

**COMMONWEALTH OF MASSACHUSETTS
DIVISION OF ADMINISTRATIVE LAW APPEALS**

C.A.,¹

Petitioner

v.

Docket No. DPPC-25-0368

Commission for the Protection of Persons with Disabilities,²

Respondent

Appearance for Petitioner:

Max Gildred, student-attorney, Rule 3:03

Caroline Berg-Love, student-attorney, Rule 3:03

Angelo Petrich, Esq.

Appearance for Respondent:

Andrew Levrault, Esq.

Commission for the Protection of Persons with Disabilities

Administrative Magistrate:

Kenneth Bresler

SUMMARY OF DECISION

Petitioner committed abuse and abuse *per se* of victim, a person with an intellectual disability. Commission for the Protection of Persons with Disabilities (CPPD) may place petitioner, a caretaker of people with disabilities, on its abuser registry.

¹ The appellant's initials. I don't use his name because of my Order Regarding Confidentiality in this case and the general requirements of confidentiality in G.L. c. 19C, §15 and 118 CMR 9.00. Because of the order, statute, and regulation, this decision also does not name the victim, witnesses, and other people with disabilities.

² The respondent agency's name in this appeal was originally the Disabled Persons Protection Commission (DPPC). The Commission's name has changed to the Commission for the Protection of Persons with Disabilities (CPPD). I have changed this appeal's caption and use "CPPD" in my narrative. I retain "DPPC" in the findings of fact where it was used in this case's history or documents.

DECISION

The petitioner, C.A., appeals CPPD's decision to place him on the registry of abusive caretakers of people with disabilities.

I held a hearing on November 18 and 19, 2025, which I recorded. Small portions of the November 19 hearing were not recorded, due to my error.

CPPD called as witnesses the victim; a housemate of the victim; three staffers who provided direct care at the group home, L.C., B.B., and S.; the current residential director of the organization that runs the group home, who was Assistant Director at the time of the incident, and whom this decision calls the Assistant Director; and an investigator for the Department of Developmental Services (DDS), who also investigates for CPPD.

The victim had three housemates. Only one was interviewed by the DDS investigator, and only that one resident testified. The victim and housemate testified by Webex; all other witnesses testified in person.

One staffer's initials are C.S. To avoid possible confusion to the reader between the petitioner, C.A., and the staffer, I refer to the staffer by his last initial, S.

S. and B.B. testified under subpoena.

At the hearing, I admitted 21 exhibits, A through U. After the hearing, I admitted Exhibits V and W. Both parties submitted post-hearing briefs in February 2026.

Findings of Fact

Victim and group home

1. At the time of the incident on December 16, 2024, the victim was a 31-year-old transgender person who identifies as a man.³ (Ex. C, p. 16; stipulation)⁴
2. The victim is a person with an intellectual disability as defined by 118 CMR 2.02. (Stipulation)
3. The victim's diagnoses include asthma, anxiety, post-traumatic stress disorder, bipolar disorder, depressive disorder, and intellectual disability. (Ex. C, p. 16; stipulation)
4. The victim has an Individual Support Plan (ISP), administered by the Department of Developmental Services (DDS). (Stipulation)
5. At the time of the incident, the victim lived in a group home in Massachusetts along with three female residents.⁵
6. DDS licenses the group home. All four residents were DDS clients. The victim's residential services were coordinated through and funded by DDS. (Ex. D, p. 3; stipulation)

³ Hence, I use the pronouns "he," "him," and "his," and have corrected feminine pronouns when they appeared in documents.

⁴ Page numbers in this decision refer to the red Bates number at the bottom of exhibits' pages; the numbers do not refer to the page numbers, starting with 1, of individual exhibits. The Bates numbers are not always sequential within the exhibits (*e.g.*, pages 239-40 do not appear between Exhibits L and M, but appear in and constitute Ex. P), and, as CPPD has explained, missing Bates numbers do not necessarily mean that pages are missing from the exhibits.

⁵ I do not identify the municipality, in case only one group home for persons with intellectual disabilities is located there, which could compromise the confidentiality of various people whose confidentiality is protected by statute, regulation, and order.

7. The victim attended a day program on weekdays, run by the same organization that runs the group home. (Stipulation)

8. The victim could be aggressive toward the group home's staff, but the aggressiveness had significantly decreased in recent years. He exhibited "[i]mpulsive/explosive behaviors," which could put others at risk, and "[d]isrespectful interactions with others." He took "advantage of peers" by asking "for money/favors." (Ex. D, p. 33, 37, 38 (ISP))

9. Although the victim is not supposed to have caffeine because it gives him tremors and interferes with his medication, he has had his housemates buy caffeinated products for him or coerced them to do so. (Testimony of victim and C.A.; Ex. D)

10. The victim can be sneaky and manipulative in connection with accessing caffeine. (L.C. testimony)

11. The victim is an unreliable reporter who often asks to go to the hospital for contrived reasons. (Ex. C, p. 16 (Assistant Director so reported to DDS investigator))

12. The victim "tends to make chronic physical complaints and seeks out medical attention." (Ex. D, p. 35 (ISP))

13. The group home's staff can help the victim cope by telling him to take five minutes, to draw, or to listen to music. (L.C. testimony)

14. As part of his plans, the victim did not have a protocol in place under which staff members could search his backpack. (Victim testimony)

C.A.

