didn't supply or was prescribed not

How

That works by law. There is no data being collected or doctors around or clinicians monitoring children. There are camp like counselors herding kids from spot to spot. The website is total glossy BS and your child will not be safely monitored or cared for at all. No medication dispersed first day. Then medication given without consent that was not supplied by me and my child was not given a towel or time frames for showering no clocks so no idea what and when anything is happening. Trauma was kick started back to peak anxiety after waiting three weeks at Mather for this spot and stable with hope for real attentive help. What you get fancy camp grounds for profit not attentive or safe or professional counseling or therapy service that charges 4 grand a day WITH four grand a day I REPEAT that money goes to the mansion they are building to house more kids right as you pull through gates MONEY MONEY MONEY and you don't get what you pay for here. You are paying salaries of upper management that's all. Social worker at Mather who is ethically responsible for setting up proper care for your child at Hospital

Wouldn't even return my phone calls to

Let her know to not suggest this place to anyone else guess she got some

Kind of kickback. I say TURNBRIDGE will

Hopefully be shut down sooner than later as they expand and gloss it up but eventually someone is going to get really hurt I saw a lot of fancy cars there, the people who lie and mislead you sure they don't let you tour or see anything up close because you would then run with your child. If your kid is behavioral maybe a good fit or can fight and protect themselves you don't get kicked out for That either you get extra time added on MY child needed therapeutic calm experience with doctors and clinicians what it was four days of hell with kids verbally cursing and screaming at each other while staff just watches. Also they kept half our belongings I sent up when they packed my child up without telling child we were on our way. On to the next money grab victim. Absolute disgrace for profit NO way this is accredited or regulated CT nor do they have to tell you the truth look at the reviews. All horrifying !!!!! Would

Like to thank TURNBRIDGE for taking three weeks of stabilizing my child inpatient to four hundred steps backwards in four days. Oh and kids with contraband actual

Needles giving the old fashion prison tattoo with ink from pens. All that in four days. Sounds worth 16,000???? Ha

Exhibit Y-4A: Christopher M. Yelp review - first screenshot (June 15, 2025)

User-supplied screenshot preserved as public-review evidence. The review is an allegation, not an official finding.

12/9/24: At 12:17 AM, The CT State Police and True Path began sending out Amber Alerts via phone call, text and email blast to alert of a wayward teenage girl. At 1:30 AM, State Police came pounding on the front door looking for her here --- this is the fourth time this has happened now. It's the overnight of a Sunday into a Monday. The whole house is awake from the chaos, and we're supposed to be able to go back to sleep and function like normal people in a few hours.

This is absolutely outside the realm of what would be considered reasonable by any thinking person. I expressed this to the Trooper, who replied, "oh, believe me. I'm right there with you. I have this conversation all the time..."

Well, that's just great. What is going to be done about it...?

12/19/24: Ten days later, another walk-off. Today, the person is lying on the side of the road, refusing to get up. There are two black Turnbridge Suburbans on-scene, and a teenager lying half in the street. Of course, no one can touch them, so they are just going to stay lying there as long as they wish.

At the same time, there is a hunter actively hunting right now in the forest next to Turnbridge.

To boot, this weekend the temperatures are supposed to be in the single digits with windchills below zero.

12/23/24: Sure enough, a client was found on the ground in the swamp across the road from the facility. The temperatures were in the single digits, with windchill values in the negative digits. She was unable to stand up on her own two feet, and had to be carried out.

I strongly encourage people to watch the Netflix documentary "The Program." Sometimes when it walks like a duck...

03/17/25: More walk-offs today requiring Police intervention.



Helpful 1



Thanks 2



Love this 2



Oh no 3

Exhibit Y-4B: Christopher M. Yelp review - dated updates

User-supplied screenshot preserved as public-review evidence. The review is an allegation, not an official finding.



Christopher M.

Saybrook Manor, Old Saybrook, CT

@ 0 ★ 104 🗨 18

★ ★ ★ ★ ★ Jun 15, 2025

They have zero control over the clients, who regularly wander off the site and onto private properties in this quiet, residential neighborhood in a rural town. A tremendous amount of taxpayer dollars are regularly wasted when emergency services have to participate in efforts to corral wayward teenagers who have serious psychological and emotional problems. When they wander off, all the staff does is follow them. This often happens at night, and then the clients and the workers are walking along a rural road with no lights where cars are traveling at high rates of speed. In addition, it's hunting season half of the year here, and they also often end up in the State Forest behind the facility, where active hunting with bow and arrow, as well as rifle, is commonplace. On no fewer than three occasions, wayward clients who are looking for someplace to go other than back to the facility have come onto our private property, causing us to install a gate at the end of the driveway. Last night, they decided to bypass the gate, and trespass anyway. Moreover, while standing on my own property, I was screamed and cursed at by a teenage girl who was having an episode. We are made to feel unsafe on our own property by this type of intimidating behavior, which is, indeed, extremely dangerous behavior for all parties involved; and after speaking with the CEO on the phone about it, it's clear that he is in denial about the problem and has no solutions for it. He told me, "they are teenage girls with severe emotional and psychiatric issues, and we cannot put our hands on them. All we can do is follow them when they leave." We live in scary times when we know that wandering up the wrong driveway can have very serious consequences, and I expressed this concern to the CEO. That, too, seemed to fall on deaf ears. He told me, "they are teenagers, and they are going to go where they want to." Hmm, not in my world. It's shocking to me, really, that his attitude is so cavalier--he is knowingly and willfully putting the welfare of the people he purports to be helping and protecting in danger by not having any protocols in place to prevent walk-offs, much less deal with them swiftly and effectively when they do happen. I strongly urge parents to consider these safety concerns prior to registering your kids here.

Exhibit Y-5: Jessica B. Yelp review (June 21, 2026)

User-supplied screenshot preserved as public-review evidence. The review is an allegation, not an official finding.



Autumn G.

San Francisco, CA

🗣️ 0 🌟 1 📝 0

...



Feb 7, 2024

My daughter was being verbally abused by another patient at Turnbridge. She reported the bullying to staff who conducted mediations. During the mediations the bully would apologize and state she would do better, only to continue with the bullying after the mediation. They also had just changed my daughters medications and she was reporting that the medications were making emotional regulation difficult. Turnbridge is very understaffed. My daughter was left alone with the bully. The bully began verbally assaulting my daughter. My daughter, unfortunately, felt that fight (and not flight) was her only protection. Clearly, she made a bad decision and I completely understand why Turnbridge decided to discharge my daughter. What I don't understand is why they discharge patients for physical abuse but not verbal, especially when the other patients there are suffering from mental health disorders and not everyone can tolerate verbal abuse. When they discharge your child they make you immediately pick up the child and refuse to help you find new placement. This is where the issues will begin. PHP programs won't take your child because they didn't finish the residential program. The residential programs won't accept your child because your child now has a bad mark against them. The family is stuck in a loop trying to find care for their child and Turnbridge doesn't care. I tried to reach out to the clinical director to see if they could implement changes with discharge, so future families will not be negatively affected like we were, but they have ignored me. The administration simply does not care about your children and will punish the families if something goes amiss. They do not prevent bullying by other patients. Be wary of sending your children to this facility and look into a facility who handles verbal abuse in the same way they handle physical: by discharging the offender. Other residential programs do assist in helping you find another residential program in case of early discharge. There are better programs out there.



Helpful 8



Thanks 5



Love this 2



Oh no 3

Exhibit Y-6: Ryan C. Yelp review (Nov. 5, 2018)

User-supplied screenshot preserved as public-review evidence. The review is an allegation, not an official finding.



Anon N.

NY, NY

 0  1  0

     Feb 8, 2023

Manipulative. They just want your money, they will brainwash parents about their children. The clients voice is never heard. Full of lies, drama, and zero confidentiality. You are lied to the minute you step into the place when they don't tell you how long the program actually is. Some of the staff are helpful but the higher ups just want to keep you there for as long as possible. If you are paying in full, not on a scholarship, prepare to be stuck there for even longer. You'll write down phone numbers from your phone when you get there and they will never give them back to you, so you have no contact with anyone on the outside in phase 1. They go through your phone constantly once you finally get it back. They punish you for refusing medications. It is nearly impossible to AMA even if you are above 18. Staff will talk about other clients to other clients. I was thought to be mentally ill when I was there, but really it was just the place driving me crazy. They breathe down your neck and watch your every move. No one there actually wants to be there, so you are constantly surrounded by negative influences. It may work for some people, the concept of the program itself sounds ideal for transitioning back into society. But in my experience, the longer I was there the more I drove myself crazy. You have to put on a fake face and give them what they want, even if it's not beneficial to you in order to get out.



Helpful **6**



Thanks **5**



Love this **4**



Oh no **4**

Exhibit Y-7: Mo R. Yelp review (Sept. 1, 2021)

User-supplied screenshot preserved as public-review evidence. The review is an allegation, not an official finding.



Mo R.

SoMa, San Francisco, CA

0 2 0

Sep 1, 2021

I have been in Turnbridge since June 8th, 2020. I "ran" on July 10th 2021. When I say I ran, I had a sober house lined up to move into the next week which is the decision I thought best for my recovery. Turnbridge however did not agree with it. Leaving, I did not expect my parents to be happy with me, however I did not expect to hear that turnbridge told my parents I am in danger and HAVE to come back. Only two staff members reached out to me to make sure I was safe in the first 3 days. Besides the whole situation with me running away, Turnbridge is not a good choice for you to send your loved ones too. Before I arrived at Turnbridge, my mental health was horrible and I was using primarily weed, acid, and Xanax. After almost 13 months of being there, my mental health was on its last legs and I was at my breaking point. The support staff that work there are amazing. Out of all 3 case managers I had, 1 I am still in contact with and the other is nice but nice doesn't always get the job done. They pay their staff members minimum wage which is not enough to be dealing with the disrespect given by some clients. Also, if you are looking for a place for someone you love or yourself to be treated for an eating disorder, Turnbridge is not it. I cannot count on my fingers or toes how many times I was told, "eat healthier", "lose weight", or "just don't eat as much". I would also like to point out that in my time there, I came to be in a relationship with a past client. I was told multiple times that she was dealing drugs and called her names like a predator. When I relapsed in phase 3, STAFF spread a rumor saying I was dealing drugs out of my house given to me by her. Staff spread that. Not clients. In my opinion, that is extremely inappropriate and unprofessional and within the month and a half I have been out of turnbridge, my friend was raped and did not want anybody to find out except her case manager and her friends. Almost 2 weeks after it happened Staff around all 3 houses found out because one staff member went from person to person spilling my friends business. Long story short, if you value your relationship with your family member, and you want them to recover and get better this is not the place or environment you want to send them too. Im not writing this because I hate Turnbridge (even though I do), I just don't want anybody else to go through what me or any one of friends has gone through in our experiences there.



Helpful 1



Thanks 1



Love this 1



Oh no 2

VIII. Archive Allegations Compared with Public Review Themes

The public reviews independently raise similar risk categories from other vantage points. The overlap does not prove every archive allegation. It supports requesting records.

1. Peer safety

Archive examples:

- M.J. / C.S. CCTV incident
- 90 Ford chair assault involving C.
- A.S. threats
- M.S. Venmo / outing threat
- Younger client allegedly returned to housing with feared peer

Public-review overlap:

- Aria alleges weak contraband controls.
- Leighann Hutchinson / Margaret Doty alleges self-harm monitoring failure.
- NunyaBizness alleges patient-on-patient sexual assault.
- Samuel raises client safety.

Records to request:

- Incident reports
- Separation plans
- CCTV logs
- Rosters
- House logs
- Complaint notes

2. Sexual boundaries

Archive examples:

- L.M. incident at 1212 Quinnipiac
- Mark Grasso allegedly overheard disclosure
- E. / M.S. incident after movie trip
- J.E. / D.A. early-2022 sexual-privacy / nonconsensual intimate-video recording and distribution lead,

with firsthand memory of video

circulation and J.E.'s direct account of staff knowledge and internal handling

- Liam and Steve Tobey relayed concerns

Public-review overlap:

- NunyaBizness raises sexual-safety allegations.
- Samuel explicitly raises sexual-boundary complaints.

Records to request:

- Clinical notes
- Mandated-reporting records
- Staff schedules
- Protection plans
- Family communications

3. Staff conduct / vetting

Archive examples:

- Six-name staff-vetting cluster: Peter McConnell, Tom Marzili, Mark Grasso, Dayton Kingery, Ian Parker, Chris Meyer
- Conduct allegations involving Drew Behr, Douglas Roberto, Dave Murphy, Will, and others
- Chris Meyer transportation and public-record cluster
- Liam staff-boundary / termination-context cluster

Public-review overlap:

- Google and Rehabs.com reviews allege dismissive or uncaring staff.
- Glassdoor raises management / staff-culture concerns.

Records to request:

- Background-check policies
- Licensing checks
- Social-media / public-history review
- HR files

- Discipline / rehiring records
- Termination / separation records
- Staff transportation records

4. Money / marketing gap

Archive examples:

- Archive alleges due-diligence mismatch between marketing image and lived conditions.
- Chris Meyer transportation account includes recollection that he disclosed how much my parents were paying him.
- Joseph Moura / September 28, 2021 intake account includes my firsthand recollection that I openly told friends during the transport from Holy Family Hospital that I believed I would be gone for "28 days," signed contracts at 189 Orange Street that same day, and was only then told by Moura that Turnbridge was actually a year-long program.

Public-review overlap:

- Sarah Glenn Leventis, Eliza Taylor, Jessica, Steven O, Philip Spano, and others allege money motive or marketing

mismatch. Records to request:

- Admissions scripts
- Length-of-stay representations
- Refund policies
- Complaint / discharge records
- Outcome data
- Family payment policies
- Staff transportation-payment policies

5. Review integrity

Archive examples:

- Bad Review Index and positive-review analysis track suspicious or low-probative reviews.

Public-review overlap:

- Sarah Glenn Leventis alleges some positive reviews were requested from former staff / clients.
- Google capture includes recent clustered positives and one-line positives.

Records to request:

- Review-solicitation policies
- Internal communications
- Staff / alumni review requests
- Incentives
- Removal requests

IX. General Patterns Observed

These are not presented as single-event allegations. They are recurring patterns observed or experienced in the

Turnbridge environment, and later echoed in public-review material.

1. Fistfights / client-on-client violence

There were repeated physical altercations and violent incidents among clients, including incidents significant enough to be captured on CCTV.

2. Sexual assault / sexual-boundary violations

I experienced and/or was aware of sexual-boundary incidents involving clients. In at least one instance, a staff member

overheard my disclosure and appeared to leave further action up to me rather than initiating a clear protective

response. Public reviews independently raise related sexual-safety and patient-on-patient harm concerns, especially the Rehabs.com loved-one review preserved above. This updated memo also preserves an early-2023 forced-exposure allegation involving L.M., an early-2023 Dave Murphy sexual-rumor / pronoun-interrogation concern, and a 2021 secondhand legal-

proceeding lead involving "Scarface Adam" and T.K., all of which should be tested through records, witnesses, policies, and contemporaneous disclosures.

3. Casual cruelty by higher-ups and support staff

I observed staff and higher-level personnel treat client suffering, humiliation, violence, or fear as material for mockery.

The repeated replaying of CCTV footage while laughing at clients is central to this pattern.

4. Inadequate response to threats and harassment

I observed failures to meaningfully discipline or separate clients after threats, harassment, coercion, or violence.

5. Vetting concerns for direct-access staff and leadership-adjacent staff

Publicly available records concerning later Turnbridge staff raise questions about whether Turnbridge adequately

screened people placed in direct-access roles with vulnerable clients, especially support staff, case managers, program

directors, and professional-development personnel. The six-name staff-vetting cluster should remain focused on Peter

McConnell, Tom Marzili / Marzilli, Mark Grasso, Dayton Kingery, Ian Parker, and Chris Meyer. The Chris Meyer item is

especially significant because it combines multiple categories: Turnbridge's own public description of him as Phase I

support staff; a firsthand transportation / judgment concern; a prior archive / Reddit recollection involving alleged client

assault and rehiring; public police-log charge reporting; a deleted Reddit lead defending "Chris" and old Turnbridge

staff culture; and the new recollection that Meyer discussed the "Fast Eddie" murder and allegedly said he was the

intended target. These items should not be collapsed into a single proven finding, but together they raise serious

staff-vetting, supervision, retention, transportation, and family-disclosure questions.

6. Licensing and professional-credential concerns in leadership

Public licensing records concerning senior leadership figures raise additional questions about whether Turnbridge

adequately evaluated professional histories, credential status, prior license actions, and the appropriateness of placing

individuals in residential-services leadership.

7. Ideological / political boundary concerns from staff

My experience included staff using treatment authority to moralize or pathologize clients' politics, identities, and

perceived laziness. This was especially concerning where queer-presenting or left-wing clients were redirected into

political conversations about conservatism, socialism, personal responsibility, and leftists allegedly being irresponsible.

8. Shame-based family-pressure rhetoric

My experience included staff using clients' parents and family dependency as material for shaming. The Dave Murphy

Phase 3 East Haven lecture is one example: clients were framed as lazy, burdensome, and people whose parents could

not take care of them, rather than as vulnerable young people in a treatment setting.

9. Failure to respond to coercion / outing threats between clients

My experience included situations where coercion, outing threats, harassment, and threats through social media were disclosed to staff but not meaningfully addressed. The Phase II movie-trip / Venmo incident involving M.S. is one example: after I reported that I felt pressured to send money under threat of being outed, the response I remember was dismissive rather than protective.

10. House security / staff judgment concerns

Secondhand allegations heard from multiple people raised concerns about house security and staff judgment, including the allegation that Douglas Roberto left a Phase 3 house open, that a masked intruder entered, and that a client was allegedly involved in searching the house rather than staff contacting authorities or following a clear safety protocol. This allegation requires corroboration, but it fits the broader concern about supervision, reporting, and client safety.

11. Staff sexual-boundary / inappropriate self-disclosure concerns

The Steve Tobey / C.R. allegation raises a separate concern about staff discussing their own sex addiction, cheating, marriage collapse, and client masturbation in a treatment setting. If corroborated, this would fit a broader concern about staff using clients as containers for their own sexual material, projecting their own recovery issues onto clients, or pressuring clients around sexual behavior in ways that blur treatment boundaries.

12. Client autonomy / attempted departure / outside-contact interference

concerns Secondhand allegations and firsthand memories of client statements raise concerns about how Turnbridge handled clients who expressed that they had been brought to the program against their wishes or who attempted to leave through outside support. The J. airport story, H. denied-access story, and March 2026 R. / Drew Behr account are included as separate accounts in which clients allegedly tried to leave or obtain help leaving through girlfriends, family members, or outside support, after which Turnbridge staff or representatives allegedly contacted, pressured, interfered with, blocked, or spoke through outside family or relationship channels. Public reviews also raise related autonomy, discharge-pressure, difficulty-leaving, and "being treated as unsafe when wanting to leave" themes.

13. Medical safety / medication-access concerns

My experience included an incident in which a staff member allegedly refused to provide access to an inhaler during an asthma attack after saying I was "faking it" and that other clients said I was "getting high" off albuterol. Public reviews separately raise medication and self-harm monitoring concerns, including Leila Terry's medication-related review and Leighann Hutchinson / Margaret Doty's self-harm monitoring allegation.

14. Staff physical-boundary / judgment concerns

The Will inhaler incident overlaps with broader staff-boundary concerns because I remember the same staff member restraining and tickling clients and telling clients stories about robbing gas stations in ski masks with

toy guns and not getting caught. These details require corroboration, but if corroborated they would raise questions about physical boundaries, judgment, and direct-care suitability.

15. Therapist-boundary / adolescent-program cruelty concerns

The allegation involving adolescent-program client J. and Matt Fields / Matthew Fields, LMFT raises a separate concern about therapist judgment, cruelty / humiliation, and possible discouragement of disclosure in an adolescent-treatment context. If corroborated, this would fit a broader concern about whether vulnerable adolescent clients were protected from humiliating, unsafe, or professionally inappropriate comments by clinical staff, and whether staff attempted to suppress reporting after crossing boundaries.

16. Staff transportation / client-contact boundaries

The Chris Meyer transportation account raises a separate concern about staff transportation and client-contact boundaries. A staff member transporting a vulnerable client should not allegedly drive recklessly, disclose family payment arrangements, conduct chaotic personal calls, discuss drug-world stories, or recount local murder-related material during a paid client transport. The added "Fast Eddie" detail makes this concern more serious as a boundary / judgment issue. I remember Meyer saying, during the client transport, that he had been the person who was supposed to be killed by the person later charged in the "Fast Eddie" case. Public reporting says Edward Andrew "Fast Eddie" Thompson was killed in Fair Haven, that Larry Johnson was arrested on a warrant for murder, that police said Thompson was not the intended target, and that Johnson was later found not guilty. This public reporting does not verify Meyer's alleged statement. It only confirms that the real-world case existed and involved an official statement that Thompson was not the intended target. The due-diligence issue is why a staff member in a client-transport role would discuss this material with a vulnerable client. Public reviews also raise transportation-safety concerns, including a neighborhood Google review alleging a Turnbridge SUV driver nearly hit pedestrians while looking at a phone with passengers.

17. Staff-culture / Reddit discourse concerns

The deleted Reddit comment defending older Turnbridge / Ford Street culture and praising "a guy named Chris" is not proof of authorship and should not be attributed to Chris Meyer as fact. However, it is relevant as a public-comment lead because it disparages critical clients, frames newer clients / parents in anti-"woke" terms, and suggests that clients got "Chris" in trouble. In context with the Chris Meyer discussion cluster, it should be preserved as an unattributed staff-culture lead requiring careful caveating.

18. Staff boundary / termination-context concerns involving Liam

The Liam allegations raise a separate staff-boundary and termination-context concern. In late 2022 or 2023, I

remember Z.T. discussing the case of why Liam was fired in a hushed voice with another client and becoming hesitant to tell me details. Later, in 2023 or 2024, W.H. informed me by phone of the allegation that Liam was fired after allegedly trying to meet up with an underage former adolescent-program client while he was an adult support staff member in the young-adults program. Separately, I heard that Liam allegedly gave H.V. and C. hits from a THC pen while they were sequestered at a separate property after relapse. These allegations require corroboration, but they raise questions about staff boundaries, adolescent-program safeguards, relapse-management supervision, termination practices, internal documentation, and whether Turnbridge quietly removed staff after serious misconduct allegations without transparent reporting.

19. Public-review integrity / reputation-management concerns

The review record raises questions about whether families can rely on star averages alone. Sarah Glenn Leventis's review alleges that reviews can be taken down and that some five-star reviews were requested from former staff and clients. This allegation requires corroboration, but it is directly relevant to review integrity. The Google capture also shows positive review clusters, short one-line positive reviews, relationship-based reviews, professional/referral-adjacent reviews, and detailed positive family accounts. These should be treated as a mixed record. Positive reviews may be genuine, but they do not resolve safety questions about incident documentation, separation protocols, staff vetting, medication access, sexual-boundary complaints, transportation safeguards, or family disclosure.

20. Client property / missing-belongsings response concerns

My experience also included a missing-property incident involving a PlayStation 4 left at 1212 Quinpiac around January 2023 and discovered missing around May 2023. I raised the missing PS4 with case manager Eric Regensburg, but I do not recall any meaningful effort to retrieve it, document it, investigate it, or create a missing-property report. The PS4 was never returned. This raises a broader due-diligence question about how Turnbridge documented, safeguarded, investigated, and resolved missing client property inside residential housing.

21. Admissions / informed-consent / program-length representation concerns

My experience now includes a September 28, 2021 intake and transportation account involving Joseph Moura. I recall being picked up from Holy Family Hospital in Haverhill, Massachusetts, while I believed I was going to Turnbridge for "28 days." During the approximately three-and-a-half-hour drive, I spoke with friends on the phone about that understanding. After arriving at 189 Orange Street and signing contracts, Joseph Moura told me Turnbridge was actually a year-long program and said he did not want to "ruin" my last day of freedom. This raises questions about admissions representations, informed consent, contract timing, family reliance, and whether clients were clearly informed of expected program duration before paperwork was signed.

