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6  
7 **COMMONWEALTH OF MASSACHUSETTS**

8 **IN THE MATTER OF IAIN  
9 MELCHIZEDEK,**

**Case No.:** N/A

**AFFIDAVIT OF MELCHIZEDEK**

10 I, **Iain Melchizedek**, being duly sworn, hereby state under penalty of perjury that the  
11 information contained herein is true and correct to the best of my knowledge and belief. This  
12 affidavit is submitted to document events occurring on December 4, 2025, and to formally record  
13 associated procedural irregularities, access failures, data solicitation practices, and protected  
14 disclosure interference within the Veterans Home at Chelsea (formerly Chelsea Soldiers' Home).  
15 I am over eighteen (18) years of age. I have personal knowledge of the facts set forth in this  
16 affidavit. If called as a witness, I could and would testify competently to these matters.

17  
18  
19 **Background Context**

20 I am a current resident of the Veterans Home at Chelsea, a state-operated domiciliary facility for  
21 veterans. During my residency, multiple procedural, ethical, and regulatory issues have been  
22 observed and previously communicated to oversight entities, including the U.S. Office of  
23 Inspector General (OIG). These notifications did not result in posted corrective action, publicized  
24 remediation, or transparent institutional response.

25 The facility does not maintain or display:

- 26  
27
  - grievance procedures

- 1 • retaliation protections
- 2 • privacy rights notices
- 3 • whistleblower contact channels
- 4 •
- 5 • OIG hotline access information
- 6 • patient or resident rights documentation
- 7 • formal federal complaint pathways

8 No digital grievance system exists. Complaints are processed exclusively through a single  
9 clinical social work director without timestamping, without evidentiary tracking, and without  
10 chain-of-custody safeguards. There is no neutral or legally trained adjudicator, and no formal  
11 investigative repository exists for complaint logging.

13 All resident complaints are manually submitted and internally resolved through a clinical-  
14 pathology model rather than a regulatory, legal, or compliance framework. This structure  
15 removes auditability, contradicts principles of governmental complaint handling, and increases  
16 potential exposure to narrative reinterpretation or retaliatory characterization.

### 18 **Institutional Non-Posting and Procedural Omission**

19 At the time of this affidavit:

- 20 • There are no postings related to whistleblower protections
- 21 • No accessible reporting procedures
- 22 • No guidance on retaliation policies
- 23 •
- 24 • No signage indicating veterans' rights under federal protection statutes
- 25 • No formal notice of grievance escalation pathways
- 26
- 27

1 The only posting observed concerns elder abuse, with conditions that restrict abuse recognition  
2 solely to incidents reported within two hours. This limited and conditional framework does not  
3 constitute comprehensive rights disclosure as required under standard public institution practice.  
4

### 5 **Identity and Authority Breakdown**

6 On December 4, 2025, an individual entered the Kevel Domiciliary Building of the Veterans Home  
7 at Chelsea. She presented herself verbally as an employee of the Department of Veterans Affairs.  
8 The identification badge displayed by the individual did not conform to federal Personal Identity  
9 Verification (PIV), Common Access Card (CAC), or VA hard-credential design standards. The  
10 badge appeared non-governmental in material and construction.  
11

12 Security Director Jeff McAllister provided contradictory explanations regarding the individual's  
13 employment classification:

- 14 • Initially asserting she was a VA employee
- 15 • Subsequently suggesting she was a contractor
- 16 • Later reasserting she was definitively a VA employee  
17

18 These contradictory representations prevented verification of lawful access authority, official duty  
19 status, chain of supervision, and data handling responsibility, thereby obstructing institutional  
20 accountability. No escort, staff assignment, security presence, or credential validation occurred at  
21 any point.  
22

### 23 **Access Control Failure**

24 The individual conducted unaccompanied door-to-door ingress in a male domiciliary building.  
25 No public safety officer, social worker, or administrative escort was present.

- 26 • No sign-in procedure was documented
- 27 • No identification authentication occurred  
28

- No authority confirmation was provided
- No privacy advisement was issued
- No pre-notification was supplied to residents

In comparison, during the prior year’s purported “annual survey,” residents received advance contact and the individual was accompanied by a social worker. This establishes a regression from previously claimed protocol rather than continuity of an established practice.

### **Unlawful Direct Solicitation of Protected Disclosure**

On December 4, 2025, the unidentified woman approached the affiant’s door, knocked, and introduced herself as being from “the VA.” No identification verification was requested or supplied beyond her verbal assertion, and her badge did not meet federal PIV, CAC, or VA-issued standards.

The individual positioned herself directly at the affiant’s doorway threshold, rather than remaining in the hallway, which constituted a proximity posture consistent with presumed access or anticipated entry, despite no authority or consent having been established. The individual began by asking if the affiant “had any concerns” or “wished to discuss anything,” in the general frame of a welfare or satisfaction inquiry. The affiant replied that prior issues had already been reported through the Office of Inspector General and stated that the matters were beyond the scope of her inquiry.

The individual then asked, “Why do you say that?”

The affiant responded: “Because I already reported what I needed to report to OIG.”

Without pause, the individual followed with: “What did you report?”

This transition marked a shift from general open-ended inquiry to targeted solicitation of a protected disclosure. No confidentiality assurance, advisement of rights, or privacy

1 accommodation was provided. The setting remained a shared hallway with audible adjacency to  
2 neighboring resident rooms.

3 The individual indicated an intent to continue the discussion inside the affiant's assigned living  
4 quarters, which would have further removed any witness presence or privacy boundaries. The  
5 affiant declined entry.  
6

7 At no time did the individual clarify her investigatory capacity, chain of authorization, data  
8 handling procedure, or legal basis to request disclosure of OIG-reported material.

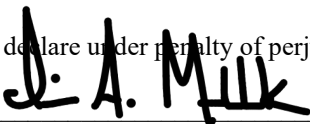
9 This exchange, taken in sequence, constitutes:

- 10 • An unsolicited escalation from general inquiry to direct extraction of federal protected  
11 complaint content
- 12 • An attempt to relocate disclosure into a private space without escort, oversight, or  
13 procedural safeguards
- 14 • A coercive context, given the absence of confidentiality guarantees, consent procedures,  
15 and supervisory disclosure authority  
16  
17

18 This interaction therefore meets the criteria of unauthorized extraction of protected OIG disclosure  
19 and creates exposure to:

- 20 • retaliatory reinterpretation,
- 21 • testimonial inversion,
- 22 • narrative manipulation,
- 23 • and post-report behavioral characterization.  
24

25 I declare under penalty of perjury that foregoing is true and correct to the best of my knowledge and belief.

26 

27 Iain Melchizedek

Dated: December 5, 2025