15. At the time of the incident, C.A. was the group home's residential manager. (Stipulation)

16. C.A. was a care provider under 118 CMR 2.02. (Stipulation)⁶

17. CPPD has not found C.A. to have committed abuse or abuse *per se* before this case.
(Stipulation)

Safety-Care, physical restraint, and floor holds

18. Safety-Care entails how a person, such as a caregiver, should engage with a person, such as one with intellectual disabilities, who exhibits certain behaviors. (B.B. testimony)

19. The Core Curriculum Specialist Manual, Version 7 for 1997-2022, by Quality Behavioral Solutions to Complex Behavior Challenges (QBS) states:

Safety-Care is a training program for staff working with...adults who may exhibit challenging or dangerous behavior. The focus in Safety-Care is on prevention, safety, and humane, supportive, evidence-based interventions.

(Ex. I, p. 90)

20. On September 20, 2024, C.A. earned 12 hours of Safety-Care Specialist training. On October 2, 2024, C.A. earned six hours of Advanced Skills Module Specialist training in Safety-Care. (Ex. J)

21. The Core Curriculum Specialist Manual advises staff:

A. "Assume that aggression could happen, even when it doesn't seem likely." (Ex. I, p. 108)

B. "A behavioral antecedent, or 'signal,' is a behavior that a person exhibits before more serious behavior." (Ex. I, p. 112)

⁶ Although "care provider" and "caretaker" are not always synonymous in 118 CMR, 118 CMR does use them interchangeably, as will this decision.

C.

Be aware of triggers, signals, and any other indicators that a crisis might happen. Whenever you might need assistance, call for it. It's better to call for help early (even if that might mean a false alarm) than not get it soon enough.

(Ex. I, p. 115)

22. The Core Curriculum Specialist Manual discusses the prompt strategy, which entails a staffer speaking quietly or suggesting to a person such things as "Walk with me," "Sit down," or "Let's take a slow breath." (Ex. I, p. 123-24, 150)

23. The Core Curriculum Specialist Manual also discusses the de-escalation process. The discussion advises: "If you can't control your own...physical behavior, it's best to ask another staff person to take over." (Ex. I, p. 126)

24. The Core Curriculum Specialist Manual advises:

Physical management procedures must be used only when there is **no safe alternative**. **All three** of these conditions must be met in order to *consider* use of physical management:

....

- 1) There must be imminent risk of serious harm to the agitated person or someone else.
- 2) There must be no other practical way to prevent that harm without physical management.
- 3) The risk of not intervening must be greater than the risk of intervening.

(Ex. I, p. 148) (bold in the original; italics added)

25. The Core Curriculum Specialist Manual also advises:

A. "Physical management *may sometimes* be necessary in response to **dangerous behavior**, *but it is always important to seek alternatives*." (Ex. I, p. 148) (bold in the original; italics added)

B.

Using physical management is always risky, but for certain individuals the risk may be greater....Some medical conditions, such as...asthma...may place a person at increased risk of injury even when Safety-Care physical management interventions are used correctly. If so, some Safety-Care procedures might need to be prohibited for this person.

(Ex. I, p. 149)

C. "Check for breathing at least every 30 seconds." (Ex. I, p. 149)

D. "Watch for indicators of discomfort, such as verbal complaints...." (Ex. I, p.

149)

E. If an additional qualified staff member is not available to act as a safety monitor, "the leader [of the restraint] acts as the monitor." (Ex. I, p. 149)

26. The Safety-Care Advanced Skills Module, Specialist Manual, Version 1 1997-2022, by QBS discusses floor holds, including supine restraints (which are relevant to this appeal, because, as discussed soon, C.A. put the victim into a floor hold that was or resembled a supine restraint).

27. The Safety-Care Advanced Skills Module, Specialist Manual states:

A floor hold is a physical management procedure in which an individual is required to lie down. Floor holds are the most intrusive, restrictive, and staff-intensive procedures in the Safety-Care curriculum. They should be used *only* when less restrictive interventions are not sufficient to manage imminent risk of harm during a severe behavioral crisis.

(Ex. H, p. 80) (emphasis in original)

28. The manual continues:

✓ It is recommended that floor holds not be used unless the person has been assessed in advance by a licensed medical professional to determine if the proposed transition to a floor hold, as well as the supine position itself, are

appropriate for this person.⁷ For some individuals, a floor hold may be contraindicated. If so, that information must be clearly communicated to all staff.