22. Client culture / identity-based hostility / peer humiliation concerns

The client-culture accounts above raise a broader concern about Turnbridge / Turning Point's peer environment. The issue is not that every offensive statement by a client is automatically an institutional act. The issue

is whether

Turnbridge adequately supervised, interrupted, documented, and clinically addressed a peer environment where

clients could be sexually shamed, mocked for perceived same-sex sexuality, called anti-gay slurs, racially targeted,

physically attacked, humiliated through mugshot / arrest-article sharing, emotionally terrorized because of gender

identity, or retaliated against after being labeled a "snitch." These incidents overlap with existing archive categories:

peer safety, sexual-boundary response, staff supervision, adolescent-program safeguards, identity-related safety,

group culture, retaliation, clinical-building safety, and whether staff treated harmful client behavior as clinically

significant or merely as ordinary peer conflict.

Due-diligence questions include how Turnbridge documented anti-gay slurs, racial slurs, sexual shaming, identity-based harassment, cyberbullying, retaliatory violence, mugshot / arrest-article sharing, and harm to

transgender clients placed in gendered young-adult housing.

X. Records and Questions Required to Test the Evidence

A rigorous escalation packet should request records rather than rely on rhetoric. The public reviews and archive

allegations generate specific questions that Turnbridge should be able to answer with documents. Incident documentation Request all incident reports, house logs, and clinical notes for 189 Orange, 90 Ford, 1212 Quinnipiac,

520 Whitney / Whitney-Canner, East Haven, and Phase III incidents identified in the archive. CCTV Request footage-retention policies, CCTV access logs, names of staff who reviewed footage, and records showing whether

footage was replayed outside formal investigation. Peer separation Request policies and actual records showing

separation after assault, threats, sexual-boundary complaints, coercion, harassment, client fear, or client-on-client

violence. Sexual safety Request complaint protocols, mandated-reporting decision records, family-notification records,

response to unsafe outside contact, and protection plans. Contraband / self-harm Request package-check logs, search

policies, room-check logs, sharps / broken-glass records, suicidal-ideation monitoring logs, contraband reports, and

environmental safety audits. Staff vetting Request background checks, public-record searches, licensing checks,

social-media / public-history review, HR discipline records, rehiring decisions, and staff-retention records. Staff

termination / quiet removal Request records showing whether staff were quietly let go, terminated, transferred,

suspended, or separated after misconduct allegations, including any Liam-related HR or internal reporting records.

Transportation Request staff transportation policies, vehicle / driver protocols, records of client transports, staff

phone-use policies while driving clients, family-payment handling policies, and any incident reports involving transport

safety. Admissions / retention Request length-of-stay representations, admissions scripts, family communications,

intake-day contract-signing records, transportation records, hospital pickup records, refund / withdrawal rules,

discharge-against-advice records, and policies governing attempts to leave. Review integrity
Request internal communications soliciting, coordinating, incentivizing, pressuring, suppressing, or
removing public
reviews; review-solicitation policies; staff / alumni review requests; and any requests made to platforms
regarding
negative reviews.

XI. Evidence To Preserve / Follow-Up List

Names to confirm

- M.J. [client involved in February 2022 M.J. / C.S. CCTV incident]
- C.S. [client involved in February 2022 M.J. / C.S. CCTV incident]
- C. [older client involved in late-2021 90 Ford Street chair assault]
- Mark Grasso
- Liam [staff last name to identify through 2021-2023 support staff / case manager logs]
- L.M.
- A.S.
- H.V.
- C. [client involved in Liam THC pen allegation; distinguish from C. in 90 Ford chair assault if records allow]
- Z.T.
- E.O.
- E.
- M.S.
- C.R.
- Mark David Grasso / Mark Grasso [staff member identified by me as present for the late-2022 1212

Quinnipiac / L.M.

disclosure; public Instagram handle @markdgrasso22; official employment records and docket details to confirm]

- J. [former adolescent-program client from 189 Orange / Matt Fields allegation; identity to distinguish from other J. entries if needed]
- Matt Fields / Matthew Fields, LMFT [therapist identified by public photo review and public Turnbridge-associated materials]
- Will [last name to confirm; summer 2022, Foxon Boulevard / Hobby Lobby-area house]
- Joseph Moura / Joe Moura [staff member identified as September 28, 2021 Holy Family Hospital pickup / 189 Orange intake transport staff; role, schedule, and records to confirm]
- J. [client from late-2021 airport story]
- J.'s girlfriend
- J.'s girlfriend's father
- H. [client from early-2022 denied-access story]
- H.'s girlfriend
- H.'s girlfriend's father
- Skinny younger client from early-2023 Phase 1 safety concern [name unknown]
- Heavier client returned to Phase 1 after alleged restraint / beating incident [name unknown]
- Second client who heard the early-2023 concern [name unknown]
- Second case manager present when I disclosed the M.S. Venmo / outing-threat incident to Douglas Roberto
- Client allegedly asked by Douglas Roberto to sweep the Phase 3 house after the alleged ski-mask intruder incident
- Other clients who heard or repeated the Douglas Roberto / ski-mask intruder allegation
- Other Structured Group / Carriage House clients present for Steve Tobey's alleged self-disclosure
- Other clients present for Dave Murphy's March / April 2022 East Haven lecture
- Other clients who heard J. say he felt "conned"
- Other clients who knew J. was watching The Wire and not attending groups
- Other clients who heard H. describe the denied-access / girlfriend's father incident
- Other clients present during the Will inhaler / asthma incident
- Other clients who witnessed Will allegedly restraining or tickling clients
- Other clients who heard Will allegedly tell gas-station robbery stories

- Chris Meyer / Chris Myer [employment identity, Turnbridge staff role, public police-log identity, transportation role, and court disposition to verify]
- Witnesses to the alleged Chris Meyer client-assault / rehiring incident
- Clients or staff who saw the deleted Reddit account before deletion or can identify the author
- Witnesses to the Chris Meyer late-2022 NYC transportation arrangement
- Family members with payment or arrangement records for the Chris Meyer ride
- W.H. [source of later phone allegation concerning Liam]
- Other client who was speaking with Z.T. during the hushed Liam discussion
- Former adolescent-program client allegedly involved in the Liam allegation, if legally and ethically obtainable

Records to seek or preserve

- CCTV footage from the February 2022 M.J. / C.S. fire-extinguisher incident
- CCTV footage from the late-2021 90 Ford Street chair assault involving C.
- CCTV/camera-access logs showing who reviewed or replayed footage
- Phase 1 incident reports
- 90 Ford Street shift logs
- 1212 Quinpiac Avenue shift logs
- Mark David Grasso / Mark Grasso employment / shift records showing assignment or presence at 1212

Quinpiac

Avenue

around the L.M. disclosure

- Records or witness accounts showing that Mark Grasso overheard my disclosure to E.O. about L.M.
- Early-2023 Phase 1 records involving any client taken off site after restraining / beating another client and then returned

to shared housing

- Phase II records and client/staff schedules for 520 Whitney Avenue / Whitney-Canner in early-to-mid 2022
- Peter McConnell Phase II schedules, meeting records, and client accounts concerning political /

ideological lectures or

private-meeting redirections

- Public property / article records for 520 Whitney Avenue as a CT Clinical Services / Turning Point sober-house property

- Phase 3 East Haven house rosters / staff schedules from March or April 2022
- Records identifying the Phase 3 transitional house in East Haven a few blocks from Hobby Lobby
- Records identifying the Turnbridge house a few blocks from Foxon Boulevard / Hobby Lobby in summer 2022
- Dave Murphy schedules, meeting notes, house logs, or client accounts concerning the March / April 2022

"lazy / burden

on

parents" lecture

- Will's full name, employment records, and staff schedules for the Foxon Boulevard / Hobby Lobby-area house in summer 2022

- Medication logs showing inhaler access, denial, or request timing during the Will / asthma incident
- House logs or shift notes from the day of the asthma attack
- Medical records, therapist disclosures, family disclosures, or contemporaneous messages concerning the asthma attack

or

inhaler denial

- Witness accounts from clients present when I asked Will for the inhaler
- Witness accounts from clients who heard Will say I was "faking it" or "getting high" off albuterol
- Witness accounts from clients who saw Will restrain or tickle clients
- Witness accounts from clients who heard Will tell stories about gas-station robberies with ski masks and

toy guns

- Phase II Tuesday movie-trip schedules around November 2022
- Records showing a Phase II outing to see Nope
- 520 Whitney Avenue house roster from the November 2022 movie-trip period
- Venmo record showing \$50 payment to M.S.
- Social-media messages / threat texts from M.S.
- Douglas Roberto case-management notes or records concerning my disclosure about the Venmo / outing threat

- Identity and records of the second case manager present during that disclosure
- C.R.'s direct account concerning the Steve Tobey allegation
- Other client accounts concerning the Steve Tobey allegation
- J.'s direct account concerning the Matt Fields / 189 Orange walk allegation
- Other adolescent-program clients who may have heard J. describe the Matt Fields / 189 Orange allegation
- Employment records confirming Matt Fields / Matthew Fields, LMFT's adolescent-program role, dates, and

assignment to

189 Orange and his last name

- Staff schedules showing Matt Fields assigned to 189 Orange during late 2021 / early 2022
- Clinical-building records, appointment schedules, or movement/walk records involving J. and Matt Fields
- Prior complaints, clinical notes, staff communications, or contemporaneous disclosures concerning Matt

Fields' conduct

with adolescent clients

- Liam employment records / termination timeline
- W.H.'s direct account of the 2023/2024 phone call concerning the Liam allegation
- Call logs, texts, notes, or contemporaneous messages connected to the W.H. phone call
- Z.T.'s account of the late-2022 or 2023 hushed discussion concerning why Liam was fired
- The other client who was speaking with Z.T. during that hushed discussion
- Internal Turnbridge records concerning any complaint, investigation, mandated report, or separation

involving Liam

- Former adolescent-program client's account, if legally and ethically obtainable
- Records showing whether Liam was quietly let go, fired, suspended, transferred, or otherwise separated
- Staff schedules for separate-property relapse sequestering involving H.V. and C.
- Records connecting Liam to separate-property relapse sequestering involving H.V. and C.
- Records concerning allegations that Liam gave clients THC pen hits while on or around staff duty
- Written reports involving L.M., A.S., C., M.J., C.S., M.S., E., C.R., Will, Matt Fields / Matthew

Fields, Liam, or

adolescent-program client J.

- House logs, police reports, incident reports, 911 calls, or internal communications concerning the alleged Douglas

Roberto

/ ski-mask intruder incident

- HR / termination records showing whether Douglas Roberto was fired and when
- J.'s direct account concerning being brought to Turnbridge against his wishes, feeling "conned," not

attending groups,

arranging a plane ticket, and the alleged girlfriend's-father contact

- J.'s girlfriend's account
- J.'s girlfriend's father's account
- J.'s flight / airline records, if preserved
- Texts or call logs between J. and his girlfriend
- Turnbridge records concerning J.'s intake, consent status, discharge attempt, departure, or return
- Staff notes or communications around J. leaving / attempting to leave
- H.'s direct account concerning the alleged denied-access / girlfriend's-father contact
- H.'s girlfriend's account
- H.'s girlfriend's father's account
- Texts or call logs between H. and his girlfriend
- Turnbridge records concerning H.'s intake, consent status, attempted departure, discharge request, or

outside contact

- Staff notes or communications around H. attempting to leave
- R.'s direct account, if he consents, concerning the March 2026 90 Ford Street attempted departure / sober-house transfer issue
- D4rkhunter55's current-client witness account and message screenshots concerning R.'s alleged March 2026 departure-interference incident
- R.'s girlfriend's and family members' accounts, if legally and ethically obtainable
- Bark Phone logs, call logs, number-blocking records, bus-ticket records, Phase 1 / 90 Ford Street house logs, and Drew Behr staff schedules from early March 2026
- Turnbridge records concerning R.'s request to leave, transfer, discharge, AMA status, phone access, family contact, outside contact, and any morning-meeting comments after R. left
- Public articles and archived copies for Peter McConnell, Chris Meyer / Chris Myer, Thomas Marzilli /

Marzilli, Dayton

Kingery,

Ian Parker, and Douglas Roberto

- Court dispositions where available, especially for public-record items currently described only as arrests/charges
- Original police/news/court sources for Peter McConnell identity and disposition verification
- Records confirming exclusion of the separate 2023 Coventry / different-McConnell item from Peter McConnell evidence
- Chris Meyer criminal case / court disposition records
- Chris Meyer incident reports, staff schedules, HR/rehiring records, witness accounts, and internal communications concerning the alleged client assault / beating and alleged return to work afterward
- Patch / Southington police-log clipping naming Christopher William Meyer, age 35, of Ford Street, Hamden, and listing charges
- Court disposition records for Christopher William Meyer
- Turnbridge "Unsung Hero" / staff-profile materials for Chris Meyer / Chris Myer
- Records showing Chris Meyer transportation duties, rehiring, client-contact responsibilities, or late-2022 transportation arrangements
- Family payment records, calendar records, texts, emails, or other records concerning the late-2022 Chris Meyer NYC transport
- Contemporaneous therapist, family, or client disclosures about the Chris Meyer car ride
- Public reporting anchoring the Fair Haven / "Fast Eddie" murder story
- Records or witness accounts showing that Chris Meyer discussed the "Fast Eddie" case during a client transport
- Any witness, text, note, or disclosure confirming Meyer stated he was the intended target in the "Fast Eddie" case
- Transportation policy addressing staff discussion of personal criminal histories, local violence, drug-world stories, or sexual / relationship content with clients
- Records showing whether Turnbridge knew of or evaluated Meyer's personal-history disclosures, transportation judgment, or client-contact boundaries
- Reddit thread screenshots / Wayback captures involving the deleted commenter who defended old Turnbridge / Ford Street culture and praised "a guy named Chris"
- Evidence, if any, identifying the deleted Reddit commenter before deletion
- Witnesses who remember seeing the deleted Reddit account name or account history
- Colorado DORA licensing documents / online documents for Thomas Paul Marzilli voluntary surrender / relinquishment action
- Archived Google Reviews capture
- Original Google review screenshots: Sarah Glenn Leventis, Leighann Hutchinson / Margaret Doty, David M, Eliza Taylor, Aria
- Live Google URLs or video captures showing path from Turnbridge Google listing to each review
- Rehabs.com screenshots and live page captures
- Glassdoor screenshots and live page captures
- Bad Review Index backup
- Positive-review pattern notes
- Review-solicitation / review-removal communications, if obtainable
- Internal policies on public reviews, review requests, reputation management, or removal requests
- Additional records to seek or preserve for Joseph Moura / September 28, 2021 intake / program-length disclosure concerns
- Holy Family Hospital discharge / transfer records from September 28, 2021
- Turnbridge transportation records identifying Joseph Moura / Joe Moura as the pickup staff member
- Joseph Moura employment, role/title, staff schedule, and assignment records for September 28, 2021

- Turnbridge intake records and contracts signed at 189 Orange Street on September 28, 2021
- Admissions materials, admissions scripts, and family communications describing expected length of stay
- Records, notes, emails, texts, or call logs referring to "28 days," "30 days," "long-term," "year-long,"

expected duration, or length-of-stay assumptions

- Call logs and witness accounts from friends who spoke with me during the transport and heard me say I would be gone for "28 days"

- Internal notes concerning my understanding of program duration, contract signing, transportation, consent, or intake

- Billing / payment records showing expected duration, monthly costs, deposits, or family payment expectations

Additional records to seek or preserve for PS4 / client property concerns

- 1212 Quinipiac client-property records from January-May 2023
- Property inventory or missing-property report concerning the PS4, if any
- Eric Regensburg case-management notes concerning the missing PS4
- Staff schedules and house logs for 1212 Quinipiac during the relevant period
- Client-property policies, reimbursement policies, and missing-belongings procedures
- Communications with family, staff, or clients about the PS4 being left at 1212 Quinipiac or later

missing

- Records concerning Eric Regensburg leaving or planning to leave for a Florida job, if relevant to timeline reconstruction

Additional records to seek or preserve for client-culture concerns

- Clinical staff present during the early-2023 D. / L.M. sexual-shaming incident, including Chris Rush
- Other clients present during the early-2023 sexual-shaming incident
- Group schedule, clinical schedule, or room assignment for the early-2023 incident
- Clinical notes or incident notes concerning the false L.M. sexual allegation / sexual shaming
- H.V.'s account of allegedly calling J. an anti-gay slur, if obtainable
- J.'s account of being called an anti-gay slur after accusing H.V. of beating women
- Witnesses to the H.V. / J. late-2021 incident
- K.G.'s account of the alleged adolescent-house beating
- W.H.'s account of the alleged adolescent-house beating
- Adolescent client's account, if legally and ethically obtainable
- Adolescent house rosters, staff schedules, incident reports, and medical records connected to the K.G. /

W.H. allegation

- D.W.'s account of calling Q.R. an anti-gay slur
- Q.R.'s account of the December 2021 520 Whitney group conflict
- C.M.'s group records, staff notes, or participant records from 520 Whitney Avenue around December 2021
- D.W.'s account of the racial-slur / fried-chicken incident involving L.B.
- L.B.'s account of the racial-slur / fried-chicken incident
- Witnesses to the L.B. / D.W. fistfight
- House logs, incident reports, or staff notes concerning the L.B. / D.W. fight
- Reddit thread screenshots / Wayback captures involving the deleted commenter defending "Chris" and old

Turnbridge /

Ford Street staff culture

- Staff member's account concerning the trans woman allegedly "emotionally terrorized" in the men's young-adult

program

- Placement records and policy records concerning transgender clients in gendered programming
- Records concerning the trans woman's placement circa early 2021
- Clinical notes, incident reports, or staff communications concerning gender-identity harassment or

emotional

terrorization

- Screenshots of the Q.R. group chat using D.W.'s mugshot / arrest article, if preserved
- D.W.'s account of the mugshot / arrest-article group chat
- Q.R.'s account of the group chat
- Other clients who received, saw, or mocked the group chat
- Staff notes or clinical interventions concerning the mugshot / arrest-article group chat
- Identity and account of the client allegedly "knocked out" on the first floor of 189 Orange Street after

being labeled a

"snitch"

- Identity and account of the client who allegedly knocked him out
- Witnesses to the alleged 189 Orange first-floor incident

- 189 Orange Street clinical-building staff present at the time
- CCTV footage from the first floor of 189 Orange Street, if available
- Incident reports, clinical notes, medical documentation, or staff communications concerning the alleged

189 Orange

"snitch" retaliation incident

Additional records to seek or preserve for L.M. / forced exposure / Dave Murphy / "Scarface Adam" sexual-safety concerns

- House address, roster, and staff schedules for the Turnbridge house nearest to 189 Orange Street, across the bridge near Fair Haven, in early 2023
- B.H.'s account of the alleged L.M. pants-pulling / forced-exposure incident
- A.'s account of the alleged L.M. pants-pulling / forced-exposure incident
- Identity and account of the third client present during the alleged forced-exposure incident
- L.M.'s account
- Any house logs, incident reports, clinical notes, or staff notes concerning L.M. pulling down my pants and underwear
- Records showing whether Turnbridge staff were aware of ongoing sexual-boundary or harassment concerns involving L.M.
- Records showing whether I was separated from L.M. or given a safety plan after the 1212 Quinpiac disclosure
- Dave Murphy's account of the early-2023 office meeting concerning sexual rumors and pronouns
- Dave Murphy staff schedules / case-management notes / meeting notes from early 2023
- Any documentation of sexual rumors involving me and L.M.
- Any records showing how Turnbridge enforced rules against client sexuality or client dating across same-sex, queer-coded,

and male-female client relationships

- Client accounts concerning male-female client dating during the same period, including R.P. and A.K.
- Policies on client sexuality, client dating, gender identity, pronoun use, LGBTQ client support, sexual rumors, and sexual-boundary complaint handling
- Identification of the client known as "Scarface Adam"
- T.K.'s direct account, if legally and ethically obtainable
- Court records, police reports, docket records, or legal filings concerning the alleged "Scarface Adam" / T.K. matter
- Clients who told me in 2021 that "Scarface Adam" was facing legal proceedings related to the alleged rape of T.K.
- 90 Ford Street house rosters, staff schedules, clinical notes, house logs, or incident reports concerning "Scarface Adam,"

T.K., or client discussion of the alleged matter

- Records showing whether Turnbridge staff knew about the alleged "Scarface Adam" / T.K. legal-proceeding issue and what

action, if any, was taken

Additional records to seek or preserve for J.E. / D.A. sexual-privacy incident concerns

- J.E.'s direct account and direct-message screenshots concerning the alleged recording / distribution and staff response
- Names / accounts of clients who received, saw, or discussed the video
- Records identifying D.A., his placement, and any phase-down / disciplinary action in early 2022
- House rosters, staff schedules, case-management notes, incident reports, house logs, and clinical notes

for the Foxon Boulevard / Hobby

Lobby-area house in early 2022

- Douglas Roberto case-management notes, staff communications, or supervision records connected to the incident
- Documentation showing whether staff knew the details, what action was taken, who was notified, and whether police, parents, guardians, legal counsel, or outside authorities were contacted
- Records showing whether J.E. was interviewed, supported, safety-planned, asked what he wanted, or meaningfully involved in the response
- Device / phone handling records, message-preservation records, recipient-identification records, and deletion / evidence-preservation documentation, if any

XII. Findings and Recommended Use

Finding 1: Negative public reviews are specific enough to warrant preservation The negative public reviews do not read

as a single generic complaint. They allege concrete issues: self-harm monitoring failure, contraband / weapons / drug

checks, unsafe outside contact, sexual assault by another patient, staff dismissiveness, poor supervision, money motive, poor communication, admissions mismatch, identity-related unsuitability, medication concerns, and review-management concerns. Finding 2: The positive review record should be treated as mixed, not dismissed wholesale. Some positive reviews are detailed parent / alumni accounts. Others are thin, relationship-based, clustered, professional / referral-adjacent, or temporally suspicious enough to require context. The star average is therefore insufficient as a due-diligence answer. Finding 3: The employee-review record is relevant but not dispositive. Glassdoor's reported employee-review pattern and visible management / culture allegations support asking staff-quality questions, but employee reviews alone cannot prove client-safety incidents. Finding 4: The strongest archive posture remains records-based. The memo should ask Turnbridge, regulators, journalists, and attorneys to test the allegations through incident reports, CCTV logs, rosters, staff schedules, HR records, family communications, clinical notes, medication logs, transportation records, staff-termination records, and review-solicitation records.

XIII. Recommended Public Sentence

This archive does not ask families to accept every allegation as proven. It asks Turnbridge to produce the records that should exist if client-safety complaints, sexual-boundary disclosures, self-harm risks, contraband concerns, medication concerns, staff-vetting concerns, transportation concerns, admissions / program-length representations, contract-signing concerns, staff-retention concerns, staff-termination concerns, and review-integrity concerns were documented and addressed.

