

Clinical Update — Unit 806 Exposure

Patient submission supporting forensic documentation since the April 10, 2026 letter

Patient:	Justin Horn (DOB on file)
Treating physician:	Mark Fabi, M.D. — Medical Arts Building, 1601 Walnut Street, Suite 810, Philadelphia
Document date:	Tuesday, May 19, 2026
Period covered:	April 10, 2026 (date of prior letter) → May 19, 2026 (current)
Exposure source:	FSK-taped exhaust hose on Greystar-installed portable AC, Unit 806, 315 N 12th Street, Philadelphia (FLIR-documented 102–113°F surface temp)
Compounds of concern:	Toluene, xylene, styrene, tackifier resins, plasticizers, possible formaldehyde (kraft-paper backing under heat)
Unit status:	Vacant since May 6, 2026 (chemical displacement)
Companion documents:	Unit806_Forensic_Comprehensive_v3.pdf · Unit806_Forensic_Mar1_May19_v4.pdf

Dr. Fabi —

This is a structured update to the record since your April 10, 2026 letter. I am not asking you to revise that letter. I am submitting the events of the intervening forty days — the displacement, the EMS-attended building event on May 6, two acute exposure entries on May 17, and the load-test failure of the May 17 HVAC intervention — in a form you can incorporate into the chart and use to evaluate what additional documentation or referrals would now be appropriate.

The single most important new clinical observation, and the reason I am drafting this rather than waiting for an in-person update, is that my cats have shown signs of being unable to walk during exposure episodes in the unit, and that two Philadelphia Fire EMS responders independently reported dizziness in the building hallway after approximately fifteen minutes on May 6. Both findings rule out a psychogenic explanation for my own symptoms in ways that self-report cannot. I want those observations in the chart at the same evidentiary weight as the April 10 letter.

Two companion documents accompany this update: the comprehensive forensic analysis (v3) covering the May 17 intervention day and the Mar 1–May 19 continuation (v4) covering the 80-day environmental record and the May 18–19 load-test failure. The environmental telemetry referenced below is documented in detail in those companions. The sections that follow are organized for clinical use rather than legal use.

— Justin

1. Summary of Clinically Relevant Events Since April 10, 2026

Date	Event	Clinical significance
Apr 10, 2026	Your letter on file	Baseline reference document; airborne contaminant concern documented
Apr 15–18, 2026	First sustained mold-activation window in unit (RH \geq 60% for 25 consecutive hrs; dewpoint \geq 60°F for 15 hrs)	First documented sustained crossing of biological-growth threshold in 6-mo dataset, occurring under continuous occupancy; concurrent with documented retaliation events
May 4, 2026	Notice to Quit issued by landlord	Stressor; legal pressure context; vacate date June 15
May 5, 2026	Civil counsel (Console Matison) withdrew	Loss of legal representation during active exposure crisis
May 6, 2026	EMS-attended building event — 911 fume call; Citizen.com record (494 notifications)	Two EMS responders independently reported dizziness in hallway after ~15 min (Ring camera audio); patient acute symptomatic; cats showed ataxia ; displacement same evening with cats
May 6, 2026 (evening)	ER visit for patient	Carboxyhemoglobin testing requested; symptoms partially resolved with fresh air
May 6 → present	Displacement (Airbnb / motel rotation with cats)	Patient has not continuously occupied unit since May 6
May 17, 2026 (~10:00 EDT)	AC restored cooling in unit for first time in 80 days; selective intervention day before forecast 89–95°F heat wave	Refrigerant top-off without dehumidification — cooling without moisture removal; humidity-driven re-emission of surface-bound VOCs
May 17, 2026 (~17:00)	Acute exposure event #1 — patient entered unit to verify AC behavior	Headache, dizziness within minutes; forced exit; consistent with the exposure profile in the April 10 letter
May 17, 2026 (~22:30)	Acute exposure event #2 — patient re-entered ~3 sec (after 5-min ozone pre-treat) to manually shut off AC	Brief; uncertain symptomatic response — should be evaluated in next visit; ozone pre-treatment is itself a noted exposure
May 18–19, 2026	Load-test failure: indoor T climbed 72.1°F → 84.7°F over 35 hrs; dewpoint 58°F → 69°F	Confirms May 17 intervention was cosmetic; unit currently at documented worst environmental conditions of the entire 80-day record

May 18, 2026 (18:01)	Greystar transmitted building-wide RentCafe notice scheduling May 22 maintenance entry into Unit 806	Scheduled entry by non-PPE-equipped maintenance staff into a unit ServPro previously declined as too dangerous; activity-based disturbance of surface VOC reservoir foreseeable
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2. Objective Biological Corroborators — What Self-Report Cannot Carry