....

✓ Floor holds should only be implemented on a safe surface. The recommended surface is a padded gym or yoga mat, at least large enough to accommodate the person's head and body, with additional mats provided for staff if possible. A mat should be clean, undamaged, and firm enough to prevent a person lying on it from sinking in more than ¼ inch. If a mat is not available, then it is recommended that the procedure be done on a soft surface such as carpet or a towel placed under the person. It is not recommended that the procedure be implemented on hard or rough surfaces such as tile, concrete, pavement, or dirt.⁸

✓ The person's head should be protected during a floor hold from significant impact with the floor while he or she is initially lowered and also in the event of struggle or head-banging. Use a mat or soft surface, as well as a spotter whenever possible, when lowering the person to the floor.⁹ Once on the floor, use the methods described in the floor hold procedure....

(Ex. H, p. 80)

Incident on December 16, 2024

29. On December 16, 2024, C.A. picked up the victim and two other group home residents from the day program. He drove them to the group home. On the ride, the issue arose of the victim's possibly possessing caffeinated products, which he wasn't supposed to have, or hot sauce, which belonged to another resident, or both. C.A. told the victim that he

⁷ The record does not reveal whether a licensed medical professional assessed whether a floor hold was appropriate for the victim. Such an assessment would have been especially important for the victim, who has asthma (Ex. C, p. 16) and a back condition that C.A. was aware of. (Testimony of victim and C.A.)

⁸ The victim may have been restrained on a tile or hardwood floor. (Ex. S, p. 300, 303, 305 (photographs))

⁹ The record does not reveal that the victim's head was protected with a soft surface or that a spotter was used.

needed to check the victim's backpack. (Testimony of victim, housemate; Ex. C, pp. 18, 19; Exs. U and V)

30. After arriving at the group home, the victim entered first, followed by C.A., and then the two other residents. (Testimony of victim, C.A., S.; Ex. C, p. 17; Ex. L, pp. 218-19)

31. The victim started climbing the group home's stairs to the second floor, where he had his bedroom. (Testimony of victim, C.A.; Ex. C, pp. 17, 19; Ex. L, pp. 218-19)

32. C.A. asked to inspect the victim's backpack. The victim declined C.A.'s request. (Testimony of victim, C.A., S.; Ex. C, pp. 17, 19; Ex. G, p. 52-53; Ex. L, pp. 218-19; Ex. T; Exs. U and V)

33. At some point, the following things happened:

A. The victim swore at C.A. (Testimony of victim, C.A.; Ex. G, p. 52-53; Ex. L, pp. 218-19; Exs. U and V)

B. The victim swung his fist and slightly caught C.A.'s face. (Testimony of victim, C.A., S.; Ex. C, pp. 17, 18; Ex. G, p. 52 ("slightly"); Ex. L, p. 213-14; Exs. U and V ("slightly"))

C. The victim and C.A. pushed, pulled, and shoved each other. (Ex. C, pp. 17; 18-19; Testimony of L.C.) It resembled a fight. (Testimony of S; testimony of Assistant Director (passing on L.C.'s comment); Ex. T)

D. C.A. spilled his coffee. (Testimony of C.A.; Ex. C, p. 17; Ex. L, pp. 218-19; Ex. T)

E. C.A.'s physical contact with the victim entailed contact with the victim's backpack, whether C.A. used it to maintain control of and maintain distance from the victim, drag him down the stairs, or drop him to the floor, or whether C.A. took the backpack away from the victim. (Testimony of victim, C.A., S., housemate; Ex. C, pp. 17, 18; Ex. L, pp. 218-19)

34. C.A. did not de-escalate the situation or use prompts. (Testimony of S., L.C., B.B. (no testimony about de-escalation or prompts by any of three witnesses))

35. C.A. placed the victim on the floor, either by pulling the victim's backpack, hand or hands, or shirt. C.A. placed the victim roughly on the floor and not according to Safety-Care training. (Testimony of S., L.C., B.B.; Ex. C, pp. 17, 18, 19; Ex. T; Exs. U and V)

36. C.A. asked L.C. and S. to assist him with putting the victim into a supine restraint, that is a restraint in which the victim was flat on the floor, face up, with legs straight and arms out to his side. C.A. and S. each restrained one of the victim's arms. L.C. restrained his legs. (Testimony of victim, S., L.C.; Ex. C, pp. 18, 19; Ex. L, pp. 218-19; Exs. U and V)

37. C.A. had his knee on the victim's shoulder or otherwise applied too much pressure to it. The victim told C.A. that C.A. was hurting him and was going to dislocate his shoulder. (Testimony of victim, L.C., housemate; Ex. C, p. 18; Ex. T)