XIV. Archive-Safe Conclusion

The material above suggests a pattern of potential institutional failure involving client-on-client violence, sexual-boundary issues, coercion / harassment between clients, staff cruelty, inadequate response to threats and harassment, questionable staff vetting for direct-access and leadership-adjacent roles, possible licensing / professional-credential concerns in leadership, ideological / political boundary issues from staff, shame-based family-pressure rhetoric, house-security / staff-judgment concerns, staff sexual-boundary / self-disclosure concerns, therapist-boundary / adolescent-program cruelty concerns, client-autonomy / attempted-departure concerns, medical-safety / medication-access concerns, staff physical-boundary / judgment concerns, staff-transportation concerns, staff-retention concerns, staff-termination concerns, public-review concerns, review-integrity concerns, client-property / missing-belongings concerns, and client-culture / identity-based hostility concerns. The strongest firsthand material concerns events I personally witnessed or experienced, including staff replaying CCTV footage of client violence while mocking clients, staff inaction after a sexual-boundary disclosure, violent incidents captured on

camera, staff-conduct concerns involving transportation and boundaries, staff using authority in treatment settings to moralize clients' politics and identities, staff shaming clients as lazy burdens on their parents, staff failing to meaningfully respond after I disclosed an alleged outing threat and coerced Venmo payment, the September 28, 2021 Joseph Moura / Holy Family Hospital pickup and 189 Orange contract-signing account involving my stated "28 days" understanding and later disclosure that the program was actually year-long, my firsthand memory of a circulated intimate video involving J.E. and D.A. with J.E. later alleging staff knowledge and internal handling, and staff allegedly refusing access to an inhaler during an asthma attack. The public-record material should be used carefully. Arrests and charges should not be described as convictions unless final court disposition is verified. Same-name hits should not be used unless multiple identity anchors confirm that the public record belongs to the same person later employed by Turnbridge. Licensing records should be described only according to what the licensing source actually shows unless underlying board documents establish additional facts. The Chris Meyer / Chris Myer material is a central staff-vetting and staff-retention cluster. It includes Turnbridge's own public identification of Meyer as Phase I support staff; a firsthand recollection of a late-2022 client-transport ride involving reckless driving, disclosure of family payment information, chaotic personal phone calls, Fairhaven drug-story material, discussion of the Fair Haven / "Fast Eddie" murder, and Meyer allegedly stating that he was the person who was supposed to be killed by the person later charged in that case; prior archive / Reddit recollections that Meyer allegedly assaulted or beat up a client and was then rehired or allowed back; public police-log reporting listing charges against Christopher William Meyer of Ford Street, Hamden; and a deleted Reddit comment defending old Turnbridge / Ford Street staff culture while singling out "a guy named Chris" as "by far the best SS and employee." These Chris Meyer items should not be collapsed into a single proven finding. The public police-log item should be described only as charge reporting unless court disposition is verified. The alleged client-assault / rehiring item should be described as a recollection requiring corroboration. The deleted Reddit comment should be described as an unattributed public Reddit lead; I suspect the commenter may have been Chris Meyer, but authorship is unverified. The "Fast Eddie" item should be described only as something Meyer allegedly discussed during the car ride; no claim should be made that Meyer was involved in the Fair Haven murder. Meyer's alleged statement that he was the intended target should be treated as a firsthand recollection of what Meyer said, not as a verified fact. The Liam material should be handled as a staff-boundary / termination-context cluster requiring corroboration. In late 2022 or 2023, I remember Z.T. discussing why Liam was fired in a hushed voice with another client and becoming hesitant to tell me details. Later, in 2023 or 2024, W.H. informed me by phone of the allegation that Liam was fired after allegedly trying to meet up with an underage former adolescent-program client while Liam

was an adult support staff member in the young-adults program. Separately, I heard that Liam allegedly gave H.V. and

C. hits from a THC pen while they were sequestered after relapse. These allegations should not be

stated as proven without corroboration, but they raise serious questions about staff boundaries, adolescent-program safeguards, relapse-management supervision, internal reporting, termination practices, and whether serious staff-conduct concerns were documented or quietly handled. The Mark David Grasso / 1212 Quinnipiac item is included as both a firsthand staff-response concern and a staff-vetting / reentry-background context note. Specific charge, docket, conviction, or disposition claims should not be made unless official records are located and confirmed. Secondhand allegations, including the newly preserved 2021 "Scarface Adam" / T.K. sexual-assault legal-proceeding lead, the Douglas Roberto / ski-mask intruder allegation, the Steve Tobey / C.R. sexual-boundary allegation, the Matt Fields / adolescent-client J. 189 Orange allegation, the J. airport story, and the H. denied-access story, should be preserved as leads requiring corroboration rather than stated as proven fact. The J. and H. stories are included because they may bear on a broader question of whether Turnbridge used outside family or third-party pressure to interfere with clients' attempts to leave or obtain help leaving. The public-review record independently echoes several categories already present in the archive: peer-safety concerns, supervision failures, sexual-boundary and complaint-handling concerns, staff-quality concerns, money / retention concerns, admissions mismatch, marketing mismatch, identity-related concerns, medication concerns, transportation concerns, and review-integrity concerns. It does not prove every specific allegation, but it strengthens the case for written due-diligence questions and records requests. The central institutional question is not whether every allegation can be proven from memory alone, but whether Turnbridge maintained adequate supervision, documentation, reporting, admissions representations, informed-consent procedures, contract-signing safeguards, staff conduct standards, pre-employment screening, professional-credential review, political / ideological boundary standards, staff-retention safeguards, staff-termination safeguards, staff-transportation safeguards, house-security protocols, sexual-boundary standards, therapist-boundary standards, adolescent-client safeguards, client-autonomy protections, outside-contact boundaries, medication-access procedures, medical-response protocols, physical-boundary standards for staff, public-review integrity controls, client-property safeguards, identity-based harassment response protocols, and client-safety procedures for people placed in direct authority over vulnerable clients. This record is held for archival preservation, institutional transparency, and due-diligence review. Drew Behr "Curbstomp" Allegation, W.S. Suicide-Attempt / Phase-Down Concern, Maura/Moira/Mara 189 Orange Group-Removal Incident, and Recent Google Review-Integrity Concern

Prepared by: Former Turnbridge / Turning Point client

Date: June 2026

Purpose: Addendum to existing Turnbridge / Turning Point investigative / due-diligence memo

Short Description

This addendum supplements my existing Turnbridge / Turning Point investigative memo with four additional concerns

that should be preserved and tested through records.

The lead item is a firsthand allegation involving Drew Behr, then my Phase 1 case manager at 90 Ford Street, allegedly

telling me he had thought of "curbstomping" me and explicitly referencing American History X. The addendum also

preserves a W.S. suicidality / phase-down concern; a summer 2022 group-removal incident at 189 Orange involving

Maura / Moira / Mara [last name unknown] after client D. criticized the Turnbridge care team's influence over parents;

and a recent Google review-integrity concern involving a detailed negative former-client review followed shortly

afterward by a thin 5-star review.

The purpose is not to ask readers to accept every item as proven without records. The purpose is to preserve the

allegations, distinguish firsthand from reported material, and identify records Turnbridge should be able to produce if

serious staff-conduct, client-safety, suicidality, autonomy, family-communication, complaint-response, and review-integrity issues were properly handled.

I. Lead Addendum: Drew Behr Staff-Threat / "Curbstomping" Allegation

Approximate date: Late September / early October 2021

Location: 90 Ford Street

Program context: Phase 1

Staff involved: Drew Behr

People involved: Drew Behr; myself; my parents as relevant family-contact context

Type: Staff intimidation; violent threat-adjacent statement; family-contact interference; misuse of authority; client

safety; staff-boundary concern; records-preservation issue

Account

In late September or early October 2021, while I was in Phase 1 at 90 Ford Street, Drew Behr instructed my parents

not to take my phone calls. After an altercation between Drew and me that began in that context, Drew took me into his

office at 90 Ford Street.

In that office, Drew told me that he had told his wife he thought of "curbstomping" me. He explicitly referenced the film

American History X to describe what he wanted to do to me.

This is included as a serious staff-conduct and client-safety allegation. A staff member in a treatment setting allegedly

restricting a client's family contact and then privately describing a desire to "curbstomp" that client raises questions

about intimidation, retaliation, violent language, staff judgment, clinical oversight, supervision, family-contact practices,

and whether violent staff statements were documented or addressed.

This allegation is especially important because Drew Behr is already discussed in the main memo in connection with

my allegation that he replayed CCTV footage of client-on-client violence while mocking clients. The new allegation

strengthens the same institutional question: whether Turnbridge documented, tolerated, ignored, normalized, or

promoted staff behavior that treated violence and humiliation as part of the treatment environment.

It also matters because Drew Behr was not merely a random person in my experience. He was my Phase 1 case manager during this period, and to my understanding he later became a major institutional figure at Turnbridge. That

raises additional questions about staff supervision, promotion, internal accountability, and whether prior client-safety or staff-conduct concerns were preserved or considered.

Why this matters

This allegation is not about ordinary staff harshness, tough love, or interpersonal conflict. If accurate, it involved a staff

member in a paid treatment setting describing a desire to commit extreme violence against a client after allegedly

interfering with that client's family contact.

That combination raises institutional questions:

- What authority did Drew Behr have over client phone access and family contact?
- Was my family instructed not to take my calls?
- Was there a written policy or clinical rationale for that instruction?
- Was the altercation documented?
- Was the private office meeting documented?
- Were violent staff statements to clients prohibited, reported, supervised, or disciplined?
- Did Turnbridge have any record of staff intimidation or violent language involving Drew Behr?
- Were any such concerns considered in Drew Behr's later institutional role progression?

Potential records / corroboration

Records or witnesses that could test this allegation include:

- My parents' recollection of Drew Behr instructing them not to take my calls.
- Family call logs, texts, or emails from late September / early October 2021.
- 90 Ford Street house logs and staff schedules from late September / early October 2021.
- Phase 1 family-contact / phone policies.
- Any incident report, clinical note, or staff note related to the altercation.
- Any staff note or clinical documentation concerning a private office meeting between Drew Behr and me.
- Contemporaneous disclosures to family, therapist, sponsor, staff, or other clients.
- Turnbridge employment and promotion records showing Drew Behr's role progression.
- Turnbridge policies governing staff threats, violent language, retaliation, intimidation, and private

staff-client meetings

after conflict.

- HR, supervision, or internal records concerning complaints about Drew Behr's conduct.

Archive classification

Firsthand allegation involving staff conduct, family-contact interference, violent threat-adjacent language, and

client-safety concern. Corroboration may exist through family recollection, phone/contact records, staff schedules,

house logs, clinical notes, and any contemporaneous disclosure.

II. Addendum: W.S. Reported Suicide Attempt, Five-Day Removal, Return,

and Phase-Down to 520 Whitney

Approximate date: Mid-2022

Initial program/location: Phase 3 house

Return / later placement: Phased down to 520 Whitney / Phase 2 after return

Client involved: W.S.

Type: Suicidality / self-harm concern; removal from facility; phase-down after crisis; client autonomy; alleged refusal to

permit departure; retention concern; records-preservation issue

Account

In mid-2022, W.S. was living in a Phase 3 Turnbridge house. W.S. reported to me that he had tried to kill himself and

had been removed from the facility for approximately five days. I can personally confirm that W.S. was absent from the

program environment for approximately five days.

After he returned, W.S. was not returned to the same level of freedom. He was "phased down" from Phase 3 to 520

Whitney / Phase 2.

According to what W.S. reported to me, Turnbridge refused to let him leave or remain out of the program and instead took him back into the program, where he remained for approximately another year despite his stated wishes and complaints.

I did not personally witness the suicide attempt or the internal decision-making around W.S.'s removal, return, or phase-down. The suicide-attempt account and alleged refusal to let him leave come from W.S.'s report to me.

However, I can confirm his approximate five-day absence and later presence at 520 Whitney after being phased down.

Why this matters

This allegation raises serious questions about self-harm response, discharge rights, client autonomy, clinical decision-making, family communication, safety planning, level-of-care decisions, and whether Turnbridge retained a vulnerable client after a serious safety crisis despite that client's stated opposition.

If W.S.'s account is accurate, Turnbridge should have extensive records explaining how a Phase 3 client's reported suicide attempt, five-day removal, return to program care, phase-down to 520 Whitney / Phase 2, and roughly year-long continued placement were assessed, documented, justified, and communicated.

The institutional questions include:

- What happened during W.S.'s reported suicide attempt?
- Where was W.S. removed to for approximately five days?
- What outside provider, hospital, ER, crisis service, family member, or clinical authority was involved?
- Who authorized his return to Turnbridge?
- Why was he phased down from Phase 3 to 520 Whitney / Phase 2?
- What safety plan existed after his return?
- Did W.S. request to leave?
- Did W.S. object to returning or remaining?
- What was his family told?
- What was billed during or after this period?
- What documentation exists regarding discharge, refusal of care, client autonomy, and continued placement?

Potential records / corroboration

Records or witnesses that could test this allegation include:

- W.S.'s direct account.
- Phase 3 house logs / rosters from mid-2022.
- Records confirming W.S.'s approximate five-day absence.
- 520 Whitney / Phase 2 rosters showing his return and phase-down.
- Incident reports or clinical notes concerning suicidality / self-harm risk.
- Hospital, ER, crisis center, or outside-provider records, if applicable and legally obtainable.
- Discharge / return-to-program documentation.
- Level-of-care / phase-down decision records.
- Family communications about W.S.'s removal, return, and phase-down.
- Clinical risk assessment and safety-plan records.
- Records of whether W.S. requested to leave or objected to returning.
- Policies on suicide attempts, self-harm monitoring, phase-downs, discharge, refusal of care, and client autonomy.
- Billing / retention records, if relevant to how long W.S. remained after the incident.

Archive classification

Mixed firsthand / reported allegation. I can personally confirm W.S.'s approximate five-day absence and later presence

at 520 Whitney after being phased down. The suicide-attempt account, alleged refusal to let him leave, and alleged

continued placement against his wishes come from W.S.'s report to me and require corroboration through W.S.,
program records, family communications, medical records, and house logs.
Key addendum sentence
This allegation is significant because it raises the question of whether Turnbridge responded to a reported suicide attempt by prioritizing client safety and autonomy, or by using a phase-down and continued placement to retain a vulnerable client despite his stated opposition.

III. Addendum: Maura / Moira / Mara 189 Orange Group-Removal Incident

After D. Criticized Turnbridge Care Team's Influence Over Parents

Approximate date: Summer 2022

Location/program: 189 Orange Street / Turnbridge clinical or group therapy setting

Staff involved: Maura / Moira / Mara [last name unknown], therapist or clinical staff member

Clients involved: Myself; D.

Type: Clinical suppression of criticism; family-manipulation concern; staff retaliation / group removal; client speech /

complaint-response concern; family-communication concern; records-preservation issue

Account

In approximately summer 2022, during a therapy or group setting at 189 Orange Street, client D. said words to the

effect of: "Nobody can be as manipulative as the Turnbridge care team toward my parents." I laughed and said,

"Facts."

Maura / Moira / Mara, a therapist or clinical staff member whose last name I have not yet confirmed, responded by

kicking me out of the therapy / group setting.

This is included because D.'s statement criticized Turnbridge's care team and its alleged influence over parents. Rather

than treating that statement as clinically relevant feedback about how clients experienced family communication, staff

power, and parental messaging, Maura / Moira / Mara allegedly removed me after I verbally agreed.

Why this matters

If clients believed the care team was manipulating their parents, that should have been treated as meaningful clinical

information, not simply defiance, disrespect, or disruption. Removing a client for agreeing with that criticism raises

questions about whether Turnbridge therapists used group authority to suppress criticism of the program, especially

criticism involving family communication and parental influence.

This concern matters because family communication was central to Turnbridge's power over clients. Families paid

substantial money, received program updates, and were often instructed how to interpret clients' complaints, distress,

resistance, or requests to leave. If clients were explicitly saying that the care team was manipulating their parents, that

statement should have been documented and explored, not shut down.

The fact that this allegedly occurred at 189 Orange Street matters because 189 Orange was a central clinical / program

location rather than a casual offsite conversation. If a therapy or group setting inside the clinical building treated

criticism of the care team as grounds for removal, that is directly relevant to Turnbridge's clinical culture, complaint

response, and family-systems practices.

The institutional questions include:

- Who was Maura / Moira / Mara, and what was her role?
- What group or therapy session was this at 189 Orange?
- Was I formally removed from group?
- Was the removal documented?
- How did Turnbridge therapists handle client criticism of the program?
- Did Turnbridge treat criticism of care-team influence over parents as clinically relevant feedback or as defiance?
- Were clients permitted to discuss whether the program was manipulating, pressuring, or managing their parents?
- What policies governed group removal and client speech in therapy settings?
- Were concerns about family communication documented or shared with families?

Potential records / corroboration

Records or witnesses that could test this allegation include:

- Identity and full name of Maura / Moira / Mara.
- Summer 2022 group / therapy schedules for 189 Orange.
- Records identifying the 189 Orange group location and participants.
- Clinical notes, group notes, or incident notes from the relevant session.
- Any record of my removal from group.
- D.'s account of saying the care team manipulated his parents.
- Other clients present in the group.
- Turnbridge policies on group removal, client complaints, family-communication concerns, and criticism of the program.
- Any family communications around that period reflecting Turnbridge guidance to parents about client calls, complaints, resistance, or requests to leave.
- Records showing how Turnbridge documented client concerns about staff influence over parents.

Archive-safe public framing

A concise public version would be:

"In summer 2022, at 189 Orange, a therapist or clinical staff member allegedly kicked me out of group after D. said the care team manipulated his parents and I said 'facts.' That is not clinical care; that is protecting the institution from client criticism."

Archive classification

Firsthand account of group removal at 189 Orange after agreeing with D.'s criticism of Turnbridge's care team and parental influence. Staff identity requires confirmation as Maura / Moira / Mara [last name unknown].

Corroboration may

exist through 189 Orange group schedules, D.'s account, other client accounts, clinical notes, group notes, incident notes, and records of group removal.

IV. Addendum: Recent Google Review Integrity Concern After Detailed

Former-Client Review

Approximate date: June 2026

Platform: Google Reviews / Google Maps listing for Turnbridge

Reviews involved: Detailed negative former-client review posted under "Samuel Clemens"; later 5-star review by "Mickey Dice"

Type: Review-integrity concern; timing-sensitive positive-review pattern; low-probative 5-star review; consumer-information concern; records-preservation issue

Account

After I posted a detailed negative former-client Google review of Turnbridge under the name "Samuel Clemens," I

observed a timing pattern that raises a review-integrity concern.

At the time, the last visible Google review before mine appeared to have been approximately six days earlier. Within hours of my detailed negative review, a new 5-star Google review appeared from "Mickey Dice." The "Mickey Dice" profile appeared to have only one review, and the review itself appeared to be generic praise rather than a detailed firsthand account.

This should be stated carefully. I am not claiming as proven fact that Turnbridge created, ordered, solicited, or coordinated the "Mickey Dice" review. I am also not claiming that a one-review profile is automatically fake. The appropriate characterization is that the timing, account history, rating, and generic nature of the review create a review-integrity lead worth preserving.

Why this matters

Families often rely on Google reviews when evaluating high-cost treatment providers. A detailed former-client review alleging serious safety and institutional-response concerns can be diluted if a favorable review appears shortly

afterward, especially where the positive review is thin, generic, and from an account with little visible review history.

The issue is not whether one positive review proves manipulation. It does not. The issue is whether negative

former-client reviews are quickly counterweighted, buried, diluted, reported, suppressed, or pushed down by low-detail

positive reviews in ways that make public star ratings less useful for families evaluating risk.

This concern connects to the broader review-integrity section of the main memo, which already preserves public-review

pattern issues, including prior allegations that positive reviews may have been requested from former staff or clients,

clusters of positive reviews, thin one-line praise, relationship-based positive reviews, and the need to preserve dated

screenshots rather than relying on the star average alone.

Evidence to preserve

Relevant evidence includes:

- Screenshot of my detailed "Samuel Clemens" Google review.
- Screenshot showing the prior visible review was approximately six days earlier.
- Screenshot of the "Mickey Dice" 5-star review.
- Screenshot of the "Mickey Dice" profile showing only one visible review, if available.
- Timestamp or approximate timing showing the "Mickey Dice" review appeared within hours of my detailed

negative

review.

- Screenshot of the Turnbridge Google review list sorted by newest.
- Screenshot of the review count and star rating before and after my review and the "Mickey Dice" review, if available.

- Visibility checks showing whether my review remained visible when logged out, in private browser, or from another account.

- Any Google notification about review moderation, removal, restriction, or policy review.
- Any later positive-review cluster following my negative review.

Records / questions for Turnbridge

If Turnbridge or its agents engaged in review management, relevant records may include:

- Internal communications about the "Samuel Clemens" Google review.
- Internal communications about the "Mickey Dice" review.
- Communications with staff, alumni, families, consultants, or reputation-management vendors after my review

appeared.

- Communications asking anyone to post a positive review after a negative review.
- Communications with Google or any third party concerning reporting, removing, suppressing, or responding to negative reviews.

- Review-solicitation policies.
- Reputation-management contracts or vendor communications.
- Internal policies on public reviews, review requests, review responses, or review removal.

Archive-safe language

The safest current phrasing is:

"After my detailed negative Google review under the name 'Samuel Clemens,' a 5-star review by 'Mickey Dice'

appeared within hours, after what appeared to be an approximately six-day gap since the prior visible review. The

'Mickey Dice' account appeared to have only one review, and the review appeared generic. This does not prove

manipulation, but it is a timing-sensitive review-integrity concern that should be preserved with screenshots and visibility checks."

Archive classification

Review-integrity lead requiring screenshot preservation and additional corroboration. Not proof of direct manipulation

unless additional evidence establishes coordination, solicitation, reporting, suppression, or other platform /

reputation-management conduct.

V. Combined Institutional Significance

These four addendum items strengthen the core concern in the main memo: Turnbridge / Turning Point should be able

to produce records showing how it handled staff conduct, client safety, self-harm risk, family contact, client autonomy, criticism of the program, review integrity, and complaint response.

The Drew Behr allegation raises the question of whether staff intimidation and violent language toward clients were documented, addressed, or normalized.

The W.S. allegation raises the question of whether Turnbridge responded to suicidality by prioritizing safety and

autonomy, or whether a vulnerable client was returned, phased down, and retained despite objections.

The Maura / Moira / Mara allegation raises the question of whether therapists at 189 Orange treated criticism of

Turnbridge's influence over parents as clinically relevant feedback or as a problem to suppress.

The Google review concern raises the question of whether families evaluating Turnbridge have access to detailed

negative former-client accounts, or whether public review systems may understate risk through suppression, removal,

rapid counterweighting, ranking behavior, or reputation management.

The central records questions remain:

- What did Turnbridge document?
- Who knew?
- What action was taken?
- What were families told?
- What policies governed the response?
- What records exist?
- Were complaints, safety concerns, staff threats, self-harm crises, client criticisms of parent manipulation, and negative reviews handled transparently?

VI. Additional Records To Request or Preserve

For this addendum, the following records should be added to the existing preservation list.

Drew Behr / 90 Ford / "Curbstomping" Allegation

- 90 Ford Street house logs and staff schedules from late September / early October 2021.
- Phase 1 phone-contact and family-contact policies.
- Records of any instruction to my parents not to take my calls.
- Clinical notes or incident reports concerning the altercation that preceded the office meeting.
- Records of private staff-client meetings after staff-client conflict.
- Drew Behr supervision, HR, role progression, promotion, and complaint records.
- Policies on staff intimidation, violent language, retaliation, and threats toward clients.

W.S. Suicide-Attempt / Phase-Down Concern

- Phase 3 house logs / rosters from mid-2022.
- Records confirming W.S.'s five-day absence.
- Outside-provider, ER, hospital, or crisis-service records if legally obtainable.
- Return-to-program documentation.
- Level-of-care and phase-down documentation.
- 520 Whitney / Phase 2 rosters after W.S.'s return.
- Family communications about W.S.'s reported suicide attempt, removal, return, and phase-down.
- W.S. safety-plan, risk-assessment, discharge, refusal-of-care, and autonomy records.
- Billing / retention records covering the year after return.

Maura / Moira / Mara 189 Orange Group-Removal Incident

- Identity and full name of Maura / Moira / Mara.
- Summer 2022 group / therapy schedules for 189 Orange.
- Records identifying the 189 Orange group location and participants.
- Clinical notes, group notes, or incident notes from the relevant session.
- Any record of my removal from group.
- D.'s account of saying the care team manipulated his parents.
- Other clients present in the group.
- Policies on group removal, client complaints, family-communication concerns, and criticism of the program.
- Family-communication records showing Turnbridge guidance to parents about client calls, complaints, resistance, or requests to leave.