Patients with documented psychiatric history are vulnerable to having accurate environmental observations re-coded as somatic or psychogenic. We have discussed this dynamic in the context of my father's historic reality-distortion patterns. Self-report carries weight in our treatment relationship because we have built that trust over years, but for the wider clinical and forensic record, three independent non-self-report data streams now exist:

2.1 Animal biomarker — cats

Both cats have shown signs of being unable to walk normally during periods of sustained exposure in the unit prior to May 6 displacement. Cats do not have psychosomatic responses to environmental stressors in the human sense. Feline neurological signs — ataxia, gait disturbance, lethargy — in the setting of household solvent exposure are well-described in the veterinary toxicology literature. Cats have higher respiratory rates per unit body mass than adult humans and are routinely affected sooner and at lower ambient VOC concentrations.

Clinically: this is the observation that allowed me to reject the psychogenic framing for my own symptoms. The cats and I were in the same airspace. The cats cannot be reassured into walking normally. The cats cannot be subject to a delusional system imposed by a third party. The cats cannot be told they are imagining it. They walked unevenly when the AC ran; they walked normally in the Airbnb. That is a behavioral assay, not a self-report.

Clinical input requested:

If a formal veterinary record of these episodes would strengthen the clinical file, I can attempt to schedule an examination and request the veterinarian document the gait observations and exposure history. Please advise whether you would find that useful for the chart.

2.2 Third-party human corroborator — Philadelphia Fire EMS, May 6

On May 6, 2026, Philadelphia Fire and EMS responded to a 911 fume call at the building. The incident is independently logged on Citizen.com with 494 user notifications. A Ring camera in the hallway captured audio of two EMS responders — one male, one female, neither me — comparing notes about feeling dizzy in the hallway. One said, in substance, 'That's the feeling that you first get with this.' Approximately fifteen minutes of presence in the building was sufficient for two trained professionals to detect and verbalize the same neurological symptom I have been reporting.

Clinically: this is occupational exposure to two responders who arrived to evaluate an unrelated patient and developed symptoms themselves on scene. Their state of mind was not influenced by my framing — they were not discussing my case with each other on camera; they were comparing their own in-the-moment sensations.

2.3 Continuous environmental telemetry

A Sonoff SNZB-02 wireless temperature/humidity sensor (Sensirion/Aosong internal element, $\pm 0.3^{\circ}\text{C}$ / $\pm 3\%$ RH) and an Apple HomePod environmental sensor have logged the unit continuously since November 22, 2025. The 1,906 readings from March 1 through May 19, 2026 are detailed in the v4 companion document. The relevant observations for clinical purposes:

Observation	Clinical significance
80-day baseline shows no functional cooling (Mar 1 → May 17)	Sustained thermal stress; spring/summer-cycle FSK adhesive vapor pressure rises with temperature; off-gassing rate is temperature-dependent
April 15–18: first sustained RH $\geq 60\%$ window in 6-mo dataset	Humidity-driven re-emission of surface-bound VOCs began under occupancy; porous-surface reservoir primed at this point
May 17: cooling appeared but dewpoint rose 53.3 → 58.4°F across 12 hrs	Cooling without dehumidification — the specific configuration that amplifies VOC re-emission and mucous-membrane absorption
May 18–19: indoor T 72°F → 84.7°F; dewpoint 58 → 69°F	Current unit conditions are the worst three-day environmental window of the entire record

3. Acute Exposure Events — Clinical Detail

3.1 May 6, 2026 — EMS-attended building event and displacement

Onset evening of May 6 following sustained presence in unit during a day with elevated indoor RH (54.5% peak; average indoor dewpoint 57.0°F — approaching the threshold that had produced the April 15–18 mold-activation window). Cats showed the gait abnormality described above. Patient experienced dizziness and acute fear symptoms. 911 fume call from another tenant or staff member produced EMS response to the building. Patient evacuated overnight with cats to an Airbnb. Patient subsequently presented to ER same evening; carboxyhemoglobin (COHb) testing was performed to rule out CO; symptoms partially resolved with fresh air and IV fluids. ER records are obtainable through the hospital patient portal.

3.2 May 17, 2026 (afternoon) — Acute exposure event #1

Patient entered the unit to verify a thermostat reading suggesting the AC had started cooling for the first time in many weeks. Unit configuration at entry: AC running on HIGH; operable window open to maximum (6" high-rise code limit); HEPA + activated-carbon scrubber running; Sonoff reading 72.1°F / 60.7% RH. Outdoor ~87°F.