38. The victim resisted the restraint. (C.A. testimony; Ex. C, p. 18; Ex. G, p. 53)

39. The restraint lasted approximately 10 to 15 minutes. (Testimony of C.A., L.C.; Ex. C, p. 18; Ex. L, pp. 218-19; Exs. U and V)

40. During the restraint, S. asked C.A. to leave the vicinity, but C.A. declined to do so. (Testimony of victim, S., housemate; Ex. C, pp. 17, 18)

41. After the restraint, the victim opened his backpack and took out items. He did not have anything inside that he was not supposed to have. (Testimony of C.A., L.C.; Ex. L, pp. 218-19)

42. The restraint left the victim bruised where C.A. had applied pressure to him.

(Testimony of victim, L.C.; Ex. C, p. 18; Ex. Q)¹⁰

43. After December 16, 2024, the victim was diagnosed with a right shoulder strain, treated for right shoulder pain, provided a sling, and prescribed physical therapy, acetaminophen, and ibuprofen. (Ex. E, p. 41 (medical record); Ex. F, p. 40 (medical record))

44. The victim underwent physical therapy twice a week for six weeks. He wore a sling for about two weeks. (Victim testimony)

45. C.A. did not need medical attention for the punch he received. He did not experience pain or swelling. He did not take aspirin, acetaminophen, or ibuprofen. (C.A. testimony)

CPPD's action against C.A.

46. On February 25, 2025, CPPD approved an Investigation Report Form. (Ex. C, p. 21)

47. Page 1 of the Investigation Report Form entailed "Reported Allegations," which stated in part:

As [the victim] came into the home, [C.A.] asked to search [the victim]'s bag. [The victim] said no. [The victim] proceeded to walk up the steps....[C.A.] grabbed [the victim]'s bag and pulled [the victim] down the stairs by [the victim]'s bag. [The victim] went to defend [him]self and this led to a restraint. It was not a proper restraint and was very aggressive. [The victim] had bruising and was injured.

¹⁰ The bruising is ultimately not significant, because CPPD did not proceed against C.A. based on the victim's bruises, as discussed below. The investigator, who wrote that photographs did not exist (Ex. C, p. 17), was apparently unaware of the photographs of the victim. (Ex. Q) Ultimately, the photographs are not significant.

48. The form concluded twice that the victim was a victim of abuse, stated once that he was a victim of abuse *per se*, and concluded once that C.A. had committed that abuse. (Ex. C, p. 21)

49. Under one “Basis for Conclusion,” the form stated that the victim, S., B.B., and the housemate

all provided testimony that [C.A.] initiated physical contact with [the victim] in an effort to search [the victim]’s bag for hot sauce, and that this initial contact resulted in a physical restraint applied by [C.A.]. This restraint resulted in [the victim]’s later evaluation at urgent care for a strained shoulder and a subsequent referral for physical therapy.¹¹ 118 CMR 2.02 partially defines “Serious Physical Injury” as “Impairment of the physical condition of a Person with a Disability resulting from an act or omission of a caretaker including but not limited to: e. Any significant impairment of a: bodily system; function; limb or organ including human skin”.¹² [The victim] stated that [the victim] was not sure how long the restraint lasted, but that following the incident [the victim] has had shoulder pain and has been unable to sleep as a result[.] The fact that [the victim] required a referral for physical therapy for the shoulder strain presents evidence that [the victim] sustained a serious physical injury. As stated by [the Assistant Director and the Director of Quality and Improvement], [the victim] does not have a bag search protocol. [C.A.] stated that he placed [the victim] in a supine restraint after [the victim] struck him in the face, a statement corroborated by [S.], however, none of the other witness statements reflect this claim. As such there is a preponderance of the evidence that [C.A.] unnecessarily both initiated physical contact and subsequently applied the restraint which resulted in serious physical injury to [the victim]. Further, [C.A.] did not follow established training guidelines of the Safety Care program in the area of Incident Prevention for which he signed a training certificate on 9/30/24....

(Ex. C, pp. 21-22)

¹¹ CPPD’s Basis for Conclusion does not include the victim’s bruising, which the report’s earlier “Reported Allegations” mentioned.

¹² This definition excerpt does not include “(d) any significant...bruising,” indicating that CPPD proceeded against C.A. because of the victim’s arm injury, not bruising. CPPD’s post-hearing brief discussed “significant bruising” under 118 CMR 2.02. (CPPD Br. 52; see also 56) Nonetheless, CPPD did not initiate proceedings against C.A. because of bruising to the victim.