Recent Google Review Integrity Concern

- Dated screenshot of the "Samuel Clemens" review.
- Screenshot showing the review gap before the "Samuel Clemens" review.
- Screenshot of the "Mickey Dice" 5-star review.
- Screenshot of the "Mickey Dice" account / profile showing one visible review, if available.
- Screenshot of Google review sorting by newest before and after the review appeared.
- Logged-in, logged-out, incognito, and third-party visibility checks for the "Samuel Clemens" review.
- Google moderation notifications, if any.
- Turnbridge response or non-response to the "Samuel Clemens" review.
- Review-count and star-rating changes before and after both reviews.
- Later positive-review cluster timing, if any.
- Any communications with Google or reputation vendors.
- Any internal communications about recent negative reviews, survivor posts, review reporting, review removal, review solicitation, or reputation management.

VII. Addendum Conclusion

This addendum adds four serious categories to the existing Turnbridge / Turning Point archive. The regenerated whole memo also incorporates three additional July 2026 resurfaced sexual-safety / queer-client concerns: the early-2023 L.M. forced-exposure allegation, the early-2023 Dave Murphy sexual-rumor / pronoun-interrogation concern, and the 2021 "Scarface Adam" / T.K. secondhand legal-proceeding lead. This addendum adds four serious categories to the existing Turnbridge / Turning Point archive: alleged violent staff intimidation by Drew Behr at 90 Ford Street, a W.S. suicidality / phase-down / continued-placement concern, a Maura / Moira / Mara group-removal incident at 189 Orange involving D.'s criticism of the care team's influence

over parents,
and a recent Google review-integrity concern involving timing-sensitive positive-review activity after a detailed negative former-client review.

Some parts are firsthand. Some parts are reported by another client and require corroboration. Some parts are

public-platform observation concerns that require screenshots and visibility testing. The point is not to ask readers to

accept every claim as proven without records. The point is to preserve the allegations and identify the records that

should exist if Turnbridge properly documented and responded to serious client-safety, staff-conduct, suicidality,

autonomy, family-communication, client-criticism, and review-integrity issues.

The central question remains unchanged:

What did Turnbridge document, who knew, what action was taken, what were families told, and what records exist?

HQNN Investigative Reporting Addendum

Public-source evidence concerning Turnbridge adolescent residential treatment and the broader troubled-teen treatment pipeline

Source: Samuel DeFusco, “Troubled teens or a troubled industry?”, HQNN.org, published June 25, 2026.

Source status: Public journalistic reporting. The article includes attributed statements from a former Turnbridge adolescent client identified by a pseudonym, his mother, advocates, public-record materials, and Turnbridge Vice President of Clinical Services Jack Britton. The article’s allegations are not treated here as adjudicated findings. They are preserved as Class A public-source material and as leads for regulatory records requests and witness follow-up.

Purpose and relevance

The article provides unusually detailed, date-linked reporting about an adolescent client’s placement at Turnbridge’s Woodbury residential campus from December 2022 until approximately February 2023. It independently overlaps with multiple categories already preserved in this memorandum: marketing and admissions mismatch, undisclosed length of stay, family-separation and wedge-driving concerns, therapist humiliation, peer-culture concerns, neuropsychological-testing pressure, “higher level of care” escalation, and transfer into a longer out-of-state residential pipeline.

The report is particularly probative because it is not merely an anonymous review. It identifies the journalist, publication date, facility, approximate dates of placement, direct family and former-client interviews, photographs of the Woodbury campus, and on-record responses from a Turnbridge executive.

Key institutional question

Did Turnbridge accurately represent the program, document and respond to alleged therapist humiliation and harmful group practices, protect the client’s family relationship, and provide a clinically justified and transparent basis for recommending another “higher level of care” and transfer into additional long-term placement?

I. Turnbridge-specific accounts reported by HQNN

1. Admissions, amenities, schooling, and length-of-stay representations

- The mother reported meeting admissions personnel in the large main house at the Woodbury campus. She described the front-facing rooms shown to parents as attractive while alleging that the rest of the building was run down.
- The family reported being told the client would have access to a music room and would be able to burn CDs; both mother and son alleged that the promised music room did not exist.
- The family reported being told Turnbridge would coordinate with the client’s home county so he could keep up with schoolwork; the mother alleged that this process took more than a month.
- The mother stated that Turnbridge did not tell her the expected length of stay. The client remained for nearly 90 days. The article separately reports that Turnbridge’s 2025 annual report listed an average Woodbury stay of just over 45 days.

Relevance to existing memo: These accounts independently reinforce the existing admissions / informed-consent / program-length section and the broader marketing-versus-lived-experience pattern. They also raise a distinct question about whether amenities and academic services were materially represented before admission and then delayed, absent, or different in practice.

2. Alleged therapist humiliation and family-therapy breakdown

- The mother alleged that the client’s original therapist told him, shortly after admission, that he was “never going home” and that she did not send children like him home.
- The mother and client alleged that the therapist called him a “genetic trash bag” and referred to other clients as “human trash bags.”
- The client alleged that the therapist spoke negatively about his mother in ways he considered inappropriate for a professional treatment setting.

- The mother alleged that the therapist stopped conducting family-therapy calls because the calls were “too stressful.”
- The client later changed therapists and reportedly became a lead therapist’s only direct client after refusing to continue with the original therapist.

Relevance to existing memo: This public reporting closely overlaps the memo’s staff-modeled humiliation, therapist-boundary, family-communication, complaint-response, and “clients as burdens / hopeless cases” concerns. If documented, these statements should appear in clinical notes, supervision records, family communications, grievances, reassignment records, or HR / quality-assurance materials.

3. Alleged wedge-driving through sexuality and parental doubt

- The article reports that a different therapist told the mother her son was suspected of flirting with another boy.
- The mother said she did not object to her son's sexuality, but interpreted the disclosure as part of a pattern encouraging her to doubt how well she knew her child and to believe that only the institution could understand or manage him.
- The client reportedly described the original therapist as badmouthing his mother.

Relevance to existing memo: This overlaps with the memo's queer-client / sexual-rumor concerns, family manipulation allegations, and the recurring claim that treatment staff used parental uncertainty as leverage. It should be evaluated alongside records showing what was said to each parent, the purpose of sexuality-related discussions, and whether those discussions were clinically relevant, documented, and non-shaming.

4. Peer supervision, contraband, and group-culture allegations

- Within weeks of admission, the mother observed a "stick and poke" tattoo on the client's finger. The client said another resident created it using a pen.
- The former client described a group tradition clients called "Shit Talk Wednesdays." He alleged that a therapist had residents anonymously write insults about one another, place the insults in a bucket, and then repeat the selected insults to the targeted resident.
- The client reported that the exercise led to fights.
- The mother described the residential environment as depressing and alleged that residents spent substantial time sitting in a common room watching television.

Relevance to existing memo: These accounts independently reinforce existing concerns about weak contraband control, peer humiliation, staff-facilitated cruelty, group safety, violence, supervision, and whether treatment practices normalized humiliation rather than interrupting it. The group allegation is especially significant because it describes alleged staff-designed humiliation, not merely spontaneous peer misconduct.

5. Neuropsychological testing, "higher level of care," and transfer escalation

- Turnbridge reportedly sought neuropsychological testing for the client. The client refused.
- The mother alleged that she later learned the refusal was cited as a reason Turnbridge concluded that the client needed a "higher level of care."
- After nearly 90 days at Turnbridge, the client was transferred back to a Utah wilderness program for approximately three weeks so that he could become eligible for a nine-month residential program, Crossroads Academy.
- The mother alleged she was not informed in advance of the transfer plan and only learned because a Turnbridge clinical-team member called her from a personal phone while the client's father was present to take him to Utah.
- The article presents the transfer as part of a broader chain of PHP, wilderness, residential, wilderness again, and long-term residential placement.

Relevance to existing memo: This raises records-based questions about testing consent, clinical rationale, placement criteria, discharge planning, parent notification, transfer coordination, educational-consultant influence, financial or referral relationships, and whether refusal of testing or therapy participation was used to justify escalation into longer and more restrictive care.

6. Reported clinical impact

- The client told HQNN that his mental health was the worst it had ever been while at Turnbridge and that he repeatedly wanted to go home.
- The mother described the family as legally constrained from removing him because of a court order and parental tie-breaking authority.
- The former client later said the broader sequence of programs did not strengthen him in the right way and stated that such programs should not be allowed to operate.

These statements are subjective accounts, but they are relevant to outcome monitoring, adverse-event reporting, family communication, treatment-plan review, and whether worsening distress triggered reassessment or was reframed as

resistance.

II. Turnbridge’s on-record response and institutional context

The article also includes on-record statements from Jack Britton, identified as Turnbridge’s vice president of clinical services. These statements should be preserved because they provide institutional context and potential policy admissions:

- Britton stated that Turnbridge operated adolescent residential locations in Woodbury and Killingworth and was expanding bed capacity at Killingworth.
- He discussed neighborhood conflict and acknowledged that Turnbridge warns clients not to run in the direction of a particular neighboring property.
- He stated that Turnbridge sometimes transports clients to emergency evaluations in company vehicles rather than calling an ambulance, including when clients have substantial suicidal ideation but no stated plan or intent.
- He said he had not heard of the “troubled teen industry” terminology until a staff member introduced it to him in 2026 and criticized the term “troubled teen.”

These statements do not prove any allegation in the family’s account. They do, however, identify leadership knowledge, operational policies, emergency-transport practices, expansion plans, and institutional framing relevant to DPH review.

III. Cross-corroboration with existing memo categories

HQNN reporting theme	Existing memo category strengthened
Length not disclosed; amenities and school support	Admissions / informed consent / marketing mismatch / program length
“Never going home,” “genetic trash bag,” and “human trash bag”	Staff / litigation / therapist boundaries / trauma-informed care
Therapist allegedly badmouthed mother and stopped family calls	Family / contact interference / wedge-driving / complaint response
Sexuality disclosure allegedly used to generate parent concern	Queer / client safety / sexual-rumor handling / family manipulation
Stick-and-poke tattoo and alleged insult-bucket group	Contraband / supervision / staff-modeled humiliation / peer violence
Testing refusal followed by “higher level of care” recommendation	Consent / testing / retention / placement escalation
Unannounced transfer to wilderness and long-term placement	Client / transport / family notification / discharge and transfer planning

The overlap does not establish that every allegation is true. It increases the importance of testing the same institutional categories through contemporaneous records and direct interviews.

IV. Records DPH, counsel, or investigators should request

- Complete clinical and residential file for the adolescent client identified by the article’s pseudonym, subject to lawful authorization and privacy protections.
- Admissions notes, brochures, website captures, recorded calls, intake emails, and representations concerning the music room, CD access, school coordination, visitation, program duration, and expected discharge criteria.
- Woodbury staffing rosters, therapist assignment records, supervision notes, reassignment records, complaints, grievances, HR records, and quality-assurance reviews involving the original therapist.
- Clinical notes and family-session records concerning alleged statements that the client was “never going home,” a “genetic trash bag,” or a “human trash bag,” and any documentation concerning termination of family calls.
- Policies and records concerning staff discussion of a client’s sexuality with parents, including clinical purpose, consent, documentation, and anti-discrimination safeguards.
- Incident reports, contraband reports, room checks, peer-supervision records, and clinical notes concerning the stick-and-poke tattoo.
- Group schedule, curriculum, facilitator identity, group notes, complaints, and incident reports concerning any exercise matching the alleged “Shit Talk Wednesdays” insult-bucket practice.
- Neuropsychological-testing referrals, consent and refusal documentation, communications explaining why testing was recommended, and records connecting refusal to a “higher level of care” recommendation.

- Discharge and transfer records, family notifications, communications with the educational consultant, Evoke, Crossroads Academy, and the client's parents, including the clinical rationale for the wilderness-transfer bridge.
- Any referral-fee, ownership, consulting, business-development, or financial relationship records among Turnbridge, educational consultants, wilderness programs, transport providers, and subsequent residential programs.
- The 2024 and 2025 annual reports and underlying data supporting average length-of-stay figures for Woodbury, including definitions, exclusions, and distribution by discharge type.
- Policies and logs governing emergency evaluation by company vehicle rather than ambulance, including suicide-risk assessment thresholds, staff qualifications, parent consent, medical consultation, and adverse events.

V. Witness and source follow-up

- Samuel DeFusco, article author, regarding source materials, interview recordings or notes, photographs, annual-report records, and Turnbridge responses, subject to journalistic protections and consent.
- The former client and mother quoted under pseudonyms, if they consent to contact by regulators or counsel.
- The original and replacement Turnbridge therapists, the lead therapist who later accepted the client, admissions personnel, education coordinator, group facilitator, and the clinical-team member who notified the mother of the Utah transfer.
- Jack Britton regarding emergency-transport policy, elopement prevention, Woodbury operations, average length of stay, and institutional awareness of troubled-teen-industry criticism.
- Other residents who participated in or witnessed the alleged insult-bucket group, tattoo incident, therapist statements, or common-room conditions.

VI. Source preservation

- Preserve the complete HQNN article as a dated PDF, webpage archive, and screenshot set, including captions and embedded images.
- Preserve the article URL, publication metadata, author biography, revision history, and any later corrections or updates.
- Preserve the Turnbridge 2025 annual report referenced by the article and the underlying facility data if available.
- Preserve the aerial photographs of the Woodbury campus and the reported April 2, 2026 capture date.
- Preserve any public response, legal demand, correction request, or removal request made after publication.

VII. Evidentiary classification and safe use

Classification: Class A public-source investigative reporting. The article contains attributed firsthand accounts, the journalist's observations and photographs, public-record context, and on-record institutional responses. Allegations attributed to the family and former client remain allegations unless corroborated through records, other witnesses, or official findings.

Archive-safe characterization:

A June 25, 2026 HQNN investigation reported detailed allegations from a former Turnbridge adolescent client and his mother concerning undisclosed length of stay, allegedly nonexistent promised amenities, delayed school coordination, therapist humiliation, family-relationship interference, a staff-facilitated insult exercise, peer tattooing, testing pressure, and transfer into additional long-term placements. Turnbridge's executive also provided on-record operational context. The reporting should be used as a source lead and records-request roadmap, not treated by itself as a final adjudication.

VIII. Addendum conclusion

The HQNN article materially strengthens the public-source portion of this memorandum because it documents a specific adolescent placement through direct family and former-client interviews, dates, facility photographs, annual-report data, and an on-record Turnbridge executive response. Its strongest value is the convergence of allegations with categories already present throughout the archive: admissions mismatch, undisclosed duration, family wedge-driving, humiliation as treatment, peer-culture failures, and escalation into longer placements. Turnbridge and regulators should be able to test these concerns through the identified clinical, admissions, educational, HR, incident, transfer, and billing records.

The central question remains: what did Turnbridge document, who knew, what action was taken, what were families told, and what records exist?

RESTORED FULL-DETAIL EDITION

This edition uses the earlier 92-page memorandum as the controlling narrative base so that detailed source accounts, quotations, consent limitations, evidentiary distinctions, and event-specific corroboration lists are not lost through later compression.

The later July 20 material is appended after that complete base, including the 2025 annual-report addendum, source exhibits, parent/loved-one lead, and the anonymized former-client email addendum.

Important restoration rule

Where a later summary is shorter than the earlier account, the earlier full account controls. The shorter summary is not intended to replace, narrow, or supersede the detailed account.

R. / Drew Behr / Bark Phone account - details expressly preserved

- A current-client witness reported that R., an adult Phase 1 client at 90 Ford Street in his early thirties with children, wanted to leave after approximately 28 days and transfer to a sober house closer to his area.
- The witness alleged that Drew Behr tried to turn R.'s family against him, interrupted family calls while relocation plans were being made, and blocked relevant phone numbers.
- R. allegedly felt he had no other option and used the witness's Bark Phone to call his girlfriend. The witness personally allowed the call and reported overhearing the girlfriend become extremely angry about Drew's alleged interference, including the statement: "Drew is a power tripping bitch."
- After the call, a bus ticket was purchased and R. was able to leave. The witness later heard Drew refer to R. as "toxic" and complain during morning meeting about having to "police" people.
- The witness characterized this as his primary firsthand account of potential abuse and said it appeared highly consistent with the memorandum author's separate allegations concerning Drew Behr and family-contact interference.
- The witness consented to his own statements being shared forward, but said he needed to speak with R. first. R. must remain anonymous, and use that could identify or materially involve R. should await R.'s consent or independent corroboration.
- The evidentiary distinction remains essential: the witness personally observed R. using the Bark Phone, overheard the girlfriend's reaction, knew of the bus-ticket planning, and heard the later morning-meeting comments. Alleged call interruption, number blocking, and efforts to turn family members against R. remain reported allegations requiring corroboration.

J.E. sexual-privacy account - full staff-complicity details expressly preserved

- A former client disclosed that another client allegedly filmed him naked or masturbating and texted the intimate video to multiple people.
- He stated that Turnbridge staff knew the details and described staff as complicit in the way the incident was handled.
- He stated that the alleged recorder was downgraded to Phase 1 when, in his view, police probably should have been involved.
- He further indicated that he was not meaningfully asked what he wanted, was not meaningfully involved in the response, and believed internal documentation should exist somewhere.
- The memorandum author independently remembers seeing the video circulating in early 2022. The account therefore combines a direct victim/source disclosure with firsthand memory that the video circulated.
- The complete concern includes alleged nonconsensual intimate recording and distribution, staff knowledge, alleged staff complicity, possible failure to contact police or outside authorities, lack of victim-centered involvement, device and evidence handling, recipient identification, deletion or preservation of copies, protection planning, documentation, and the rationale for

phase-down rather than external reporting.

- Public use must remain anonymous and must characterize these statements as allegations and direct-source testimony rather than adjudicated findings.

Other later direct-source material retained

- - An anonymous former-client witness reported personally observing N.B. shaking continuously, drooling, and losing substantial motor control after medication; helping him open food; substituting yogurt when he could not chew; and later seeing him passed out and drooling. The witness said hospital transport appeared delayed until the next day or later.
- Two people connected to the early women's program reached out by email. One early graduate said allegations involving coercion, abuse, and harassment were consistent with her experience and offered to speak. A second person said she had been both an early women's-program client and later a Phase 3 case manager and offered to speak. These remain preliminary witness leads pending substantive interviews and consent terms.
- The complete M.J. direct-message exhibits, parent/loved-one Reddit lead, 2025 annual-report material, and anonymized J.P. email account are appended after the earlier full-detail memorandum.

Editorial assurance

No detailed account in the earlier memorandum is intentionally superseded by a compressed later summary. Future revisions should add material to this restored edition rather than rebuilding from an abbreviated version.

2025 Adolescent Residential Treatment Annual Report Addendum

Institutional data concerning Woodbury and Killingworth: significant events, medication errors, expansion, discharge pathways, staffing changes, and records-preservation questions

Source Status and Evidentiary Use

Source: *ART Annual Report 2025*, a five-page Turnbridge document describing its adolescent residential services at Woodbury and Killingworth. The preserved report is reproduced in full as an exhibit following this addendum.

This document should be treated as high-probative institutional source material because the figures are presented by Turnbridge itself. It is not an adjudication of wrongdoing, and the data does not establish the facts of any individual incident. Its significance is that it supplies Turnbridge's own aggregate counts, classifications, staffing changes, program descriptions, and discharge data. Those figures can be compared with public reporting, family and former-client accounts, and records requested from DCF, DPH, emergency services, hospitals, and Turnbridge.

Archive classification: Institutional-source document / Turnbridge self-reported operational data. The source should be preserved in its original form, with metadata and chain of custody documented where possible.

I. Program Scope and 2025 Expansion

The report describes Woodbury and Killingworth as 30- to 60-day residential programs for adolescents ages 14 to 17, with optional extended care lasting three months or longer for certain clients ages 15 to 17. It states that services include clinical, psychiatric, medical, academic, and recreational programming and that treatment teams include executive, clinical, medical, and nursing leadership, 24-hour nursing staff, clinicians, academic advisors, recreation personnel, operations managers, and support staff.

In 2025, Turnbridge expanded Killingworth by adding a twenty-seventh girls' bed in February and opening an eight-bed boys' cottage in September. The report lists five residential homes at Killingworth and two at Woodbury.

Due-diligence significance: Expansion should be evaluated alongside incident volume, medication-error volume, staffing, nursing leadership, training, supervision, and quality-assurance capacity. The institutional question is not whether expansion itself was improper, but whether clinical and safety systems expanded at the same pace as bed capacity.

II. Significant Event Reports

Turnbridge reports that Woodbury and Killingworth submitted **at least 102 significant-event reports to Connecticut DCF in 2025**, compared with 42 in 2024. The report classifies the 2025 events as follows:

- **58** reports for physical aggression that did not require emergency services;
- **16** reports involving a youth's imminent risk of harm to self or others;
- **19** reports involving elopement;
- **5** reports involving substance use;
- **4** reports involving syncope episodes requiring emergency services;
- **0** reported onsite youth injuries in the listed emergency-services category.

The report states that 75 of the 102 significant events occurred at Killingworth and 27 occurred at Woodbury. In 2024, the corresponding figures were 23 at Killingworth and 19 at Woodbury.

These figures raise records-based questions about why the total number of reported significant events more than doubled from 2024 to 2025, why approximately three-quarters of the 2025 events were concentrated at Killingworth, whether reporting practices changed, whether census growth accounts for part of the increase, and what corrective actions followed repeated aggression, elopement, acute self-harm or violence risk, substance use, and medical emergencies.

III. Medication Errors

The report states that Woodbury recorded four medication-error events in 2025, compared with eight in 2024. It lists two "five rights" violations and two diversion events.

The more significant institutional disclosure concerns Killingworth. Turnbridge reports **48 medication-error events at Killingworth in 2025**, compared with 34 in 2024, and notes that some events contained multiple errors. The listed error categories were:

Error category	Count
Incorrect dose	9
Omission	3
Medication given at wrong time	1
Medication given without licensed-prescriber order	2
Incorrect client given medication	5
Missing medication	2
Improper storage	9
Administration not documented	5
Transcription error	12

The categories "incorrect client given medication," "incorrect dose," "medication given without licensed-prescriber order," "missing medication," and undocumented administration warrant particular scrutiny because they concern direct medication-safety controls for minors. The report itself does not state the clinical consequences, severity, dates, affected medications, whether families were notified, whether medical evaluation was required, or whether any event caused harm.

Required follow-up: DPH, DCF, counsel, or investigators should obtain event-level records, medication-administration records, prescriber orders, pharmacy records, incident reviews, root-cause analyses, corrective-action plans, nursing schedules, training records, disciplinary records, family notifications, and adverse-outcome documentation.

IV. Nursing and Clinical Leadership Changes

The annual report states that a new Woodbury nursing director began in April 2025 and a new Killingworth nursing director began in June 2025. It also reports that five Woodbury therapists left while three were hired, and that a new Woodbury clinical director began in May. At Killingworth, one therapist left and four were hired.

The report does not divide medication-error events by month or identify whether they occurred before or after the nursing-leadership changes. That missing timeline is material. Investigators should determine how many errors occurred under each nursing leadership period, what prompted the leadership changes, what deficiencies had already been identified, and whether error rates improved after corrective measures.

V. Discharge Pathways and Extended Care

Turnbridge reports that 81% of clients were classified as completing the program in 2025. It also reports that 6% were discharged to a higher level of care, 6% for administrative reasons, 1% for medical reasons, and 6% against advice with parent support.

The reported discharge destinations changed materially between 2024 and 2025:

Destination	2024	2025
Home	77%	67%
Turnbridge's Extended Care	7%	14%
Hospital	10%	10%
Non-Turnbridge Extended Care	<1%	4%
Other Residential Treatment	1%	2%
Therapeutic Boarding School	3%	2%
Wilderness Program	<1%	1%

The proportion discharged into Turnbridge's own extended-care program doubled from 7% to 14%, while the proportion discharged home fell by ten percentage points. These figures do not establish improper referral or retention. They do justify examination of admission disclosures, expected duration, clinical criteria, family consent, financial incentives, internal referral practices, and whether parents were clearly informed before admission that a nominal 30- to 60-day placement could lead into a Turnbridge-controlled program lasting three months or longer.