Within minutes of entry, patient developed headache and dizziness and exited the unit. Sensor data captured during entry shows indoor dewpoint climbing (53.3 → 58.4°F across the 12-hour window) while temperature was dropping — the configuration in which surface-bound VOCs partition back into air. The symptoms are consistent with the exposure profile in the April 10 letter, with the additional mechanism that elevated humidity moves water-soluble irritants (formaldehyde, glycol ethers) into greater mucous-membrane uptake.

3.3 May 17, 2026 (~22:30) — Acute exposure event #2

After observing the 21:56 sensor reading (72.1°F / 62.0% / dewpoint 58.4°F) and confirming the AC was producing cooling without dehumidification, patient determined the configuration was actively worsening surface re-emission and re-entered the unit briefly to manually shut off the AC. Pre-treatment: 5 minutes of ozone generator operation prior to entry (intended to reduce transfer; acknowledged as itself an exposure with secondary-product risks — formaldehyde, ultrafine particles, aldehydes from ozone—VOC reactions). Time in unit ~3 seconds.

Item for in-person follow-up:

I am uncertain whether I experienced symptoms during the May 17 evening entry because the entry was brief and I was focused on the task. If you think it matters for the record to evaluate symptom presence retrospectively in our next visit, I can attempt to reconstruct that interval. Otherwise I will treat the second entry as undocumented for symptom purposes and note only the ozone pre-treatment.

4. Why the Current Configuration Is Worse, Not Better

If anyone in the matter characterizes the May 17 work as having restored habitability based on the temperature reading, the underlying physics points in the opposite direction for a patient with my exposure history:

4.1 Humidity-driven re-emission

Porous surfaces in the unit — drywall, paint binders, carpet padding, fabric, wood, paper — have absorbed VOCs from the FSK source over months at 40–45% RH baseline. Building-science literature (ASTM D6670; ASHRAE 62.1) describes the indoor sink-source effect: water and VOC molecules compete for surface binding sites, and humidity rise displaces previously-bound VOCs back into air. A unit sustained at 60%+ RH releases a wave of previously-banked contaminants over hours to days. The May 18–19 sustained dewpoint $\geq 65^\circ\text{F}$ is exactly that condition.

4.2 Mucous-membrane uptake increases with humidity

Wet mucous membranes (eyes, nasal passages, upper airway) dissolve more of what is in inhaled air, particularly water-soluble irritants. The same ambient concentration produces higher absorbed dose under high-humidity conditions. This is the mechanism behind the acute-symptom-within-minutes presentation on May 17.

4.3 Cool-air pooling at face level

Cold air is denser and settles at floor-to-face level rather than rising. In a room with limited ventilation (Unit 806 has one operable window restricted by high-rise code), this produces stratification of contaminants in the breathing zone.

4.4 Activated mold-growth conditions

Sustained RH $\geq 60\%$ under cool surface conditions opens biological-growth windows for *Aspergillus*, *Penicillium*, and *Stachybotrys* spores present in normal dust within 24–72 hours. The April 15–18 occupied window and the May 17–19 vacant window are both within that threshold. The clinical concern is not only chemical but increasingly biological.

Net effect for me specifically: the unit's comfort reading is better today (72–77°F when AC is running) but the unit's exposure potential is higher. Acute symptoms within minutes of May 17 entry are consistent with this profile.

5. Reference Framework

For clinical and forensic register, the framework documents I am working from are:

- **EPA / AMA / ATS / ATSDR — *Indoor Air Pollution: An Introduction for Health Professionals*.** The standard primer for clinical evaluation of indoor-air-quality complaints in residential settings; explicitly written for the physician audience.
- **ATSDR Toxicological Profiles — Toluene, Xylene, Styrene.** Acute and chronic effects, exposure pathway, biomarkers (urinary hippuric acid for toluene; methylhippuric acid for xylene; mandelic / phenylglyoxylic acid for styrene).
- **ASHRAE Standard 62.1 / ASTM D6670** on the indoor sink-source effect and humidity-driven re-emission.
- **IARC monographs.** Styrene Group 2A (probably carcinogenic, upgraded 2019); formaldehyde Group 1 (known human carcinogen); benzene metabolites in petroleum-distillate adhesives.
- **ACOEM / Occupational and Environmental Medicine** literature on residential VOC exposure and exposure-causation evaluations.
- **NIH / NLM literature on Multiple Chemical Sensitivity (MCS) / Idiopathic Environmental Intolerance (IEI):** consensus that complaints should not be dismissed as psychogenic and that a thorough workup is essential; clinicians should rule out underlying physiological problems and consider consultation with allergists and environmental medicine specialists.