50. On March 5, 2025, CPPD sent C.A. an Abuser Registry Notification, stating that CPPD had determined that sufficient evidence existed that he had committed abuse or abuse *per se*, which is registrable abuse. The Notification did not specify abuse or abuse *per se*. (Ex. K, p. 186) The Notification attached a redacted copy of the Investigation Report Form, which, as stated above, did not invoke bruising as a basis for concluding that C.A. abused the victim. (Ex. K, p. 203)

51. On March 30, 2025, C.A. emailed CPPD to appeal the finding. (Ex. L, p. 213-14)

52. On April 7, 2025, C.A. emailed CPPD “with a follow-up to [his] previous appeal.” It was titled “Official Petition for Review.” (Ex. L, p. 217)

53. On May 19, 2025, CPPD issued a Decision on the Petitioner’s Petition, affirming the findings of registrable abuse and abuse *per se*. (Answer of CPPD; stipulation)

54. In its decision, a CPPD Assistant General Counsel stated:

The Petitioner failed to offer any specific evidence that he meets the regulatory requirements for exclusion from the DPPC Abuser Registry....Caretakers of individuals with disabilities may sometimes encounter situations where a client becomes frustrated or aggressive towards a caretaker, and caretakers may become frustrated or lose patience. The fact that the Petitioner took out his frustration with [the alleged victim] by grabbing [the alleged victim] and aggressively pulling [the alleged victim] to the ground shows a fundamental misunderstanding of the Petitioner’s duty as a caretaker. Moreover, the Petitioner fails to recognize that even if [the alleged victim] did hit the Petitioner during the incident, the Petitioner’s own conduct caused [the alleged victim] to escalate. Had the Petitioner used de-escalation techniques instead of dangerously grabbing [the alleged victim]’s backpack while [the alleged victim] was on the stairs, [the alleged victim] likely would not have needed to be restrained and would not have been injured. The Petitioner’s conduct was egregious and demonstrates such poor judgment and control that his conduct could not be reasonably addressed by further training or education. Given the nature of the Petitioner’s abusive acts against [the alleged victim], [the alleged victim]’s injuries, and the fact that the Petitioner took no responsibility for his

actions despite a credible eyewitness account, I find that the Petitioner should be placed on the DPPC Abuser Registry.

(Answer of CPPD)

55. On June 6, 2025, C.A. timely appealed. His “Summary of Grounds for Appeal of DPPC Findings” on the appeal form was:

Denial of Due Process
Bias and Retributory Motive Behind False Allegations
Lack of Substantial Evidence
Failure to consider Exculpatory and Contextual Evidence

C.A. attached a sheet to the appeal form. He asserted, among other things that “[w]itness accounts were inconsistent,” which led to a “[l]ack of [s]ubstantial [e]vidence,” and

The investigation overlooked critical contextual and exculpatory evidence, including my professional record, compliance with Safety Care protocol, and the fact that the intervention...involved multiple trained staff and was in response to a physical assault against me. I followed policy and acted in accordance with my responsibilities.

(DALA Appeal Form Pursuant to 801 CMR 1.01; stipulation)

Discussion

Facts

The plethora of accounts of the incident made it harder to determine the details of what actually happened in the group home in December 16, 2024, because various people observed and reported different details, or remembered the events differently. Ultimately, many details, such as the exact sequence of events and whether the victim was restrained once or twice, are not significant. My findings of fact above are generally based on a consensus of witnesses who reported the larger picture of what happened on December 16, 2024.

The differences among accounts are well within the parameters of witnesses making good-faith efforts to accurately remember and honestly recount what happened on December 16, 2024. The incident was fast-paced, involved violence (albeit low-level violence), loud shouting, and the need for at least some witnesses to tend to and calm the group-home residents who were not involved in the incident. These factors made it hard for witnesses to observe, record memories, and retrieve memories of the incident identically or nearly identically. In addition, the first language of S. and B.B. does not appear to be English. That factor, too, seemed responsible for making their accounts less detailed than those of other witnesses.

The differences among witnesses' accounts do not amount to inconsistencies that lead me to doubt that the incident happened, to find that substantial evidence was lacking, as C.A. alleged in his appeal to the Division of Administrative Law Appeals, or to suspect that the witnesses' various accounts were intentionally inaccurate. Finally, I note that C.A. himself provided multiple accounts of the incident, which confirm the broad outlines of it.

As for a finer point about my factual findings, I am aware that the victim tends to make chronic physical complaints, seeks medical attention, and is an unreliable reporter who often asks to go to the hospital for contrived reasons. (Ex. D, p. 35; Ex. C, p. 16) Nonetheless, I have found that he was injured on December 16, 2024. I do so for three reasons.

One, even people who seek medical attention and contrive reasons to go the hospital can become injured, need medical attention, and need to go the hospital. Two, the victim was *diagnosed* with a right shoulder strain (Ex. E, p. 41), presumably by an objective medical

professional and not simply on the victim's report of pain. Three, in his post-hearing brief, C.A. concedes that the victim was injured. (Pet. br. 31)

Law

CPPD maintains a registry of caretakers who have been found to have committed what is called "registrable abuse" of people with intellectual disabilities. A person on the abuser registry cannot work as a caretaker of people with intellectual disabilities. G.L. c. 19C; 118 CMR.