The report also states that 10% of discharges went to a hospital in both 2024 and 2025. Investigators should determine whether these transfers reflected expected acuity, deterioration during placement, medication-related events, suicidality, aggression, medical emergencies, or admissions beyond the program's capabilities.

VI. Demographics and Specialized Safety Questions

The report describes the 2025 client population as 83% white, 5% Black, 5% Hispanic, 4% Asian or Other, and 3% multiracial. It states that Turnbridge treated more trans-male than trans-female clients in both 2024 and 2025. It also reports that 13% of 2025 admissions had a diagnosed autism-spectrum disorder.

These figures do not themselves establish misconduct. They are relevant to determining whether Turnbridge maintained adequate cultural-competency training, LGBTQ and transgender placement safeguards, anti-harassment procedures, autism-informed care, sensory and communication accommodations, and incident tracking by protected or clinically relevant characteristics.

VII. Cross-Corroboration with Existing Memo Categories

Annual-report disclosure	Existing concern strengthened
58 physical-aggression reports	Peer violence, supervision, separation, incident response
19 elopement reports	Walk-off prevention, environmental risk, police and emergency response
16 imminent-harm reports	Suicide/self-harm and violence-risk assessment
48 Killingworth medication-error events	Medication administration, nursing oversight, consent, documentation
75 of 102 significant events at Killingworth	Site-specific supervision and expansion-capacity questions
Turnbridge extended-care discharges doubled	Program length, internal referral, retention, informed consent
10% discharged to hospital	Acuity screening, destabilization, emergency transfer practices
Therapist and nursing leadership changes	Continuity of care, quality assurance, institutional knowledge

The annual report does not prove every allegation or public-review account preserved elsewhere in this memo. Its importance is convergence: Turnbridge's own aggregate data confirms that aggression, elopement, acute danger, medication errors, hospital transfers, and extended-care referrals were substantial operational realities requiring documentation and oversight.

VIII. Records DCF, DPH, Counsel, or Investigators Should Request

- All 2025 significant-event reports from Woodbury and Killingworth, including narratives, dates, site, house, staff present, injuries, emergency-service involvement, family notification, and disposition;
- Underlying census and occupied-bed data by site and month, allowing incident rates to be calculated rather than relying only on raw counts;
- All medication-error reports, medication-administration records, prescriber orders, pharmacy communications, diversion investigations, missing-medication records, and adverse-event documentation;
- Root-cause analyses, corrective-action plans, quality-assurance reviews, retraining records, and evidence of whether error rates changed after nursing-leadership transitions;
- Elopement logs, police and emergency-service records, environmental-risk assessments, transport records, and post-event reviews;
- Risk assessments and emergency-transfer documentation for imminent harm, syncope, hospital discharge, and medical discharge;
- Admissions and consent materials explaining the 30- to 60-day program, extended care, expected duration, discharge criteria, and potential movement into Turnbridge's own longer-term services;
- Internal referral criteria, financial arrangements, billing records, and communications associated with referrals to Turnbridge extended care, outside extended care, wilderness, therapeutic boarding school, or other residential treatment;
- Staffing ratios, vacancies, turnover, credentials, schedules, supervision records, and nursing coverage by site and month;

- Board, leadership, compliance, insurer, DCF, and DPH communications concerning the increase in significant events and medication errors.

IX. Archive-Safe Public Characterization

Turnbridge's own 2025 adolescent residential-treatment annual report states that its Woodbury and Killingworth campuses submitted at least 102 significant-event reports to Connecticut DCF, including 58 reports for physical aggression, 19 for elopement, and 16 involving imminent risk of harm to self or others. Seventy-five of those events occurred at Killingworth. The same document reports 48 medication-error events at Killingworth, including incorrect doses, medication given to the wrong client, medication given without a licensed-prescriber order, missing medication, improper storage, and undocumented administration. These are institutional self-reported figures, not external findings, but they create concrete questions about supervision, nursing systems, expansion, corrective action, family notification, and regulatory oversight.

X. Addendum Conclusion

The 2025 annual report materially strengthens the records-based posture of this memorandum. It converts several categories previously supported primarily by personal accounts, public reviews, or journalism into areas where Turnbridge itself acknowledges substantial reportable-event and medication-error volume. The central issue is not whether every significant event or medication error proves abuse. The issue is whether Turnbridge and regulators can produce the event-level records, explain the concentration at Killingworth, show what corrective actions were taken, and establish that expansion and extended-care referral practices were supported by adequate safety, staffing, nursing, consent, and quality-control systems.

Exhibit follows: complete preserved copy of *ART Annual Report 2025*.



Program Description

Overview

Level of Care: residential, the level of care between a hospital and any type of outpatient

Target Population: boys and girls ages 14 to 17

Diagnosis: mental health and substance use diagnosed youth

Services: clinical (e.g. individual, group, and family therapy), psychiatric, medical, academic, and recreational services in individual and group formats

Delivered by: mental health professionals and/or trained paraprofessionals

Major Changes in 2025

In February, a 27th girl bed was added in Killingworth. In September, an 8-bed boys' cottage opened in Killingworth.

Campuses

Woodbury:

- Two residential homes with 11 beds (boys) at the main house and 7 beds (girls) at the cottage
- 65 acres of secluded forested land
- On-location adventure course spread across one acre of wooded land
- Multiple dining and lounging areas.

Killingworth:

- Five residential homes where three houses are for girls (11 beds at the main house, 8 beds at one cottage, and 8 beds at another cottage) and two houses are for boys (12 beds at the main house, and 8 beds at the cottage)
- 100 acres of secluded land including woods, paddocks, expansive lawns, a pond, and an apple orchard
- Horses as well as stables, horse arena, and equine grounds
- Large carriage house with fitness room, art room, and academic center on bottom floor, as well as event space on top floor
- Multiple dining and lounging areas.

Program Description

Turnbridge's Adolescent Residential Services – Woodbury and Killingworth sites are 30- to 60-day residential programs for 14- to 17-year-olds. When medically necessary, there is an optional extended care program (3+ months) for 15- to 17-year-olds, located in and around New Haven. The Woodbury and Killingworth residential treatment programs provide a comprehensive range of gender-specific programming including clinical (e.g. individual, group, and family therapy), psychiatric, medical, academic, and recreational services. Each client is provided with a treatment team consisting of the executive director, clinical director, medical director, nursing director and 24-hour nursing staff, a primary clinician and supporting clinicians, care team director, academic advisors, recreation staff, operations managers, and support staff including resident liaisons.

The adolescent residential treatment programs' mission is to develop diagnostic clarity and build a sound continuing care plan. Treatment focuses on the client's psychological, emotional, and physical health within the context of recovery and wellness concepts and principles.

Clients are given a daily schedule of treatment activities, which also includes appointments and individualized services tailored to their specific goals and needs. These may include (a) group therapy, (b) individual therapy, (c) family therapy, (d) wellness and fitness activities, (e) nutritional support, (f) spiritual support, (g) educational services, and (h) continuing care planning. The program's therapeutic curriculum uses evidence-based modalities and is designed to help teens begin recovery from their mental health and substance use diagnoses. Principal therapies used are Cognitive-Behavioral Therapy, Dialectical Behavior Therapy, Motivational Interviewing, and Acceptance and Commitment Therapy, all coupled with pharmacology, as appropriate, psychoeducation, and mindfulness activities.

In-Network Access

Turnbridge has been an in-network provider with Anthem-BCBS since December 2018 and United/UHC/Optum since November 2022.

Accessibility

- 99% of clients who admitted in 2025 used commercial insurance to pay for treatment, and 78% used in-network insurance to pay for treatment, further reducing cost and increasing access to critical services. In 2024, these percentages were 98% and 73%, respectively.
- In the fourth quarter of 2025, an average of 10 boys and 7 girls were waitlisted per month. In the fourth quarter of 2024, those figures were 8 and 7, respectively.
- Average length of time a client needed to wait for an available bed in the fourth quarter of 2025 was about 17 days for boys and 11 days for girls (12 days for boys and 8 days for girls in Q4 2024).

2025 Demographics

- Race
 - 5% of clients identified as Black (4% in 2024)
 - 5% of clients identified as Hispanic (5% in 2024)
 - 4% of clients identified as Asian or Other (3% in 2024)

- 3% of clients identified as Multi-Racial (3% in 2024)
 - 83% of clients identified as White (85% in 2024)
- Gender (as of mid-September 2025, across the two locations the bed count was 34 girls to 31 boys):
 - 55% of clients were female at birth (52% in 2024)
 - 45% of clients were male at birth (48% in 2024)
 - In both 2024 and 2025, we treated more trans-males than trans-females.
- Age at Admission:
 - 13: 1% (1% in 2024)
 - 14: 15% (17% in 2024)
 - 15: 30% (23% in 2024)
 - 16: 29% (29% in 2024)
 - 17: 25% (29% in 2024)
 - 18: 0% (>1% in 2024)
 - Connecticut's Department of Children and Families (DCF) allows age waivers for clients who are almost 14 or just turned 18.

2025 Outcomes

- 526 clients were treated in 2025 (414 in 2024), 470 of whom admitted in 2025, and the other 56 admitted in 2024 and completed the program early in 2025.
- State of origin for the 470 admissions in 2025:
 - Connecticut: 18% (18% in 2024)
 - Massachusetts: 11% (14% in 2024)
 - New Jersey: 17% (22% in 2024)
 - New York: 18% (22% in 2024)
 - Pennsylvania: 7% (7% in 2024)
 - Other: 29% (18% in 2024)
- Primary diagnosis – In treatment and with managed care, clients' primary disorder is either mental health or substance use. In 2025, 97% of clients were considered primary mental health (97% in 2024). In 2025, primary mental health disorders were:
 - Depression and dysthymia disorders: 95% (87% in 2024)
 - Bipolar disorders: 3% (8% in 2024)
 - Anxiety disorders: 1% (1% in 2024)
 - Schizo-related disorders: <1% (0% in 2024)
 - ADHD: <1% (0% in 2024)
 - Autism disorder: <1% (0% in 2024)
 - Oppositional-defiant disorder: 0% (<1% in 2024)
 - Post-traumatic stress disorder: <1% (0% in 2024)
 - Borderline personality disorder: <1% (0% in 2024)

Of the clients with a primary mental health disorder, 63% of 2025 admissions had a co-occurring substance use disorder diagnosis (65% of 2024 admissions).

13% of 2025 admissions had a diagnosed autism spectrum disorder (7% in 2024).

- Average number of days enrolled in Woodbury and Killingworth for clients who discharged in 2025:

- Woodbury: 45.1 days (42.9 in 2024)
 - When enrollments <15 days in duration are removed: 49.9 days (49.1 in 2024)
- Killingworth: 47.2 days (41.7 in 2024)
 - When enrollments <15 days in duration are removed: 50.3 days (46.6 in 2024)
- Discharge reason in 2025:
 - Completed Program: 81%; 2024: 73%
 - Discharged to Higher Level of Care: 6%; 2024: 8%
 - Discharged for Administrative Reasons: 6%; 2024: 10%
 - Discharged for Medical Reasons: 1%; 2024: 1%
 - Discharged against Advice with Parent Support: 6%; 2024: 8%
- Location to which clients discharged in 2025:
 - Home: 67%; 2024: 77%
 - Turnbridge's Extended Care: 14%; 2024: 7%
 - Therapeutic Boarding School: 2%; 2024: 3%
 - Other Residential Treatment: 2%; 2024: 1%
 - Hospital: 10%; 2024: 10%
 - Wilderness Program: 1%; 2024: <1%
 - Sober Living: <1%; 2024: 1%
 - Non-Turnbridge Extended Care: 4%; 2024: <1%
 - Juvenile Detention (due to prior court case): <1%; 2024: <1%

2025 Significant Event Reports & Medication Errors

Connecticut's Department of Children and Families (DCF) requires two types of reports from facilities like the Woodbury and Killingworth sites: significant events and medication errors. In 2025 the Woodbury and Killingworth sites combined submitted at least 102 significant event reports to DCF (42 in 2024):

- **Those not requiring emergency services:**
 - 58 for physical aggression, a figure we will measure in future years as well.
- **Those requiring emergency services:**
 - 16 (18 in 2024) reports regarding a youth's imminent risk to harm self or others;
 - 19 (21 in 2024) reports regarding elopement;
 - 5 (0 in 2024) reports regarding substance use; and
 - 0 (0 in 2024) report regarding onsite youth injury;
 - 4 (0 in 2024) for a syncope episode (medical).

Of 2025's 102 significant event reports, 75 occurred in Killingworth and 27 occurred in Woodbury (23 and 19 in 2024, respectively).

The Woodbury site reported 4 medication error events in 2025 (8 medication errors reported in 2024). The reasons were: violation of five rights (2); and diversion (2).

The Killingworth site reported 48 medication errors in 2025 (34 medication errors reported in 2024), some of which had multiple errors within one event. The reasons were: incorrect dose (9); omission (3); medication given at wrong time (1); medication given without LP order (2); incorrect client given medication (5); missing medication (2); improper storage (9); administration of medication not documented (5); and transcription error (12).

Clinical and Other Major Staff Changes

Woodbury in 2025:

- Therapists: Five therapists left the organization, and three therapists were hired. A new clinical director started in May.
- Nursing: A new nursing director started in April.

Killingworth in 2025:

- Therapists: one therapist left the organization, and four therapists were hired.
- Nursing: A new nursing director started in June.

Forward-Looking Goals

1. Continue to implement systems for curating a uniform experience across the two sites and as Killingworth grows.
2. Offer clinician training opportunities for Accelerated Resolution Therapy (ART).
3. Develop a family feedback council.

Exhibit M.J.-1: Initial direct account and request for initials only - July 15, 2026, approximately 5:32 PM.

Source screenshot preserved as direct former-client disclosure evidence. Names are restricted in public use to M.J.

You should also mention the time Cole and a bunch of others ran off and stole a bunch of Dxm and drank it and had no repercussions as well as when I ran off property and robbed a liquor store with another client than got so intoxicated I almost died in a field since it was also winter and had the emts not found me I would have died in the forest next to the baseball fields and then I repeated it the next day by myself and had no consequences or repercussions until I said I needed to go to a detox to separate myself for a few days . They also told me to pack my shit one time and said they didn't care if I left and than once I packed my stuff and was ready to leave they took it back and wouldn't give me my money so I could leave

Add a personalized message. [Try it](#)

I can give u more details but just use my initials don't put my full name on anything

Exhibit M.J.-2: Date clarification, fentanyl-overdose account, alleged video circulation, and police / EMS clarification - July 15, 2026, approximately 6:12 PM.

Source screenshot preserved as direct former-client disclosure evidence. Names are restricted in public use to M.J.

happened before and after, whether police/ems were involved, and whether there were any incident reports, texts, discharge records, or witnesses.

I swear I will protect your anonymity. I will use only your initials, will not publish your full name, username, contact information, or anything else that could identify you, and I will not share your identity with anyone without your explicit permission.



I remember these incidents clearly when you almost died i think that was september 28th 2021

I'm not sure what the exact dates are but I'll try and figure it out when I get a minute- ik for the field it was almost December - and the cough syrup was also in the inter time - I also was filmed while I went on a lapse on fentanyl and had staff showing everyone videos of me nodding off and being fucked up while I was overdosing the entire time and luckily I got to hospital some how and narcanned

Police were called and emts when the field drinking thing happened and I believe ems were also called during my overdose

Exhibit M.J.-3: Program-phase clarification - July 15, 2026, approximately 6:23 PM.

Source screenshot preserved as direct former-client disclosure evidence. Names are restricted in public use to M.J.

Everything was phase one except the overdose cause I was in phase two

Will also try and figure out more details but may take a bit

Understood. Based on what you've described, you may have serious potential legal claims. If you decide you want to pursue it, I can help connect you with attorneys who handle treatment-center abuse, negligence, medical emergencies, privacy violations, and related civil cases. I can't promise what a lawyer will conclude, but your account is absolutely worth a confidential legal review.

I can also serve as a witness because I remember all these events

Exhibit M.J.-4: Full thread view confirming Phase 1 / Phase 2 distinction - July 15, 2026, approximately 6:38 PM.

Source screenshot preserved as direct former-client disclosure evidence. Names are restricted in public use to M.J.



you went to, and any staff names you remember. I will continue your initials and will not share anything that could identify you without your explicit permission.

Everything was phase one except the overdose cause I was in phase two

Will also try and figure out 6:22 PM pills but may take a bit

Understood. Based on what you've described, you may have serious potential legal claims. If you decide you want to pursue it, I can help connect you with attorneys who handle treatment-center abuse, negligence, medical emergencies, privacy violations, and related civil cases. I can't promise what a lawyer will conclude, but your account is absolutely worth a confidential legal review.



I can also serve as a witness because I remember all these events

Word potentially, but even with going to court system u think that could be enough to do some damage to turnbridge and prevent them from doing shit in the future to others? And how much would that all cost to figure out with legal counsel? And what would the long game be? Would we be looking for a settlement? Or trying to get them to shut down their programs?

Exhibit A - Citizen Dispatch-Audio Screenshot

Preserved screenshot dated June 13, 2026. Citizen labels the item as an AI-generated summary of public dispatch audio and not an official report. Included here as a public-source lead, not as proof of Turnbridge involvement.

7:33

LTE 100



Dispatch Audio



Edit

Teen girl reported after attempted hanging near Parker Hill Road Extension



Heard on: Middle

00:00

00:14

00:00 Killing for rescue, killing f...

Expand

Jun 13, 2026 · 8:53 PM EDT

Medical Emergency

Parker Hill Road Ext



[View on map](#)



Not official report. AI-generated from public dispatch audio. Always verify with official sources.

As discussed during the dispatch call, emergency medical crews were dispatched to the Parker Hill Road Extension area in Killingworth for a reported 14-year-old girl who attempted hanging.



Help the community verify

Is this activity real?



Confirmed

False alarm



Exhibit B - Parent / Loved-One Reddit Comment Screenshot

Preserved July 18, 2026 screenshot. The statements are allegations / leads attributed to the commenter and require clarification and corroboration. The commenter and daughter should remain anonymized absent explicit consent.



Present-now-5629 • 2d ago

I'll happily share our story.

There was also a recent hanging attempt I think the 14 yo person survived. That was the Last week of May 2026.

There was also a sexual assault female to female (residents) May 2026, .

My daughter said many of the staff used vapes and there was also a vape a girl had on her .



4



Reply



Award



Share



Turnbridge / Turning Point Due-Diligence Memo

PUBLIC-SOURCE VIDEO ADDENDUM - December 6-9 adolescent runaway, alleged AMA / child-protective-services threat, parental fear, and post-recovery confirmation

Source status: Transcript supplied by the memorandum author from a public video posted approximately 83 weeks before July 21, 2026 by a parent / advocate associated with the troubled-teen-industry survivor community. The speaker describes her own direct messages with the mother of a fourteen-year-old Turnbridge client and a publicly reported missing-person event. The video itself is public-source material; statements attributed to the mother and Turnbridge remain reported allegations unless confirmed through the mother, police records, DCF records, Turnbridge records, or other contemporaneous documentation.

Placement in memorandum: This addendum belongs in the public-source / adolescent-program / client-autonomy / parent-pressure / elopement / records-request sections. It also cross-references the existing Killingworth and Woodbury significant-event material, parent/loved-one leads, the HQNN reporting addendum, and the broader pattern concerning threats to involve parents or outside authorities when families seek discharge.

I. Complete chronology preserved from the video

- **December 6:** The speaker states that a mother contacted her by direct message because the mother's daughter had just been sent to Turnbridge. The mother reportedly expressed extreme concern, said she had a strong gut feeling that something was wrong, and asked for information or insight. The speaker told the mother that she did not have personal experience with the girls' side but could describe her experience with the boys' side. She advised the mother to remove her daughter if the placement felt wrong.
- **After the December 6 contact:** The mother reportedly told the speaker that unidentified Turnbridge personnel said she was not allowed to take her daughter home because doing so would be against medical advice. The mother further reported that Turnbridge threatened to call DCFS if she attempted to bring her daughter home. The speaker responded that, absent a court order or other legal restriction unknown to her, the decision should belong to the parent. She interpreted the alleged statements as an effort to scare the parent and retain the placement.
- **Sunday, December 8:** The speaker states that a fourteen-year-old girl was reported missing from Turnbridge. She later learned that the missing girl was the same mother's daughter.
- **Monday, December 9:** The girl was reportedly found safe. The speaker contacted the mother about the public report, and the mother confirmed that the missing girl was her daughter.
- **After the recovery:** The mother reportedly told the speaker that the daughter was on her way home. The speaker said she intended to continue checking in, help the mother navigate next steps, encourage the mother to keep the daughter home, and support home-based treatment if care remained necessary.

II. Alleged AMA and child-protective-services pressure

The central institutional allegation is not merely that a parent was told discharge would be against medical advice. The reported escalation was that Turnbridge personnel allegedly told the mother she was not allowed to remove her daughter and threatened to call child-protective services if she attempted to do so. If accurate, this would raise serious questions about whether clinical language and the possibility of state intervention were used to frighten a parent away from exercising lawful custody and discharge authority.

- Who made the alleged statement, and what exact words were used?
- Was the client under any court order, custody order, emergency commitment, or legal restriction?
- What clinical condition or documented risk assessment supported the claim that discharge was against medical advice?
- Was the parent told the difference between an AMA discharge recommendation and a legal prohibition on taking her child home?
- Was any DCF / DCFS report actually made, drafted, discussed, threatened, or requested?

- What policy governed staff statements to parents about reporting them to child-protective services?
- Were financial, census, utilization-review, insurance, or length-of-stay considerations discussed internally at the time?

III. Runaway / elopement and recovery

The reported sequence creates a discrete records trail: a fourteen-year-old girl reportedly left or ran from Turnbridge on December 8, was reported missing, and was found safe on December 9. The mother's alleged effort to remove her daughter before the runaway is directly relevant to the event. Investigators should determine whether the girl had expressed fear, requested discharge, attempted to leave earlier, or communicated that she did not feel safe; whether those communications were documented; and whether the runaway was a foreseeable escalation after the parent was allegedly discouraged or threatened from taking her home.

IV. Records, witnesses, and corroboration required

- Police incident, missing-person, CAD, dispatch, body-camera, search, recovery, and supplemental reports for December 8-9 involving a fourteen-year-old girl reported missing from a Turnbridge adolescent location.
- Any Silver Alert, Amber Alert, public bulletin, internal BOLO, emergency notification, or media communication associated with the disappearance and recovery.
- EMS, ambulance, hospital, emergency-department, crisis-evaluation, and transport records, if any.
- Turnbridge elopement / runaway incident report, significant-event report, DCF report, house logs, shift notes, clinical notes, safety-plan records, observation logs, room checks, staffing assignments, and post-event review.
- Admissions records, custody documentation, consent forms, court-order status, discharge rights notices, AMA policies, and written parent communications.
- All calls, texts, emails, portal messages, and case notes between Turnbridge and the mother from December 6 through at least December 10.
- Any record of staff stating that the mother could not remove her daughter, that removal would be AMA, or that DCF / DCFS would be called.
- Any actual DCF / DCFS hotline report, mandated-reporting consultation, supervisor review, legal consultation, or internal communication about making or threatening a report.
- Names and schedules of admissions staff, clinician, therapist, case manager, program director, nursing staff, support staff, and on-call leadership involved.
- The mother's direct account and preserved direct messages with the public-video speaker.
- The daughter's direct account, if she freely consents and can participate without harm.
- The public video in its original form, complete transcript, URL, username / account metadata, posting date, captions, comments, and any follow-up videos or corrections.
- Billing, insurance authorization, utilization review, census, expected-length-of-stay, discharge, and refund records covering the placement and immediate aftermath.