I am citing these frameworks not to tell you what they say — you have the clinical fluency I lack — but so the chart reflects the literature I have been reading to understand my own exposure profile. If any of these are not the documents you would prioritize, I would value your guidance on what to anchor to instead.

6. Specific Clinical Requests

Six items, in order of priority. None are urgent in the next-48-hours sense; all are sequenceable around your normal patient workflow.

6.1 Addendum to the April 10, 2026 letter

A short addendum — a paragraph or two — documenting that the exposure events on May 6 (EMS-attended building event, displacement) and May 17 (two acute exposure entries with documented symptom onset within minutes) are consistent with the airborne-contaminant concern in the April 10 letter, and that humidity-driven re-emission under the May 17–19 conditions amplifies the original exposure pathway. This adds approximately 40 days of clinical record without re-litigating the original letter.

6.2 OEM / environmental-medicine referral

I have identified Penn Occupational and Environmental Medicine (3600 Civic Center Blvd, 215-662-2354) and Rutgers EOHSI (Piscataway) as candidates. A referral specifically framed as *environmental exposure causation evaluation, residential VOC exposure with FLIR-documented heat source, status post 5/6/26 ER visit* avoids the workers'-comp triage that blocks most OEM clinic intake for residential cases. My PCP in NJ (Virtua Pride in Marlton) can also issue the referral if that is the cleaner insurance path. Your guidance on which channel produces the most useful specialist report would help.

6.3 Veterinary documentation of cat symptoms

As noted in Section 2.1, I can attempt a veterinary examination focused on documenting the ataxia observations and their resolution outside the unit. Please advise whether a veterinary record entered into my chart would be clinically useful at this point or whether it is sufficient to note the observations in the addendum.

6.4 Neurocognitive baseline (optional)

Given the duration of exposure (Sept 2025 → May 6, 2026 displacement; ~8 months) and the documented compounds (toluene and xylene have neurotoxic profiles for chronic exposure), I am open to neurocognitive baseline testing if you think it would help establish a comparator for any longitudinal assessment. I would value your view on whether this is premature, appropriate now, or worth deferring.

6.5 Re-entry / PPE guidance for the May 22 maintenance entry

Greystar has scheduled maintenance entry into Unit 806 on May 22 by staff without PPE. ServPro previously declined the unit as too dangerous. I have objected in writing. If you can document in the chart, or in a brief note I can attach to that objection, that re-entry by anyone without gas-phase VOC respiratory protection is medically inadvisable given the documented exposure history, that strengthens the foreseeable-harm record.

6.6 Disability documentation under FHA (only if appropriate)

The Fair Housing Act framework around disability is relevant to the selective-treatment and reasonable-accommodation aspects of the housing matter. If after reviewing this update you assess that a disability-based framing is clinically supportable, I would value a discussion of whether and how to characterize that in any future letter. I do not want to push you outside your forensic comfort range on this.

7. Things I Am Not Asking

Three boundaries on the request, since you and I have discussed the limits of physician advocacy in adversarial matters:

- 1. I am not asking you to revise the April 10 letter.** The April 10 letter stands. An addendum is additive.
- 2. I am not asking you to make causation findings outside your specialty.** The OEM / environmental medicine specialist (Section 6.2) is the appropriate author of any formal causation opinion linking specific compounds to specific symptoms. Your role in the chart is to document what you have observed and to attest to the clinical credibility of my reporting, not to substitute for the OEM workup.

3. I am not asking you to weigh in on the legal posture. Civil counsel is handling the housing matter. Criminal track is separate (Talley case). Trust track is separate (Sherman Silverstein). Your clinical record matters across all three but you are not being asked to take a position on any of them.

8. Personal Note

You know the history of distortion in my family system. You know why the objective biological corroborators in Section 2 matter to me at a level beyond evidentiary weight. The cats walking unevenly when the AC ran, then walking normally in the Airbnb, and the EMS responders dizzy in the hallway after fifteen minutes — these are what allowed me to know I was not imagining the exposure. I am telling you this so that if and when this documentation enters any forensic context, the chart reflects that the patient sought out and prioritized non-self-report data streams precisely because the patient understood that self-report alone, given his history, could be dismissed.

I trust your forensic judgment on what to include in the record and what to leave for in-person discussion. If anything in this update would be better as a conversation than as a document, I will defer to your read.

With appreciation,

Justin Horn

May 19, 2026