The relevant definition of "Abuse" is: "An Act or Omission which results in Serious Physical Injury...to a Person with a Disability." 118 CMR 2.02 (definitions) (words starting with capital letters indicate that they are defined in the definitions section).

The relevant definition of "Abuse *per se*" is:

An Act or Omission of a Caretaker that includes or results in the following, regardless of whether a Serious Physical Injury...is manifested:

....

(d) the intentional, wanton or reckless application of a physical force in a manner that inflicts physical pain...as determined by an evaluation of the totality of the circumstances.

118 CMR 2.02.

Throughout 118 CMR, "Abuse" includes "Abuse *per se*." 118 CMR 2.02 (definition of "Abuse").

An "Act" is "A Caretaker's intentional, reckless, or negligent action, regardless of whether the Act is performed with an intent to harm." 118 CMR 2.02.

The relevant definition of "Serious Physical Injury" is:

Impairment of the physical condition of a Person with a Disability including, but not limited to...(e) any significant impairment of a...limb....

118 CMR 2.02. (Although the definition of “Serious Physical Injury” includes “(d) any significant...bruising,” CPPD did not proceed against C.A. on the basis of the victim’s bruising.)

The commentary to the definition of “Serious Physical Injury” provides in part:

In determining whether there is Reasonable Cause to Believe that the injury is a Serious Physical Injury resulting from Abuse, the Commission shall consider the significance of the injury in the totality of the circumstances....

Once it has been determined that a caretaker engaged in abuse or abuse *per se*, that is not the end of the inquiry. The regulations provide:

It shall be considered an Accident and not Abuse when a Person with a Disability incurs a Serious Physical Injury...and/or is subjected to Abuse *Per Se*, and the injury at the time it is incurred:

(a) is not the result of a Caretaker’s negligent Act;

(b) is not the result of a Caretaker’s reckless Act;

(c) is not the result of a Caretaker’s Omission;

(d) is caused by a Caretaker’s application of an appropriate degree of physical force given the circumstances; or

(e) is caused by a Caretaker’s good faith attempt to prevent physical injury...[or] pain...to the Person with a Disability.

118 CMR 2.02.

If it is determined that a caretaker engaged in abuse or abuse *per se* and the injury was not an accident, that is still not the end of inquiry. A caretaker in that situation is not necessarily placed on the abuser registry. “Registrable Abuse” does

not include instances in which...the incident was isolated *and* unlikely to reoccur *and*...the Care Provider is fit to provide services or supports to persons with intellectual or developmental disabilities.

G.L. c. 19C, §15; 118 CMR 14(3)(a) (emphasis added). The regulation continues:

Factors that may be considered...in determining whether the incident was isolated and unlikely to reoccur and the care provider is fit to provide services and supports to persons with intellectual or developmental disabilities may include, but are not limited to:

1. the nature and extent of the serious physical injury, serious emotional injury, or abuse *per se* sustained by the person with an intellectual disability or person with a developmental disability; and
2. relevant details about the care provider, such as whether the care provider received training relevant to the incident at issue; the care provider's employment history in working with individuals with disabilities; prior instances of similar conduct by the care provider, regardless of whether said conduct constituted abuse or abuse *per se*; any statements or communication regarding the care provider's work history and fitness to provide services and supports to persons with disabilities; and whether the care provider's conduct could reasonably be addressed through training, education, rehabilitation, or other corrective employment action and the care provider's willingness to engage in said training, education, or other corrective employment action.

118 CMR 14(3)(b).

The relevant regulations refer to:

- “intentional, wanton or reckless” (definition of “abuse *per se*”);
- “intentional, reckless, or negligent” (definition of “act”);
- “negligent” (discussion of accident, which is not abuse *per se*); and
- “reckless” (same).

118 CMR 2.02.

“The terms ‘wilful,’ ‘wanton,’ and ‘reckless’ are often used interchangeably.”

Manning v. Nobile, 411 Mass. 382, 388 n. 8 (1991).

Wilful, wanton, or reckless conduct is

“intentional conduct, by way either of commission or of omission where there is a duty to act, which conduct involves a high degree of likelihood that substantial harm will result to another.” *Commonwealth v. Catalina*, 407 Mass. 779, 789, 556 N.E.2d 973 (1990), quoting *Commonwealth v. Welansky*, 316 Mass. 383, 399, 55 N.E.2d 902 (1944). See *Desmond v. Boston Elev. Ry.*, 319 Mass. 13, 16, 64 N.E.2d 357 (1946). Two characteristics of wilful, wanton, or reckless conduct distinguish it from negligence. First, the defendant must knowingly or intentionally disregard an unreasonable risk. See *Catalina, supra*; *Welansky, supra*. Second, the risk, viewed prospectively, must entail a “high degree of probability that substantial harm would result” to the plaintiff. *Desmond v. Boston Elev. Ry., supra* at 16, 64 N.E.2d 357. See Restatement (Second) of Torts § 500 (1965).