V. Cross-memo significance

- **Client autonomy and parent authority:** The account independently overlaps with allegations that Turnbridge discouraged adult or adolescent clients from leaving, pressured families, interfered with outside support, or framed departure as dangerous or impermissible.
- **Family manipulation / wedge-driving:** The mother reportedly arrived with a strong intuitive concern and was then allegedly told she could not take her daughter home. The sequence raises the question of whether parental doubt was overridden through fear rather than addressed through transparent clinical information.
- **Elopement:** The daughter reportedly ran away shortly after the mother sought guidance about removing her. This overlaps with Turnbridge's own later acknowledgment that elopement is a substantial operational category and with public reports of repeated walk-offs.
- **Threatened state intervention:** Allegedly invoking DCF / DCFS against a parent seeking discharge is a distinct coercion concern and should be investigated separately from ordinary mandated reporting.

- **Marketing and retention:** The speaker interpreted the alleged resistance to discharge as financially motivated. That interpretation is not itself proof, but the event creates a direct records question concerning census, insurance authorization, billing, and internal retention discussions.
- **Adolescent safety:** A fourteen-year-old client reportedly reached the point of running away and becoming the subject of a missing-person response. The institutional question is what Turnbridge knew before she left and what it changed afterward.

VI. Evidentiary classification and source-protection

Classification: Class A public-source video containing a first-person account by the speaker of direct communications she says she received from the mother, combined with a publicly reported missing-person / recovery event. The speaker's account of what the mother told her is direct-message hearsay until the mother confirms it. The alleged Turnbridge statements are not adjudicated findings. The disappearance and recovery should be tested through official police, DCF, EMS, and Turnbridge records.

Source protection: Unless the mother and daughter have already publicly identified themselves and expressly consent to identification in this archive, both should remain anonymous. Do not publish the minor's name, photographs, exact residence, medical information, or family contact information. Any outreach should be trauma-informed and should not pressure either person to participate.

VII. Archive-safe public characterization

A public video posted by a troubled-teen-industry parent advocate describes a December incident involving a fourteen-year-old Turnbridge client. According to the speaker, the girl's mother contacted her on December 6 with an intense concern about the placement and later reported that Turnbridge personnel said she could not take her daughter home because it would be against medical advice and threatened to call child-protective services if she tried. The girl was reported missing on December 8, found safe on December 9, and the mother later confirmed to the speaker that the missing child was her daughter and that she was bringing her home. The account is a public-source lead, not an official finding, but it creates specific records questions concerning parental discharge rights, alleged threats to involve DCF, elopement prevention, police response, clinical documentation, family communications, and billing / retention practices.

VIII. Complete transcript exhibit

Exhibit TTI-M-1 - Transcript supplied July 21, 2026

[00:00-00:28]

So, let's talk about Turnbridge in Connecticut for a minute. Um, I have a personal disgust for that place given the fact that it was one of the places that my ex sent our son. Um, but, uh, on Sunday, it was reported that a girl was missing from there, on December 8th. And apparently, she was found on Monday, December 9th, and reported safe.

[00:28-01:16]

Uh, the backstory to that is a little interesting from my perspective because I had gotten a DM from a mom on December 6th because she reached out to me to say that she-her daughter had just been sent to Turnbridge, and she was extremely concerned. She had a gut feeling that there was something not right, and she wanted to know if I could share information or give her any insight. Um, naturally, I told her I don't have personal experience with the girls' side, but I was able to tell her my experience with the boys' side. Um, and told her that if she didn't feel good about it, you know, she should get her daughter out of there. Even if she did feel good about it, she should get her daughter out of there. But, um...

[01:16-02:25]

...so, she proceeded to tell me that the people at Turnbridge-I don't know specifically who-told her she wasn't allowed to take her daughter home because it was AMA, against medical advice. And if she did try to bring her daughter home, that they would call DCFS on her. And I immediately said to her, "I-there's obviously information I don't have, but unless your daughter was court-ordered to be there, it's your decision. Of course they're going to tell you it's against medical advice. They want to keep her there. They want the paycheck." But I'm not sure why they would threaten this mom with calling DCFS. Um, that's just outrageous. However, uh, these places are outrageous, and they will say anything to scare parents. That's what they do. Parents, I wish you would listen and hear this: that's what they do.

[02:25-03:09]

So, the girl-the 14-year-old girl-took it upon herself to run away on Sunday and was found on Monday. And last night, I got a message from the mom-well, actually, I reached back out to the mom to say, "Hey, did you hear about this runaway girl at Turnbridge?" And she said, "Yes, that's actually my daughter." So, the daughter is safe, and the mom told me last night that she's on her way home. I'm going to continue to follow up because I don't know what her plans are regarding next steps, but I kind of want to, like, hold her hand and see if I can help navigate her through next steps and make sure she keeps her daughter home. And if she does need some kind of treatment, that it should be home-based.

[03:09-04:10]

So, uh, there are a lot of red flags with Turnbridge. There are a lot of red flags with any of the programs in the TTI [Troubled Teen Industry]. And if you have questions about what some of those red flags are, you can always send me a DM. And if you have questions about programs, you can go to the Kids Over Profits website, and you can go to the Unsilenced website, and you can see, uh, the complaints, the lawsuits, and get some information for yourself. But the main thing that really sticks out in me-sticks out for me with this-is the gut feeling. The mom had a gut feeling. She just knew something was wrong. Don't ignore that voice. Please don't ignore that voice. These people will work overtime to manipulate you and to try to convince you that you're doing the right thing by sending your kid away. But they're lying.

Preservation instruction

- Preserve the original video file, URL, account name, profile page, visible posting date, captions, description, comments, likes, shares, and any follow-up videos.
- Preserve this transcript exactly as supplied, while separately maintaining a corrected analytical summary that does not alter the quoted words.
- If the public post is deleted, preserve a local copy and an archive capture, but do not republish identifying information about the minor.
- Use the chronology and alleged AMA / DCF threat as a roadmap for public-record requests to the responding police agency, Connecticut DCF, and Turnbridge.

Indeed Employee-Review Evidence Addendum

Integrated update to VII. Public Review Evidence and Archive Corroboration; VIII. Archive Allegations Compared with Public Review Themes; IX. General Patterns Observed; X-XI. Records and Preservation

Prepared: July 23, 2026

Source status: Thirty user-supplied screenshots of public Indeed employee reviews dated from January 2020 through March 2026, plus one capture whose date was not visible. These are anonymous public-review allegations, not adjudicated findings. They should be preserved as Class A public-source employee-review material and used as corroboration leads and records-request prompts.

Integration rule: This addendum expands the existing Glassdoor and employee-review context. It does not replace the earlier review sections. The screenshots should remain attached as exhibits because review pages may change, disappear, or become inaccessible.

1. Core Cross-Review Pattern

Across roles including support staff, direct support professionals, therapists, a nurse, an APRN, a shift manager, clinical staff, transport staff, and maintenance, the reviews repeatedly distinguish between frontline relationships and institutional leadership. Many reviewers describe clients or coworkers as the most meaningful part of the work while alleging that senior or upper management was disorganized, punitive, financially driven, unsupportive, or disconnected from care.

Management and retaliation. Repeated allegations of inconsistent instructions, favoritism, surveillance, threatened or sudden termination, ignored concerns, broken promises, and an atmosphere in which criticism of management could end a job.

Understaffing and turnover. Repeated references to short staffing, revolving-door employment, entire teams leaving, unsafe ratios, no scheduled breaks, overtime pressure, and exhaustion that made direct care harder.

Training and clinical support. Reviewers allege weak orientation, inadequate preparation, vague curricula, excessive group loads, underqualified lower-level management, and insufficient resources for clients with serious psychiatric or behavioral needs.

Client safety and level-of-care fit. Several reviews allege that credible safety concerns were waved off, clients needing higher care were retained, harmful conduct was insufficiently addressed, alarms or supervision were inadequate, and staff lacked the ability or authority to protect clients.

Financial and retention incentives. Multiple reviewers describe management as focused on the bottom line, filled beds, private-pay retention, or shareholders. These remain allegations, but they overlap the memo's admissions, program-length, internal-referral, and retention questions.

Psychological impact on staff. Reviewers describe burnout, depression, trauma, PTSD, feeling watched, being treated like children or minions, and losing faith that the work was helping anyone beyond the company.

Former-client staffing and early recovery. Several reviews state that residential staffing or lower management was heavily composed of former clients, and one review alleges that hiring people in early recovery contributed to relapse. This supports requesting hiring, sobriety-duration, supervision, training, and relapse-response policies.

2. Especially Significant Review Leads

March 30, 2026 support-staff review: Alleges favoritism, unfair firing, pressure to work while sick or perform extensive overtime, lack of support after traumatic events, and constant monitoring.

January 28, 2026 therapist review: Alleges being expected to run up to five clinical groups per day with only a vague curriculum, no prepared materials, and no meaningful help; also alleges management failed to act on credible client or staff safety concerns.

November 28, 2023 clinical review: Alleges untrained and overworked residential staff sometimes did harmful things; case managers and program directors lacked empathy or failed to take client matters seriously; and clients beyond the program's

mental-health capability were retained while clinicians struggled to secure higher care.

February 25, 2024 support-staff review: Alleges chronic understaffing, an overcrowded Prospect location, clients retained despite little progress, discharge decisions affected by profitability, and entry-level staff being overworked and underpaid.

June 13, 2022 shift-manager review: A reviewer claiming more than two years of service alleges that management changed after 49% of the company was sold to a conglomerate; full-price clients could remain despite repeated relapse, verbal abuse, or physical altercations; residential staffing was largely former clients; and the company relied on a family culture to retain underpaid workers.

September 21, 2021 support-staff review: Alleges deceptive or questionable tactics to retain employees and clients, few consequences because the program avoided discharge, and that aesthetics sometimes competed with ethics.

May 31, 2021 Woodbury support-staff review: Alleges that most Woodbury staff left at once because of mistreatment and disorganization, including the kitchen staff and five or more support staff, while real issues were ignored.

Support staff / facility manager review: Alleges lower management was often former clients or prior support staff, some were underqualified for serious problems, direct-care staff spoke poorly about coworkers in front of clients, staffing was short, and workers were pressured into transportation and broad supervision duties.

3. Integration into Existing Memo Sections

Existing section	Indeed material to add
VII. Public Review Evidence	Add this as a new Indeed subsection after Glassdoor. State that thirty employee-review screenshots across 2020-2026 repeatedly allege management dysfunction, high turnover, understaffing, weak training, inadequate clinical support, punitive or inconsistent supervision, financial pressure, and difficulty protecting clients.
VIII. Archive Allegations Compared with Public Review Themes	Expand with public review themes: understaffing, money/marketing, client autonomy, and medical/clinical response, cross-reference with public review evidence.
IX. General Patterns Observed	Expand patterns for staff retention, training, management culture, burnout, former-client hiring, no-break practices, and the need for staffing ratios, turnover by site and role, vacancy and overtime data, break compliance, training curricula, group-level supervision, and documentation of requests for additional resources.
X. Records and Questions Required	Request staffing ratios, turnover by site and role, vacancy and overtime data, break compliance, training curricula, group-level supervision, and documentation of requests for additional resources.
XI. Evidence To Preserve	Preserve all thirty screenshots, live Indeed URLs if obtainable, review dates, job titles, locations, star ratings, profile meta-data, and any other information that may be relevant to the investigation.

4. Records and Follow-Up Questions Generated by Indeed Evidence

- Annual and monthly headcount, vacancies, turnover, resignations, terminations, and tenure by role and location from 2020 through 2026.
- Staffing ratios, scheduled versus actual coverage, overtime, call-outs, sick-leave practices, and break records for New Haven, Woodbury, Killingworth, North Haven, Prospect, and other residences.
- Orientation materials, direct-care competencies, de-escalation training, medication and emergency training, trauma-informed-care training, and qualifications required for support staff, shift managers, case managers, nurses, APRNs, and therapists.
- Clinical group schedules, number of groups assigned per clinician per day, curriculum materials, supervision records, and documentation of requests for additional resources.
- Incident, complaint, grievance, HR, quality-assurance, and corrective-action records involving alleged ignored safety risks, client injury, bullying, assault, elopement, medication concerns, or clients believed to require higher care.
- Policies and event-level records governing referral to detox, hospital, emergency evaluation, higher residential care, or discharge when the current program could not safely meet a client's needs.
- Policies governing employment of former clients, minimum time in recovery, conflicts of interest, supervisory safeguards, relapse response, and promotion from support staff into management.
- Compensation, promotion, raise, and advancement criteria; evidence concerning alleged promises made during recruitment; and records of favoritism or retaliation complaints.
- Internal financial or utilization-review communications concerning census, full-price or private-pay status, occupied beds, discharge, internal extended-care referrals, and decisions to retain clients after relapse, aggression, or limited progress.
- Policies and enforcement records concerning meal/rest breaks, off-the-clock work, mandatory overtime, being required to work while sick, and use of personal vehicles or company vehicles for client transport.

5. Evidentiary Limits and Archive-Safe Characterization

Indeed employee reviews are anonymous and are not independently verified. They cannot establish the facts of any specific client incident, the identity of the reviewer, or the accuracy of every employment claim. Their value is cumulative and pattern-based: reviewers writing across multiple years, roles, and locations repeatedly allege overlapping problems involving leadership, staffing, training, retention, client safety, financial priorities, and employee burnout. The proper use is to preserve the reviews, identify corroboration targets, and request the underlying records.

Archive-safe public sentence: Thirty preserved Indeed employee-review screenshots dated from 2020 through 2026 repeatedly allege management dysfunction, high turnover, understaffing, weak training, inadequate clinical support, punitive or inconsistent supervision, financial pressure, and difficulty protecting clients. These anonymous reviews are not official findings, but their consistency across roles and locations supports specific requests for staffing, HR, training, incident, referral, and quality-assurance records.

Exhibit I-1: Indeed employee review

Support Staff, New Haven - Mar. 30, 2026

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ March 30, 2026

Clients are great upper management will make you leave.

Support Staff 📍 New Haven, CT

What is the best part of working at the company?

Engaging with the clients is highly rewarding. They are the only pro of the job. Management does not care about you. They are sneaky and will try to catch you doing anything wrong. My co workers were fired unfairly while other co workers doing worse actions were kept. There is clear favoritism among upper management. Unless you have no personal life, are willing to work a lot of overtime they will not like you. They will expect you to work when sick. Being with the clients is rewarding. The corporate structure is very apparent and not what you want to see in a healthcare setting.

What is the most stressful part about working at the company?

Lack of support from management when traumatic things would occur. Always being watched.

Exhibit I-2: Indeed employee review

Therapist, New Haven - Jan. 28, 2026

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★★ January 28, 2026

It won't make you feel good working here

Therapist 📍 New Haven, CT

In my short time at Turnbridge, I was asked to run up to five clinical groups per day with no support other than a vague curriculum. There were no materials prepared in advance and no help offered in performing this task.

I never saw management take action on client or staff concerns -- the culture very much seemed to wave these off, even when there were credible safety risks. The people who have been there the longest seem resigned to this fact. It's depressing. The clients could be fun to work with, but that paled in comparison to the sense that what you were doing there wasn't helping anyone but the shareholders.

Pros ✓

some of the clients

Cons ✗

unsupportive management, depressing culture, general sense of stagnation

Ratings by topics

1.0 ★ Work/Life Balance

3.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-3: Indeed employee review

Role listed N/A, New Haven - Aug. 5, 2024

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

☆☆☆☆☆ August 5, 2024

Terrible company with poor employee appreciation

N/A 📍 New Haven, CT

Poorly managed company with little to no support to employees; employees are expendable. The culture is dishonest; money is the bottom line. This is not the top-notch care that is advertised. Staff is untrained and ill-equipped to handle the population it serves. The overall experience can be summed up as disorganized.

Ratings by topics

1.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-4: Indeed employee review

Support Staff, Woodbury - July 3, 2024

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★★ July 3, 2024

draining

Support Staff 📍 Woodbury, CT

as much as you want to help the clients at this facility. support staff aren't in a position to do that because of the standards put in place by those who are higher up.



Exhibit I-5: Indeed employee review

Support Staff, New Haven - June 13, 2024

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★★ June 13, 2024

Treated like a minion

Support Staff 📍 New Haven, CT

As a support staff, I feel as though we are treated like minions, cleaning the facility, assigned chores, reprimanded when our cleaning chore was not completed up to par, etc. If we sat down for a second, we were looked at sideways, I came home drained and beat down as a result of being at the bottom of this totem pole. We were the minions assigned to do the dirty work and it was known that support staff was at low stature.

Ratings by topics

1.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-6: Indeed employee review

Direct Support Professional, New Haven - May 26, 2024

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ May 26, 2024

You want to believe you're doing good

Direct Support Professional 📍 New Haven, CT

The interviewing process went great and I was promised so many things...WRONG. Although there are a lot of little things you constantly have to be aware of, it seemed simple at first. Until I got transferred to another house and a situation happened where the staff seemed not to care about a client. That's when I lost faith in this company and left.

The staff are burnt out as well as the managers. It seems as if most care about the well-being of the clients but lack the proper training/resources. And the amount of pay being offered is absolutely garbage. I was making more money working at my other part-time job. This company is a joke. The amount of money they charge the parents to send their kids here and offer that is an insult.

Pros ✓

Benefits?

Cons ✗

No lunch breaks, pay, toll on mental health

Ratings by topics

2.0 ★ Work/Life Balance

3.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

2.0 ★ Management

2.0 ★ Culture

Exhibit I-7: Indeed employee review

Support Staff, New Haven - Mar. 14, 2024

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★★ March 14, 2024

An eye opener into health field looks like

Support Staff 📍 New Haven, CT

Well Turnbridge checks the boxes as far as rehab facility goes it seems as if the people that Direct and implement program structures don't concern themselves with individual welfare and they're much more concerned with a reputation than their integrity.

Pros ✓

Great start to Human Services, friendly camaraderie among staff

Cons ✗

This is a Hospitality position

Ratings by topics

2.0 ★ Work/Life Balance

4.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

2.0 ★ Management

4.0 ★ Culture

1 1

Exhibit I-8: Indeed employee review

Support Staff, New Haven - Feb. 25, 2024

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ February 25, 2024

The lack of staff perpetuates the exhaustion, the exhaustion perpetuates the lack of staff.

Support Staff 📍 New Haven, CT

Despite reading many negative reviews, I took a chance on Turnbridge, excited for a new job opportunity where I could make a difference. Orientation and trainings were exciting at first... and give you the false sense that this is a place that cares about its employees. Any "support" that you are offered from higher ups is simply to save face for the company and the fact that the main purpose of this facility is to make money is so apparent it becomes impossible to deny- even to the clients. The facility is infamous for taking on cases who need higher levels of care and keeping them there despite any progress being made, then giving the boot to one's who are not yet ready to leave if they aren't making enough money off them. The most overworked and overlooked people in this company are the entry level support staff, all while being told they are the back bone of the company. Support staff are seldom promoted as it is so hard to find dedicated, responsible ones to begin with. The place is a revolving door of disgruntled, overworked people, as well as people who have no business being hired in the first place. While this can be the case at many facilities such as these, Turnbridge stands alone as the worst. A typical shift at the Prospect location involves running throughout the chaotic house struggling to log mundane tasks in an overcrowded house, unable to support the clients due to staffing issues. Adult support staff are spoken to like children, run into the ground and insultingly underpaid. All of the aforementioned is also a big topic of conversation amongst the clients, and the wages of the staff are common knowledge to them.

If you do decide to work here, use it to get your foot in the door then take the experience and RUN to another company who will pay you what you deserve and treat you with respect.

Pros ✓

They hire without experience (though that can also be a con, as they have hired many questionable characters)

Cons ✗

Stress, insulting pay, poor management, disorganization

Ratings by topics

- 1.0 ★ Work/Life Balance
- 1.0 ★ Compensation/Benefits
- 1.0 ★ Job Security/Advancement
- 1.0 ★ Management
- 1.0 ★ Culture

Want

Exhibit I-9: Indeed employee review

Direct Support Professional, Killingworth - Dec. 6, 2023

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ December 6, 2023

Pay is good but job is horrible

Direct Support Professional  Killingworth, CT

The management makes it seem all sweet there but once you really start working it's the worst place you can ever work at. Save yourself the time and just don't work there. Management does not care about you, they will fire you whenever they are done with you for no reason at all. They let the clients get away with whatever they want, a very toxic workplace, it messed with my head so much this job gave me ptsd. I will never work for a private company again because this job ruined my experience. Management is the worst at this place!



Exhibit I-10: Indeed employee review

Direct Support Professional, Killingworth - Dec. 5, 2023

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★☆☆☆☆ December 5, 2023

Horrible place to work at

Direct Support Professional 📍 Killingworth, CT

Alarms in cottages are useless girls run anyways, nurses should get their license revoked and management is very unprofessional. This is the worst company I ever worked for and I've worked at a lot. The management don't care about their employees and how good they work, they just look at all the bad you do. I don't recommend working here, the pay is worth it but not the headaches everyday.

Pros ✓

Free dinner, pay

Cons ✗

Lack of communication, horrible management

Ratings by topics

1.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-11: Indeed employee review

Transport / Support Staff, New Haven - Dec. 3, 2023

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★★ December 3, 2023

Miss the clients

Transport/support staff 📍 New Haven, CT

What is the best part of working at the company?

There is nothing good work for them but working with the young ladies was experience I will never forget .

What is the most stressful part about working at the company?

Management/HR and lack of communication

What is the work environment and culture like at the company?

Clicky there are many clients that become staff in early recovery that causes relapse

What is a typical day like for you at the company?

Can be very stressful But miss the connection with the clients

Exhibit I-12: Indeed employee review

Clinical, New Haven - Nov. 28, 2023

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ November 28, 2023

So much potential, falls incredibly short.

Clinical 📍 New Haven, CT

You want to love it here. You want to believe in it so badly, but it leaves a lot to be desired. The residential floor staff are not trained well in mental health management and are overworked on top of it so they often do harmful things. The people in higher roles such as case managers or program directors also have little empathy or desire to take client matters seriously, often leaving clinicians in a tough spot. You can't undermine your coworkers and also have to find a way to validate your clients. It's possible, but when you know your coworker is in the wrong it makes things incredibly difficult.

There is a lot of flexibility as a clinician to do whatever work you would like with clients, however they are unmotivated and here not by their choice in many cases. The program also takes clients that are way out of their league with mental health management, therefore it's a constant battle with higher ups to refer clients out to a higher (more appropriate) level of care. They say they are residential, however they do not have major components of a residential facility, i.e. locking up sharps or chemicals as an example. If you want to get paid well this is a good place. I ultimately left when I lost complete faith in everything this program had to offer.

Exhibit I-13: Indeed employee review

Therapeutic Support Staff, New Haven - Aug. 9, 2023

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ August 9, 2023

the work place was stressful and always had to be on your toes in case if any emergencies which were every second of the days.

Therapeutic Support Staff 📍 New Haven, CT

What is the best part of working at the company?
driving the suburban for a shift.

What is the most stressful part about working at the company?
dealing with residents that have substance, mental & health problems.

What is the work environment and culture like at the company?
uncomfortable and there's no diversity unless you're white you'll get promoted to another position.

What is a typical day like for you at the company?
tiring and exhausting because 3rd shift wasn't the easiest.

Exhibit I-14: Indeed employee review

Support Staff, Woodbury - July 26, 2023

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

☆☆☆☆☆ July 26, 2023

wouldn't recommend this company to my enemy

Support Staff 📍 Woodbury, CT

My manager literally gave me PTSD. Took over a year of being gone from there to be comfortable even being in the same room as my current boss due to the trauma i received from him. Won't praise you for anything good you have done, or working 90 hours a week but is quick to make you feel like hiring you was the worst thing the company could've done. Highly toxic work environment.

Exhibit I-15: Indeed employee review

Direct Support Professional, Killingworth - May 30, 2023

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ May 30, 2023

Was amazing til it wasn't

Direct Support Professional 📍 Killingworth, CT

After the interview process I was super excited to begin working. The scenery is amazing and the building and land is beautiful.

After beginning work everything started to go down hill from there, limited staff working and number of staff to kids were unbearable and dangerous. The pay is not worth it for the amount of work your gonna have to do here.

Pros ✓

Free lunch

Cons ✗

Management, pay

Ratings by topics

1.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-16: Indeed employee review

Registered Nurse, Woodbury - May 21, 2023

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★ ★ ★ ★ ★ May 21, 2023

Unfair

Registered Nurse 📍 Woodbury, CT

Quick to let staff go. High turnover rate. Poor job security. Would not recommend fellow nurses to apply here. DNS was great. Upper management difficult to work with.

Pros ✓

Free meals

Cons ✗

No breaks

Ratings by topics

1.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-17: Indeed employee review

Support Staff, North Haven - Apr. 29, 2023

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★★ April 29, 2023

Not a fun place to work

Support Staff 📍 North Haven, CT

The most enjoyable part of the job was interacting with the clients on a one to one basis. It was nice to be able to talk to one client about their individual struggles and past experiences. I learned a lot about how different it is to grow up in the current times and how quickly teens are exposed to everything.

Pros ✓

free dinner

Cons ✗

horrible management

Ratings by topics

3.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-18: Indeed employee review

Therapist, New Haven - Mar. 1, 2023

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ March 1, 2023

Meh

Therapist 📍 New Haven, CT

Pretty standard residential treatment where clinical leadership think they are above the rules. Heard a lot of terrible things from prior to when I was working there that they would not address nor did they apparently put new policies into place to handle.



Exhibit I-19: Indeed employee review

Staff, Connecticut - Dec. 29, 2022

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★★ December 29, 2022

The management is horrible, they don't take into consideration that their d workers have outside lives that are important.

Staff 📍 Connecticut

If you want to keep your sanity and good morals don't work here. This place takes away all your energy and feeds you will negative lies and confusion. Management is horrible. They promise you one thing then go back on their word. If you're support staff good luck, you'll love the clients but you'll hate being a maid

Pros ✓

Free lunch. Meeting great clients .

Cons ✗

No breaks . Even when you're eating .make sure you don't get too comfy

Ratings by topics

3.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-20: Indeed employee review

Direct Support Professional, Killingworth - Nov. 29, 2022

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

☆☆☆☆☆ November 29, 2022

Seems legit, until it isn't.

Direct Support Professional 📍 Killingworth, CT

This job started out as a dream. A way to help teenagers who need it. It's a beautiful facility and some of the perks (the views, the on site meals) are worth it. That's where the perks end. They promise you a lot and never follow through. If you complain at all about management they will find a way to let you go. The high stress environment isn't worth the pay they offer. Proceed with caution.

Pros ✓

Free meals, nice facility

Cons ✗

Bad management, low pay, high stress

Ratings by topics

1.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-21: Indeed employee review

Support Staff, Woodbury - Sept. 26, 2022

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ September 26, 2022

Mostly paid to hangout

Support Staff 📍 Woodbury, CT

Place is cozy but comes with a catch. Very little upward mobility and trainings are lacking. Those at the top don't seem to care. Bottom level support staff mostly seem to care.



Exhibit I-22: Indeed employee review

Staff, New Haven - Sept. 14, 2022

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ September 14, 2022

not positive

Staff 📍 New Haven, CT

not the greatest place to work. management is all over the place. everyone tells you something different. focus does not seem to be on the clients at all.

Ratings by topics

2.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

2.0 ★ Job Security/Advancement

2.0 ★ Management

2.0 ★ Culture

Exhibit I-23: Indeed employee review

APRN, New Haven - July 10, 2022

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★★ July 10, 2022

Eh

APRN 📍 New Haven, CT

Overall enjoyed the experience and the work itself. Management very focused on the bottom line and will cut corners where they can. Not the strongest MOS

Ratings by topics

1.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

2.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-24: Indeed employee review

Shift Manager, New Haven - June 13, 2022

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ June 13, 2022

Bad pay, poor management, great coworkers

Shift Manager 📍 New Haven, CT

I worked for Turnbridge for over 2 years as Support Staff then Shift Manager. Overall my coworkers were amazing and I made many friends while working here. There is actually a close environment and people often get together on their days off and make lasting friends.

HOWEVER, the pay is horrendous and management isn't much better. Everyone from entry-level support staff to case managers are underpaid. Other than a state-run facility, you will be compensated better elsewhere.

Management lost touch with their staff and clients about 6 years ago (after 49% of the company was sold to a conglomerate). Clients can get away with almost anything. Multiple relapses, verbal abuse, and sometimes physical altercations will not get you kicked out if you pay full price.

Advancement is difficult in this company. Many hard-working staff members have been passed up for promotions either because they were too good at their current job or someone else had a better "face" for working with non-clients (family members, recovery coaches, higher management). Hard work and good results may not get you the advancement you are looking for. Residential staff is mainly comprised of former clients and management banks on the "family" aspect of the company to retain them. Pay raises are practically non-existent at TurnBridge.

This is a great place to work for a year or two and get your foot in the door, but this is not a long-term career option. If you have a family I would not consider working here unless you are a licensed therapist or in upper management. Any residential position or case manager position is not compensated fairly.

Ratings by topics

3.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

2.0 ★ Management

4.0 ★ Culture

Exhibit I-25: Indeed employee review

Support Staff, New Haven - Apr. 12, 2022

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ April 12, 2022

Quality people at the lowest level, gets messy fast above that

Support Staff 📍 New Haven, CT

A lot of work for non-competitive pay. They'll say things in the interview process that they don't follow up on. Great way to get entry level experience but your best chance of upward movement or pay bumps is using that experience elsewhere.

Ratings by topics

1.0 ★ Work/Life Balance

2.0 ★ Compensation/Benefits

2.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-26: Indeed employee review

Role listed N/A, New Haven - Mar. 20, 2022

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ March 20, 2022

Coworkers are great, work culture is bad

N/A 📍 New Haven, CT

The employees at Turnbridge are great, but the culture at the company is awful. There is a hierarchy, and it doesn't feel like the clients are at the core of the company mission.

Ratings by topics

4.0 ★ Work/Life Balance

3.0 ★ Compensation/Benefits

3.0 ★ Job Security/Advancement

2.0 ★ Management

2.0 ★ Culture

Exhibit I-27: Indeed employee review

Support Staff / Facility Manager, New Haven - date not visible in supplied capture

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

Support Staff/Facility Manager New Haven, CT

Overall the work environment can be summarized as everyone complains, clients and staff. From my experience I worked at a handful of locations and they are pretty much all the same. Kitchen staff complains about support staff, clients complain about kitchen staff, support staff complains about direct care staff. The management on the lower levels is mostly comprised of former clients or prior support staff members. Mostly good people but some are definitely entitled and under qualified to handle a serious problem. I've had proof of direct care explicitly speaking poorly about me/other staff members to the clients, while never hearing the negative feedback from that person. I've had problems communicating with higher up management over issues with scheduling. It is a residential program that doesn't have housekeeping so a majority of time will be spent cleaning up after fully grown men. Do not recommend this job to anyone with thin skin. The pay is mediocre for what is expected of staff, which includes cleaning, being responsible for the location of upwards of 15+ people, maintaining a positive living environment, keeping clients on schedule as most of them will not attend what they're told unless reminded multiple times and much more. If you are approved to be a driver they will have you driving everywhere. They can't really force anyone to drive their own vehicle(per the DOL) but when they ask you to drive someone it's expected you will do it without a fight. I've said no once and the manager drove the screws and basically forced me to go on a rec. trip with ≈10 guys to a haunted house. I don't like suspense as it makes me very anxious but I was forced to take the clients in the company car and walk through the house with them. I have several more stories of mistreatment but I don't want to keep writing all day. If you're interested in the field of therapy, or counseling, it's a decent place to start.

Pros

Weekly gas pay, free lunch depending on location.

Cons

No scheduled breaks, frequently short staffed, disorganized management, mostly disrespectful and antagonistic clientele.

Ratings by topics

1.0 ★ Work/Life Balance

3.0 ★ Compensation/Benefits

2.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-28: Indeed employee review

Support Staff, New Haven - Sept. 21, 2021

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ September 21, 2021

Fun work environment

Support Staff 📍 New Haven, CT

It's a fun and social work environment. Company uses some deceptive and questionable tactics to retain employees and clients. Pay is comparable to the rest of the industry. Excellent place to start a entry level position in addiction treatment. Client's can be very difficult to deal with and there is very few consequences for them as the program avoids discharging clients as much as possible but within reason. Aesthetics compete with ethics sometimes.

Pros ✓

Social, fun, unique work experience.

Cons ✗

Limited growth, difficult clients

Ratings by topics

2.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

2.0 ★ Management

4.0 ★ Culture

Exhibit I-29: Indeed employee review

Support Staff, Woodbury - May 31, 2021

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

☆☆☆☆☆ May 31, 2021

Would Not recommend

Support Staff 📍 Woodbury, CT

You will be promised advancement and whatever else so that they can get u employed and through the doors to work. Management is incredibly inefficient and unqualified. All the wrong things are made to be a big deal, while the real issues are ignored. If you do a great job you will NOT be recognized. The people running Turnbridge Woodbury are there for their pockets alone and not to help the clients (kids) coming into treatment. You will be overworked and underpaid. The company currently has lost the majority of their staff in Woodbury at one time, due to mistreatment and disorganization. The entire kitchen staff as well as 5 or more support staff so only God knows who they will be hiring to do this job. Good speed of u apply.

Pros ✓

Free lunch and dinner

Cons ✗

No breaks are given all shift.

Ratings by topics

1.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit I-30: Indeed employee review

Maintenance / Laborer, New Haven - Jan. 28, 2020

User-supplied screenshot preserved as public employee-review evidence. The review is an allegation, not an official finding.

★★★★☆ January 28, 2020

No room for growth

Maintenance/Laborer 📍 New Haven, CT

Ok job for maintenance if you just want a paycheck & no growth. The fact they expect you to be on call around the clock for snow removal is obnoxious & hardly worth the compensation. Has potential to be so much more, if anyone actually cared enough.

Pros: Paycheck

Cons: Everything else

Ratings by topics

1.0 ★ Work/Life Balance

1.0 ★ Compensation/Benefits

1.0 ★ Job Security/Advancement

1.0 ★ Management

1.0 ★ Culture

Exhibit TM-4 - Turnbridge softball team "Minus 160" jersey photograph

User-supplied photograph preserved as corroborating context for A.'s direct former-client testimony that Thomas Marzilli named a Turnbridge softball team "Minus 160," a betting-odds reference. The photograph appears to show Marzilli at a softball field wearing a red Turnbridge jersey bearing the team name. The image supports the narrower proposition that the team name was used; it does not independently establish compulsive gambling or prove any other allegation.



Turnbridge / Turning Point Due-Diligence Memo

SUPPLEMENT TO A. DIRECT-SOURCE TESTIMONY - ADDITIONAL CLIENT-ON-CLIENT SEXUAL-VIOLENCE AND STAFF-RESPONSE ACCOUNT

Source and status. On July 28, 2026, A. supplied an additional Instagram direct-message account after her longer written testimony had already been incorporated into this memorandum. This supplement is part of A.'s controlling direct-source entry. Public and circulated versions must continue to identify her only as **A.** The account is direct former-client testimony, not an adjudicated finding.

A. Additional account concerning physical violence, alleged coerced sexual activity, and staff response

A. reports that, during the broader period connected to Turnbridge and the New Haven recovery community, she had an on-and-off sexual relationship with another female former client for approximately two years. According to A., a male Turnbridge client with whom that woman had also been involved became physically violent toward the woman. A. did not report that the violence was directed at her. A. further reports that the same male client coerced another former friend into sexual activity. A. states that she recognized one of the stories previously posted by the archive as concerning the same broader situation or individual.

A. clarified that the alleged aggressor was a Turnbridge client, not a staff member. She states that the physical violence was directed at the woman A. had been involved with, not at A. She alleges that Turnbridge staff did nothing meaningful in response and instead reprimanded A. when she confronted or went after the male client because of the reported conduct.

B. Evidentiary distinctions

- A. personally reports her own relationship history and her later confrontation with the male client; she does not report being the person physically harmed or coerced.

- The allegation that the male client became physically violent toward the woman was communicated to A. by that woman and is therefore a direct-source report of a disclosure, not conduct A. states she personally witnessed.

- The allegation that the male client coerced another former friend into sexual activity is presently A.'s report and requires direct confirmation from the person allegedly harmed and any other witness.

- A. personally alleges that staff reprimanded her for confronting the male client and did not meaningfully address the underlying reported violence or coercion.

- The identities of all private clients should remain anonymized unless they independently authorize identification or regulators obtain the information through a confidential process.

C. Institutional significance

This account adds another sexual-safety and client-protection concern to A.'s testimony. If staff received or became aware of reports that a client had been physically violent toward a sexual partner and had coerced another person into sexual activity, the program should have had a documented process for immediate safety assessment, separation, clinical response, victim support, mandated-reporting analysis, family or guardian notification where applicable, and referral to law enforcement or outside authorities where legally required. Reprimanding the person who confronted the alleged aggressor, without meaningfully addressing the underlying allegations, would raise separate questions about retaliation, misplaced discipline, protection of dominant clients, and whether reporting sexual or physical harm was made unsafe.

D. Records and corroboration to preserve or request

- A.'s complete Instagram thread and original screenshot metadata.

- Direct accounts from the woman who allegedly disclosed physical violence and the former friend who was allegedly coerced into sexual activity, if they choose to participate.

- Identity, placement dates, house assignments, and case-management records for the male client, maintained confidentially.

- Incident reports, clinical notes, house logs, shift notes, safety plans, separation decisions, grievance records, and staff communications concerning any reported violence, sexual coercion, retaliation, or confrontation.

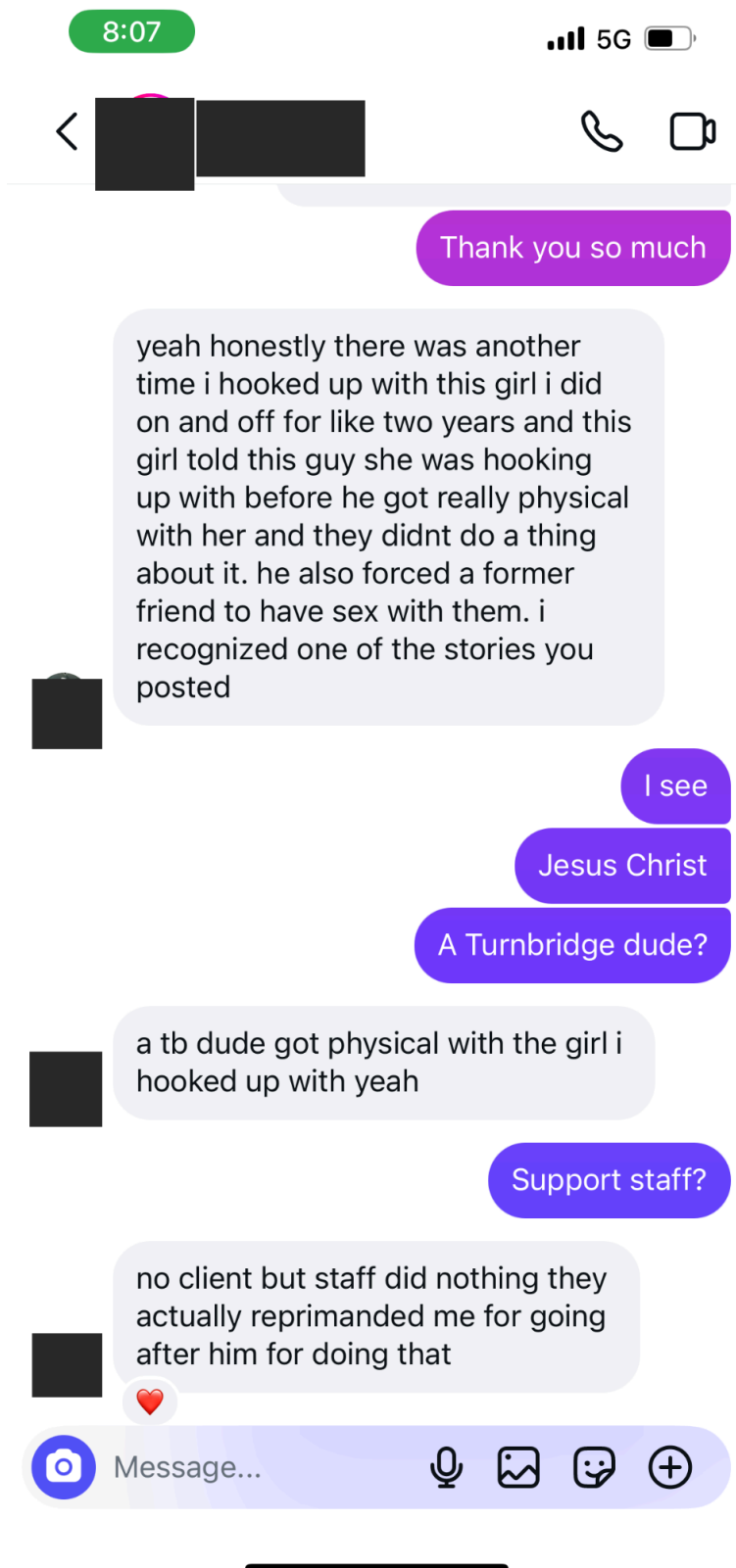
- Records identifying which staff reprimanded A., what conduct was cited, what was documented about the underlying allegations, and whether any victim-centered interview or external report occurred.
- Policies governing client-on-client sexual violence, dating, coercion, retaliation, reporting, mandated reporting, law-enforcement referral, and protection from reprisal.

E. Archive classification and use rule

Supplemental direct former-client testimony from A. relaying allegations that a male Turnbridge client was physically violent toward a woman A. had been involved with and coerced another former friend into sexual activity, together with A.'s firsthand allegation that staff failed to meaningfully respond and reprimanded her for confronting the accused client. A. does not report that the physical violence or sexual coercion happened to her. The underlying conduct remains unverified and must be attributed precisely. This supplement should be integrated into A.'s controlling entry and the memorandum's sexual-safety, complaint-response, retaliation, and client-protection pattern sections without being collapsed into a proven institutional finding.

Exhibit A-SUP-1 - Redacted Instagram follow-up from A.

This exhibit preserves A.'s additional direct-message account. It is included as source documentation, not as an adjudicated finding. The source is identified publicly only as A. Private-client identities remain omitted. The screenshot records A.'s statement that a male Turnbridge client allegedly became physically violent toward a woman with whom A. had been involved, allegedly forced another former friend into sexual activity, and that staff did not meaningfully respond but reprimanded A. for confronting him.



Turnbridge / Turning Point Due-Diligence Memo

KILLINGWORTH 2025 REDDIT SOURCE ADDENDUM - August 2, 2026

27. smackinbucketsss - direct former-client account of peer unpredictability, fights, riots, nicotine, and THC cartridges at Killingworth in 2025

Source and status. On August 2, 2026, a Reddit user identified by the handle **smackinbucketsss** responded to the memorandum author after stating that the source had attended Turnbridge's Killingworth adolescent program during 2025. The source's response is preserved as direct former-client testimony about conditions personally experienced or observed. It is not an adjudicated finding, and the exchange does not establish exact admission dates, age, house assignment, staff roster, or the dates of particular incidents.

Initial safety clarification. The source stated that nobody at Turnbridge put hands on the source "in no typa way" except in connection with fights. The wording is best read as a denial of staff assault or restraint directed at the source, while acknowledging physical contact associated with peer fights. The exchange does not identify who fought the source, how often fights occurred, whether injuries resulted, or how staff responded.

The source then described the Killingworth environment in the following terms:

"There was just mad crazy ass jits who were always mad unpredictable ... most incidents were riots or sh ... My group had nic and carts too ... Rehab js a fever dream fr."

A. Peer unpredictability, fights, and reported riots

The source described other adolescents as highly unpredictable and stated that many incidents were "riots or sh[...]." The source also referred to fights. The exchange does not define what the source meant by "riot," identify the number of events, distinguish large group disturbances from smaller fights, or state whether police, EMS, restraint, injury treatment, family notification, or significant-event reporting followed. Those details require structured follow-up and records review.

B. Nicotine and THC cartridges in the peer group

The source stated that the source's group possessed "nic and carts," reasonably understood in context as nicotine products and vape cartridges, including THC cartridges. This is direct testimony that contraband nicotine and cannabis-vape products were present within the peer group. The exchange does not identify who possessed them, how they entered the residence, whether staff knew, whether searches or drug tests occurred, or whether any medication, intoxication, or safety event was linked to them.

C. Cross-corroborative significance

This account independently overlaps several existing adolescent-program concerns already preserved in the memoranda: recurrent peer violence, large disturbances, unpredictable residents, contraband vaping, and the broader impression that the residential experience became chaotic and difficult to process. It also gives qualitative context to Turnbridge's own 2025 reporting of substantial significant-event activity at Killingworth, including physical-aggression and medication-error categories. The source's statement should not be treated as proof that every reported event was a riot or that the source personally witnessed every event in the annual report. Its value is as a direct 2025 participant account that converges with the institutional data and other former-client reports.

D. Records and corroboration to request

- Exact admission and discharge dates, age, house/group assignment, and the source's clarification of what events were called riots, including dates, participants, injuries, restraint, police/EMS involvement, and family notification.
- All 2025 Killingworth significant-event reports, incident narratives, house logs, shift notes, CCTV, staff schedules, injury records, police/CAD/EMS records, and post-event reviews relating to group disturbances and fights.
- Contraband, search, drug-testing, vaping, nicotine, THC-cartridge, confiscation, visitor, transport, package-screening, medication, and intoxication records for the source's residence or group; plus accounts from peers, staff, and parents.

E. Evidentiary classification and source-use rule

Direct former-client Reddit testimony concerning the Killingworth adolescent program in 2025. The source personally denies being physically handled by staff in the manner asked about, while acknowledging fights and describing unpredictable peers, incidents characterized as riots, and nicotine and THC cartridges within the group. The account remains preliminary and should be preserved with the full Reddit thread, timestamps, username, and any later clarification. Public use may identify the source only by the Reddit handle unless the source authorizes broader identification. The account should not be expanded beyond the source's words without follow-up.

Exhibit SB-1 - Reddit exchange concerning Killingworth in 2025

Clean-text preservation of the August 2, 2026 Reddit exchange. This exhibit preserves spelling, slang, and fragmented formatting in substance. It is not a complete interview or adjudicated finding.

HedgehogMinimum9299 - 12:02 AM

First off I agree with you tramadol sucks and that's wild - you were at the Killingworth house during the same year covered by Turnbridge's own 2025 adolescent residential report. I've been putting together a detailed regulator-facing memo based on my experience, accounts from other former clients, public records, and Turnbridge's internal materials.

Did you have any bad experiences at Killingworth - anything involving staff, other clients, medication, safety, being unable to leave, physical fights or assaults, restraint, or anything else that felt wrong? Turnbridge's own 2025 report lists 75 significant-event reports at Killingworth, including 58 reports involving physical aggression across the two adolescent sites, as well as self-harm risks, elopements, substance-use incidents, and 48 medication-error events at Killingworth.

You can share as much or as little as you're comfortable with. I won't use your name or anything identifying without your permission.

smackinbucketsss - 6:50 AM

Got damn son did the research [crying emoji]

Nb ever put

They hands on me in no typa way

Except for fights

There was just mad crazy ass jits who were always mad unpredictable

And most in

Incidents were riots or sh

My group had nic and carts too

Rehab js a fever dream fr

Preservation note

Preserve the original Reddit thread and screenshots, including timestamps, account metadata visible to the memorandum author, and any later messages clarifying the source's dates, age, house, definition of "riots," injuries, staff response, contraband access, and publication preferences. Do not infer the source's legal identity or publish additional identifying information without permission.

Turnbridge / Turning Point Due-Diligence Memo

SUPPORT STAFF DIRECT-SOURCE ADDENDUM - AUGUST 3, 2026

Source identifier: S.S. ("Support Staff")

Source status: A Turnbridge support-staff source who reported approximately three years of work at the program. The source's identity, precise employment dates, and present employment status are withheld in all circulated versions. This account is direct source testimony and a records-request lead, not an adjudicated finding.