Id. at 387–88.

As for negligence, it is the failure “to exercise that degree of care, diligence and safety that an ordinary prudent person would exercise under similar circumstances.” *Commonwealth v. Kline*, 19 Mass. App. Ct. 715, 720 (1985) (quotation marks and citation omitted).

Thus, among the questions that this decision must answer are these questions, some of which are related to each other:

Did the victim suffer a significant impairment of a limb?

Did the victim suffer a serious physical injury?

Did C.A. apply physical force that caused the victim physical pain?

If so, did C.A. do so intentionally, wantonly, or recklessly?

Did C.A. commit abuse?

Did C.A. commit abuse *per se*?

Did C.A. act negligently?

Did C.A. apply an appropriate degree of physical force given the circumstances?

Was C.A.’s injury to the victim an accident?

Was the incident isolated?

Is the incident likely to reoccur?

Could C.A.'s conduct reasonably be addressed through training, education, rehabilitation, or other corrective employment action?

Is C.A. fit to provide services or supports to persons with intellectual or developmental disabilities?

I now answer those questions.

Did the victim suffer a significant impairment of a limb?

Yes. The victim was provided a sling for his arm, which he wore for about two weeks.

(Exs. E and F; victim testimony) Therefore, his arm was significantly impaired.

Did the victim suffer a serious physical injury?

Yes. The relevant definition of "Serious Physical Injury" includes "any significant impairment of a...limb...." 118 CMR 2.02(e). The victim suffered a significant impairment of his arm. Therefore, he suffered a serious physical injury.

Did C.A. apply physical force that caused the victim physical pain?

Yes. During the restraint, the victim told C.A. that C.A. was hurting him and was going to dislocate his shoulder. (Testimony of victim, L.C., housemate; Ex. C, p. 18; Ex. T)

If so, did C.A. do so intentionally, wantonly, or recklessly?

Yes. C.A. had his knee on the victim's shoulder or otherwise applied too much pressure to it. The victim told C.A. *during the restraint* that C.A. was hurting him and was going to dislocate his shoulder. (Testimony of victim, L.C., housemate; Ex. C, p. 18; Ex. T) Thus, during the restraint, C.A. knowingly or intentionally disregarded an unreasonable risk of injuring the

victim, and the risk, viewed prospectively, entailed a high probability that the victim would be substantially harmed. *Manning*, 411 Mass. at 387–88. Therefore, C.A. conducted the restraint wantonly and recklessly, which are, in effect, synonyms. *Id.* at 388 n.8 (1991). As for intentionality, C.A. intentionally applied physical force, but no evidence exists that he intentionally caused the victim pain.

Did C.A. commit abuse?

Yes. Since abuse is “An Act...which results in Serious Physical Injury...to a Person with a Disability,” 118 CMR 2.02, and since the victim, a person with a disability, suffered a serious physical injury, namely, impairment of a limb, he suffered abuse, which C.A. committed.

Did C.A. commit abuse per se?

Yes. Since C.A. wantonly or recklessly applied physical force that caused the victim physical pain, 118 CMR 2.02, C.A. committed abuse *per se*.

Did C.A. act negligently?

Yes. When the victim complained that C.A. was going to dislocate his shoulder, an ordinary prudent person would have (1) heeded the complaint as sincere enough to (2) warrant stopping kneeling or applying pressure to the victim’s shoulder. C.A.’s failure to heed and stop was negligence. *Kline*.

Did C.A. apply an appropriate degree of physical force given the circumstances?

No. The restraint was unnecessary and inappropriate under the circumstances.

The Core Curriculum Specialist Manual advises: “A behavioral antecedent, or ‘signal,’ is a behavior that a person exhibits before more serious behavior.” (Ex. I, p. 112) When the victim

swore at C.A. and continued climbing the stairs to his room, *both* were behavioral antecedents that C.A. should have heeded by ending the attempt to search the victim's backpack.

The manual also advises:

Be aware of triggers, signals, and any other indicators that a crisis might happen. Whenever you might need assistance, call for it. It's better to call for help early (even if that might mean a false alarm) than not get it soon enough.

(Ex. I, p. 115) C.A. ignored the clear signals that an incident was possible. By ignoring the signals, he created a crisis. He did not ask for assistance until he wanted to implement the unnecessary restraint, which required at least two other staffers.

C.A. did not use prompts before restraining the victim, as he was trained to do. (Ex. I, p. 123-24, 126, 150) Rather, C.A. apparently misunderstands prompts.

Prompts entail a staffer speaking quietly or suggesting to a person such things as "Walk with me," "Sit down," or "Let's take a slow breath." (Ex. I, p. 123-24, 150) Prompts do *not* entail a staffer repeating his substantive requests to a person.