Source-protection rule: Use only the identifier S.S. in public, legal, regulatory, journalistic, or survivor-facing circulation unless the source separately authorizes identification. Preserve the original messages, timestamps, account information, and any later consent instructions in a restricted source archive. Do not publish screenshots or identifying employment details without explicit permission.

1. Clients allegedly retained despite need for hospital-level psychiatric care

S.S. reported that he had seen clients whose psychiatric needs appeared to exceed Turnbridge's level of care remain in the program for extended periods. He stated that at least two clients were in active and very intense psychosis and were kept at Turnbridge for months before the circumstances escalated enough that they were ultimately sent to a hospital or called police themselves.

S.S. characterized both clients as clearly presenting danger to themselves or others while no timely higher-level transfer occurred. His account raises questions about psychiatric screening, emergency transfer criteria, clinical authority, utilization review, family notification, financial or census incentives, and whether unlicensed residential staff were left managing clients whose needs required inpatient or hospital-based care.

Evidentiary distinction: S.S. presents this as information known through his work and direct exposure to the program. Follow-up should establish which facts he personally observed, which were documented in staff communications, and which were communicated by case managers or other personnel.

2. Specific knife and homicide-threat safety account

S.S. described a specific client housed in a residence where S.S. worked. According to S.S., the client threatened to murder other residents and was repeatedly caught with knives, yet remained in the house. S.S. stated that he personally found three large knives in the client's room over approximately a two-week period.

If accurate, this presents an acute client-safety, weapon-control, psychiatric-escalation, and supervision concern. The central question is why a resident allegedly making homicide threats and repeatedly possessing large knives remained in shared housing, what risk assessments were completed, who was notified, and what protective measures were used for the other residents.

Priority records:

- House rosters, staff schedules, room-search logs, contraband logs, sharps or weapon inventories, photographs, and chain-of-custody records for each knife discovery.
- Incident reports, clinical notes, psychiatric evaluations, safety plans, homicide-risk assessments, emergency-transfer discussions, and utilization-review communications.
- Notifications to supervisors, clinicians, families, police, mobile crisis, hospitals, DPH, DCF where applicable, or other outside authorities.
- Records showing whether the client was searched, restricted, moved, discharged, hospitalized, or permitted to remain after each threat or knife discovery.
- Witness accounts from residents and staff assigned to the house.

3. Independent corroboration of Drew Behr showing M.J. incident footage to clients

S.S. independently identified himself as one of the clients to whom Drew Behr showed the M.J. incident footage. This directly corroborates the memorandum author's existing firsthand account that Behr replayed surveillance footage of a serious client-on-client incident to multiple clients.

The existing entry describes footage of M.J. chasing and spraying C.S. with a fire extinguisher while attempting to strike him with it. S.S.'s statement supports the narrower proposition that Behr showed the footage to clients. Additional follow-up should determine whether S.S. also remembers Behr laughing, calling C.S. a "dumbass," or making other comments while displaying it.

Cross-reference: Firsthand Observations, item 1 - staff replaying CCTV footage of the M.J. / C.S. fire-extinguisher incident.

4. Retrospective account of the memorandum author's treatment and L.M. concerns

S.S. stated that when he first revisited the period, he mainly remembered the memorandum author getting in trouble. As he thought more carefully, he recalled how badly case managers and support staff treated the memorandum author on a daily basis. He also described L.M. in extremely negative terms and stated that he regretted laughing at the memorandum author during a difficult moment.

This is relevant as a retrospective account from a source with direct personal familiarity with the memorandum author during the program period. It does not independently prove every event involving L.M. or every staff interaction, but it supports the broader concern that institutional narratives about a client being "in trouble" may obscure how staff and peers were treating that client.

The memorandum author responded that S.S. had also been supportive at times and recalled shared positive experiences. This preserves the complexity of the source relationship rather than reducing it to either complete hostility or complete corroboration.

5. Direct-care culture and reported higher-level statements

S.S. described the direct-care culture in strongly critical terms, stating in substance that direct-care personnel did not care about clients. This is a broad evaluative statement rather than a discrete fact and should be tested through specific incidents, staffing records, supervision, turnover, complaints, and other staff or client testimony.

S.S. also relayed a statement through the following chain: Tom Marzilli allegedly said that "the parents are the real clients"; a former case manager identified as Carter reportedly told this to S.S.; S.S. then relayed it to the memorandum author. S.S. did not hear Marzilli make the statement directly. This is therefore a multi-level relayed allegation requiring direct confirmation from Carter, Marzilli, other staff who heard the statement, or contemporaneous communications.

If corroborated, the statement would be relevant to the recurring concern that the paying parent or family - rather than the resident receiving care - functioned as the institution's primary customer and source of authority.

6. Reported staff-client sexual-boundary and staff-substance concerns

S.S. reported learning that a former support-staff manager was fired after allegedly attempting to have sex with a client, including taking the client to dinner. The exact staff member, client, dates, ages, program, source of S.S.'s knowledge, and employment action remain to be established. This should be treated as a relayed staff-client sexual-boundary and termination lead, not a proven event.

S.S. further stated that staff were allowed to work while high and that he knew of staff members who gave marijuana to clients. The present exchange does not establish whether he personally witnessed these events, reviewed records, or learned of them from other staff. Follow-up must clarify the basis of knowledge before stronger use.

7. Institutional significance

- Possible retention of clients whose psychiatric acuity exceeded the program's safe and licensed level of care.
- Possible failure to respond adequately to homicide threats, repeated weapon possession, and foreseeable danger to residents and staff.
- Independent corroboration that sensitive surveillance footage was shown to clients by a case manager.
- A staff-culture concern in which client trouble or noncompliance may have obscured daily mistreatment by staff and peers.
- A reported parent-centered business orientation that may have placed paying families above resident autonomy and welfare.
- Potential staff-client sexual-boundary violations, impaired staff, and staff provision of substances to clients.
- The significance of support-staff witnesses later reevaluating both the institution and the treatment of specific residents.

8. Records, witnesses, and follow-up

- A source-directed interview with S.S. separating firsthand observations, contemporaneous staff knowledge, statements from Carter, statements from other employees, and later rumor.
- Exact work dates, job titles, houses, supervisors, and programs for S.S., preserved confidentially.
- Identification of the two clients allegedly retained during active psychosis, with lawful privacy protections and regulator access where appropriate.
- All incident, clinical, nursing, psychiatric, utilization-review, discharge, hospital, police, mobile-crisis, and family-notification records for those clients.
- Identification of the residence and client involved in the knife and homicide-threat account; all search, contraband, safety, risk, and staffing records.
- CCTV access logs, staff device access, incident footage, and witnesses concerning the M.J. / C.S. video display.
- Direct interview with Carter concerning what Tom Marzilli allegedly said, the identity of the former support-staff manager, and any other internal matters Carter communicated to S.S.
- HR, supervision, complaint, disciplinary, termination, mandated-reporting, police, DCF, and DPH records concerning any staff-client sexual-boundary incident.
- Drug-testing, impairment, shift, medication, supervision, HR, and incident records concerning staff allegedly working while high or providing marijuana to clients.
- Preservation of the complete August 3, 2026 message exchange, including metadata and any later clarifications or consent instructions.

9. Archive classification and safe-use rule

Direct-source testimony from a Turnbridge support-staff source, identified only as S.S. The account contains multiple evidentiary layers: direct staff observations, direct former-client recollections, independent corroboration of a prior CCTV-display allegation, broad evaluative statements, and relayed information from a former case manager or other staff. No allegation is presented as an adjudicated finding. Each proposition must remain tied to its source level and tested through records and witnesses.

Public-use rule: Public versions may state that S.S. means "Support Staff," but must not identify the source, display the source's social-media account, reveal identifying employment details, or publish original screenshots without explicit authorization. Regulator and counsel versions may preserve restricted identity information separately if the source authorizes confidential disclosure.

EXHIBIT CSS-1 - CLEAN-TEXT SOURCE SUMMARY

Direct-message exchange received August 3, 2026

This exhibit summarizes the substance of the source exchange without reproducing account names, profile images, phone numbers, or other identifying metadata. It is not a verbatim transcript and does not replace the preserved original messages.

Category	Source statement preserved in substance
Higher level of care	At least two clients were reportedly in active and intense psychosis for months before hospitalization or police involvement occurred.
Knife / threat account	S.S. reported personally finding three large knives in one client's room within about two weeks. The client allegedly threatened to murder other residents and remained in the house.
CCTV corroboration	S.S. identified himself as one of the clients shown the M.J. incident footage by Drew Behr.
Retrospective treatment account	S.S. stated that he initially remembered the memorandum author mainly as getting in trouble, but later remembered daily mistreatment by case managers and support staff.
Parent-customer statement	S.S. reported that Carter told him Tom Marzilli had said, in substance, that the parents were the real clients.
Sexual-boundary lead	S.S. reported learning that a former support-staff manager was fired after allegedly attempting a sexual relationship with a client and taking the client to dinner.
Staff impairment / substances	S.S. stated that staff were allowed to work while high and that he knew of staff providing marijuana to clients; the basis of knowledge requires clarification.

Preservation instruction: Maintain the complete original exchange, screenshots, timestamps, and any later voice or phone notes in a restricted archive. Any public exhibit should remain clean-text and identity-protective unless the source expressly authorizes otherwise.

S.S. CROSS-SECTION INTEGRATION

Support Staff testimony - targeted additions to existing sections

Source label: S.S. means Support Staff. The source has direct knowledge of Turnbridge operations. The source is not identified by name, and no statement is made in circulated versions about whether the source is a former or current employee.

Use rule. This insert does not convert any allegation into an adjudicated fact. It cross-references newly received testimony into three existing memo subjects: Tom Marzilli and parent-facing business culture; Drew Behr and replay of the M.J. / C.S. fire-extinguisher CCTV footage; and direct-care staff culture. Each proposition below states the source chain.

1. Tom Marzilli section - alleged statement that "the parents are the real clients"

S.S. reports that case manager Carter told him that Tom Marzilli had said, in substance, "the parents are the real clients." S.S. did not hear Marzilli make the statement directly. The attribution chain is therefore: Marzilli allegedly made the statement; Carter allegedly repeated it to S.S.; S.S. then reported it to the memorandum author.

The statement is relevant to existing concerns about whether Turnbridge treated paying parents as the primary audience and economic customer while clients bore the restrictions, phase consequences, family-contact controls, and prolonged placement. It also overlaps accounts in which staff allegedly influenced parents during discharge disputes or represented continued placement as necessary for safety.

Archive classification: Third-hand / relayed leadership-culture statement. It should not be presented as a direct quotation from Marzilli without confirmation from Carter, Marzilli, another person who heard it, or contemporaneous records.

Records and corroboration:

- Carter's direct account of what Marzilli allegedly said, including approximate date, setting, and other people present.
- Marzilli's account and any leadership, training, admissions, family-engagement, or business-development materials addressing whether parents were treated as the primary customer.
- Internal communications concerning family retention, parent management, discharge objections, billing, client complaints, and language describing parents or families as the program's clients or customers.
- Other staff who heard similar language from Marzilli or other leaders.

2. Fire-extinguisher CCTV section - direct corroboration of Drew Behr replaying footage

The memorandum already contains the author's firsthand account that Drew Behr replayed CCTV footage of the M.J. / C.S. fire-extinguisher incident to multiple clients while laughing and calling C.S. a "dumbass." S.S. now independently reports that he was personally one of the clients to whom Drew showed the footage.

This is incident-specific corroboration of the narrow proposition that Drew displayed the footage to clients. S.S. has not yet supplied a complete account of every statement Drew made while showing it, the number of viewers, the exact location, or whether S.S. independently remembers the "dumbass" remark. Those details should not be attributed to S.S. unless he separately confirms them.

Cross-reference significance. The new testimony strengthens the existing concerns about access to surveillance footage, client confidentiality and dignity, preservation of violent-incident evidence, casual or mocking replay of footage, and whether supervisors knew that direct-care or case-management staff showed sensitive video to residents.

Archive classification: Direct corroborating witness testimony from S.S. concerning Drew Behr showing the M.J. / C.S. footage to clients. The underlying violence and any additional comments remain separately evidence-typed.

Records and corroboration:

- S.S.'s full account of when and where Drew showed the footage, who else was present, what Drew said, and how the footage was accessed.
- CCTV access logs, export history, device logs, camera-system permissions, and any record showing playback outside a formal incident-review process.
- Accounts from other clients shown the footage, including the memorandum author and any additional viewers.
- Incident, supervision, discipline, privacy, evidence-preservation, and quality-assurance records involving the M.J. / C.S. event or later display of the footage.

3. Direct-care culture section - Carter's alleged statement about staff indifference

S.S. reports that Carter told him, in substance, that "not a single direct-care member gives a single fuck about the clients." This is Carter's alleged characterization as relayed by S.S.; S.S. did not present it as a statement personally heard from every direct-care employee, and it should not be converted into a factual conclusion about every worker.

The statement is nonetheless relevant as an alleged internal assessment from a case manager about direct-care culture. It overlaps employee-review concerns involving weak training, low morale, turnover, underqualified or disengaged staff, inadequate clinical support, and clients being managed by personnel who may have held substantial practical authority despite limited professional preparation.

It also provides context for S.S.'s own view that the program's problems were severe enough that he had considered starting a different program. That opinion should remain attributed to S.S. and should not be treated as proof of any specific event.

Archive classification: Secondhand / relayed staff-culture statement from Carter through S.S. It is evidence of what S.S. says Carter told him, not proof that every direct-care employee lacked concern for clients.

Records and corroboration:

- Carter's direct account, including the date, setting, intended scope, and basis for the statement.
- Direct-care employee surveys, exit interviews, supervision notes, complaints, training records, turnover data, staffing ratios, and performance or disciplinary records.
- Client and employee accounts describing staff responsiveness, indifference, cruelty, protective conduct, or failures to escalate safety concerns.
- Policies defining direct-care responsibilities, minimum qualifications, supervision, crisis escalation, and accountability for client welfare.

Integration instruction. These three targeted additions should be read together with the full S.S. addendum. The fire-extinguisher item is direct corroboration. The Marzilli and Carter quotations are relayed statements with explicit attribution chains. No source identity should be published without separate authorization.

CONTROLLING REPLACEMENT DIRECT-SOURCE ENTRY - I.S.C.

Replacement / identity rule. This entry supersedes any earlier reference to this source as "Cere_Bell_Umm." In all circulated versions, the source must be identified only as **I.S.C.** unless she separately authorizes broader identification. Earlier abbreviated summaries may remain for historical continuity only if they are read as superseded by this controlling entry.

Source and status. I.S.C. is a former Turnbridge women's-program client from the late-2022 through 2023 period. She supplied approximately fifty-seven photographed journal pages written during treatment, more than twenty case-manager communications, a photographed Contract for Continued Phase 3 Residence dated May 31, 2022, later complaint messages, and additional records. The contemporaneous timing materially strengthens the value of the account, but no allegation is converted into an adjudicated finding.

A. Admissions, duration, program structure, and autonomy

- Her journal records representations that phases would last roughly six to eight weeks, that graduation in roughly six months was possible, that she might leave in approximately three months, and that Phase 3 was optional. She later documented substantially longer phases, delayed phone access, and questions about timing being framed as "future tripping."
- She documented substantial unstructured time, inconsistent therapeutic content, limited life-skills work, difficulty reaching case management, and significant staff turnover.
- She experienced program progression, electronics access, weekend plans, work, family therapy, housing, and graduation as subject to broad staff discretion rather than transparent criteria.

B. Sexual-safety and psychiatric-acuity concern involving roommate

A November 2022 journal entry describes a roommate recently coming from psychiatric care who allegedly behaved in a manic or psychotic manner. I.S.C. specifically alleges that the roommate repeatedly stood near women's beds and asked women for massages, conduct I.S.C. experienced as sexually intrusive and unsafe. She states that staff minimized the concern instead of creating a clear protection or separation plan. The exact frequency, context, clinical acuity, staff knowledge, and response require incident, clinical, room-assignment, and safety-plan records.

C. Device searches, privacy, behavioral control, and property

- Journal entries and texts describe staff review of private Discord messages and Venmo activity, extended phone and laptop restrictions, unclear criteria for ending restrictions, and a behavioral contract tying continued Phase 3 residence and privileges to broad requirements.
- I.S.C. produced a photographed Contract for Continued Phase 3 Residence dated May 31, 2022. In contemporaneous texts she twice stated that she had not been given her own copy; the case manager did not dispute that and said it would be reviewed in session.
- I.S.C. alleges McCormack took or failed to return her Nintendo Switch. She also alleges other electronics and property were used as leverage or subjected to restriction. Property inventories, sign-out sheets, storage logs, receipts, family communications, and reimbursement records should be requested.

D. Medication access

I.S.C. documented being without Lamictal for more than three weeks and also without trazodone while reporting that she felt physically and emotionally unwell. In a contemporaneous text, after she stated that she felt horrible and unlike herself, the case manager replied, "It's all about priorities," and redirected the conversation to electronics use. The cause of the medication gaps remains a records question requiring MARs, pharmacy and refill data, prescriber notes, nursing records, and incident / adverse-effect review.

E. Room move, work, and family therapy

- Texts show I.S.C. being told she would switch rooms with Vivian that night and that the decision had already been made. She stated she did not understand prior comments as a formal room-move request and experienced the change as sprung on her.
- Texts document repeated conflicts between imposed family-therapy times and her job. I.S.C. explicitly warned that attendance could cost her employment. The case manager said family therapy would not move again and framed nonattendance as refusal.

F. Graduation, discharge, and proposed forensic evaluation

- Texts document a dispute over graduation, aftercare completion, canceled meetings, and responsibility for delay. I.S.C. says she was denied the graduation she expected after her parents told the program not to let her graduate.
- A text asks how she would feel about a forensic psychologist traveling to Connecticut to evaluate her for two days. When I.S.C. asked who requested it, the case manager replied, "Guess." The requesting party, purpose, consent process, funding, clinical rationale, and any resulting report require clarification.

G. Kelly McCormack - direct allegations of searches, planted items, humiliation, phase regression, and property loss

- I.S.C. alleges repeated favoritism, screaming, humiliation, invasive searches, prolonged restrictions, and gossip about other clients.
- She alleges McCormack planted marijuana / weed among her belongings and planted or later claimed to find a condom in her bag or property.
- She alleges McCormack accused her of "sucking dick for" a gift card to a vegan restaurant.
- She alleges McCormack sent her back to Phase 1 for approximately eight weeks without a legitimate clinical reason.
- She alleges McCormack took or failed to return her Nintendo Switch.
- Her later written complaints to McCormack predate the current investigation and specifically allege searches, drug-related accusations, screaming, prolonged restrictions, humiliation, and gossip. Those messages provide a contemporaneous complaint trail even though each underlying allegation still requires records review.

H. June 2023 communications with therapist Jeni

In June 2023, I.S.C. messaged therapist Jeni that weekend plans had again been taken after I.S.C. had warned McCormack that she would not make a UA and that a time slot with Jennie did not work. I.S.C. stated that McCormack had known about the scheduling issue for weeks and described the way McCormack spoke to her as unacceptable. She wrote that the situation could not continue. The next morning she contacted Jeni because Kelly was not present and she needed medication packing before work.

In later messages, I.S.C. told Jeni that she appreciated Jeni reaching back out and that Jeni was the first person she called. Jeni replied that I.S.C. deserved to feel supported and stated, regarding a gaming laptop, that she had tried to hide it so "Kelly and parents would forget." The exchange is relevant to contemporaneous notice, electronics / property control, and the quality of I.S.C.'s relationship with McCormack.

I. Alleged circumstances of McCormack's departure

I.S.C. alleges that Turnbridge later requested that McCormack take a drug test and that McCormack refused. I.S.C. has described McCormack as then leaving, being fired, or otherwise being removed from the role. The exact employment classification is unresolved. Regulators should obtain the drug-test request, policy basis, communications, HR notes, leave or suspension records, resignation / termination documents, unemployment records if applicable, and any audit of McCormack's open cases after separation.

J. 2024 Concerned Citizens of Foxon / police / DCF lead

I.S.C. supplied or discussed a screenshot from the Facebook group *Concerned Citizens of Foxon* showing two people whom the post alleged had been arrested in West Haven after driving around in a white box truck and stealing property. The post also contains a comment asking whether they were the same people who stole a woman's luggage. I.S.C., who knew McCormack personally as her case manager, identified the woman pictured as Kelly.

Turnbridge therapist Jeni separately identified the same woman as Kelly and confirmed that this was the page she had been discussing. Jeni stated that information had been provided privately to an alleged victim, that the woman contacted East Haven Police, and that there was reportedly an open investigation. Jeni also stated that a DCF report had been placed in connection with concern for a child and that Kelly's sister had become involved in the child's care. I.S.C. separately described the alleged property victim as autistic. These points require police, DCF, victim, family, and court corroboration and must not be converted into findings from the messages alone.

K. Public criminal-record context concerning McCormack

Connecticut Judicial Branch screenshots supplied for this update identify Kelly Elizabeth McCormack, birth year 1984, and show confirmed guilty findings for sixth-degree larceny in 2017 and 2019; second-degree breach of peace and second-degree threatening in 2019; and violation of probation in 2020. A 2012 Connecticut news report separately described Kelly McCormack, then 27, as charged with disorderly conduct after a property dispute. Additional 2011, 2013, and 2024 search-result cards remain docket leads pending official case-detail verification. These records do not prove I.S.C.'s allegations, but they materially sharpen the institutional question of what Turnbridge knew, what it screened, and how it supervised McCormack while giving her authority over vulnerable clients and their property.

L. Records, corroboration, and preservation

- Complete I.S.C. Turnbridge file, including all houses, phases, progress reviews, phase-downs, graduation decisions, discharge / aftercare records, family communications, and billing / utilization records.
- All Kelly McCormack case-management notes, supervision records, complaint and grievance records, HR file, performance reviews, background checks, criminal-history disclosures, disciplinary records, and separation records.
- All room / property searches, contraband logs, drug-test / UA records, condom or marijuana documentation, photographs, chain-of-custody records, incident reports, and staff witness statements.
- Property inventory, electronics logs, Nintendo Switch records, gaming-laptop records, storage / return / reimbursement records, and family communications about electronics.
- Medication administration records, refill and pharmacy records, Lamictal and trazodone prescribing records, nursing communications, medication-error reports, and adverse-effect documentation.
- Behavioral contract drafts, signature / distribution records, records showing whether I.S.C. received a copy, and the clinical rationale for each restriction.
- Family-therapy scheduling records, employment schedule communications, job-impact notes, and records supporting or contradicting characterization of missed sessions as refusal.
- Forensic-psychologist referral, requesting party, consent documentation, purpose, payment, travel, report, and communications with family or counsel.
- Jeni's complete relevant communications, supervision records, records concerning the gaming laptop, and any complaints or disclosures she received from I.S.C. about McCormack.
- Any Turnbridge drug-test request directed to McCormack, refusal, specimen / testing records, HR communications, suspension, resignation, termination, exit interview, and post-separation case audit.
- East Haven and West Haven police reports, CAD, arrest records, body-camera / incident records, DCF intake or investigation records, and court records concerning the April 2024 property allegations.

M. Evidentiary distinctions and archive classification

I.S.C. personally reports her own treatment experience and allegations concerning McCormack. Her journal pages and case-manager messages are contemporaneous or near-contemporaneous documentary support for many broader aspects of the account, but they do not automatically prove every alleged planted item, property loss, motive, or later employment event. Jeni's messages are independent contemporaneous communications from a Turnbridge therapist but remain statements requiring records corroboration where they concern police, DCF, McCormack's condition, or third parties. Court records are treated separately as public-record facts where official Judicial Branch detail pages were supplied.

Archive classification: **Direct former-client account with extensive contemporaneous documentation; high-priority source for regulators, counsel, and journalists subject to source consent. Use only I.S.C. in circulated versions.**