C.A. evidenced his misunderstanding of prompts in his account in the Restraint Management Report, when he wrote:

I asked [the victim] to either wait downstairs or meet me in the office for a quick check away from [his] housemates. [The victim] responded[,] saying 'I don't give a fuck. you are not searching my bag.['] [The victim] was prompted *again* to hold on and not go upstairs yet as I would like to meet [him] in my office and this made [the victim] upset.

(Ex. G, p. 52-53) (emphasis added)

C.A. also evidenced his misunderstanding of prompts in his account that entered the Incident Management Report, when he wrote that the victim "was prompted again to hold on and not go upstairs yet as I would like to meet [him] in my office." (Exs. U and V)

When the Restraint Management Report asked about “Less Restrictive Methods Used Prior to Restraint,” it was almost certainly C.A. who answered that the victim “was prompted.” (Ex. G, p. 52) That means that, as stated above, it was almost certainly C.A. who asserted that the less restrictive method that he used before restraining the victim was to tell the victim that he wanted to talk to him.

After C.A. failed to heed the clear signals that an incident was possible and failed to de-escalate the situation or use prompts, he failed again to avert the crisis. When the victim swung his fist, he “slightly” caught C.A.’s face. “Slightly” is C.A.’s characterization. (Ex. G, p. 52; Exs. U and V) While being punched, even slightly, is not pleasant for anyone, C.A. did not need medical attention, experience pain or swelling, or take any analgesic for the punch. (C.A. testimony) At that point, C.A. could and should have backed off from the situation and left it to other staff members. (Ex. C, p. 18 (after the restraint S. told C.A. that C.A., could have de-escalated the situation and should have asked for help before restraining the victim))

Instead, C.A. escalated the situation. He physically tangled with the victim and proceeded to a floor hold, which is the most intrusive and restrictive Safety-Care hold, a hold that should be used “only when less restrictive interventions are not sufficient” (Ex. H, p. 80), a hold that he knew was the most restrictive hold. (C.A. testimony)

Three witnesses to the incident recounted that C.A. was too aggressive, either during the lead-up to the restraint or during the lead-up and restraint itself: S., L.C., and B.B. (Ex. C, pp. 18-19; L.C. testimony)

The victim told C.A. that C.A. was hurting him and was going to dislocate his shoulder. (Testimony of victim, L.C., housemate; Ex. C, p. 18; Ex. T) Thus, C.A.'s use of physical force to restrain the victim was inappropriate under the circumstances.

As CPPD stated in its answer to C.A.'s Petition for Review:

Caretakers of individuals with disabilities may sometimes encounter situations where a client becomes frustrated or aggressive towards a caretaker, and caretakers may become frustrated or lose patience. The fact that the Petitioner took out his frustration with [the alleged victim] by grabbing [the alleged victim] and aggressively pulling [the alleged victim] to the ground shows a fundamental misunderstanding of the Petitioner's duty as a caretaker. Moreover, the Petitioner fails to recognize that even if [the alleged victim] did hit the Petitioner during the incident, the Petitioner's own conduct caused [the alleged victim] to escalate. Had the Petitioner used de-escalation techniques instead of dangerously grabbing [the alleged victim]'s backpack while [the alleged victim] was on the stairs, [the alleged victim] likely would not have needed to be restrained and would not have been injured.

Was C.A.'s injury to the victim an accident?

No. A caretaker's act is not an accident if it was one or more of five things: a negligent act; a reckless act; an omission; the application of an appropriate degree of physical force given the circumstances; or the result of a caretaker's good faith attempt to prevent physical injury or pain to the person with a disability. 118 CMR 2.02.

C.A. acted both recklessly and negligently, as discussed above. His conduct entailed an act, not an omission. He did not use an appropriate degree of physical force given the circumstances, also as discussed above. The restraint was not an attempt, let alone a good-faith attempt, to prevent physical injury to *the victim*. C.A. has not alleged that the restraint was such an attempt.

The incident did not entail any of the five scenarios that constitute an accident. Thus, C.A.'s act was not an accident.

Was the incident isolated?

Probably. The record contains no evidence of any similar act by C.A.

Is the incident likely to reoccur?

That is hard to say. If "What's past is prologue," as William Shakespeare in *The Tempest*, act 2, sc. 1, and an inscription on the National Archives instruct, then the past – only one known incident – may or may not presage another one. It is not necessary to answer this question because I find below that C.A. is not fit to provide services or supports to persons with intellectual or developmental disabilities.

Could C.A.'s conduct reasonably be addressed through training, education, rehabilitation, or other corrective employment action?

Probably not. C.A. believed that the restraint comported with his training and that his training had already been "extensive." (Ex. L, p. 214) It is not clear how more training, training that he might also not implement or misinterpret (*e.g.*, the meaning of "de-escalate" and "prompt"), could correct his conduct and prevent a similar incident. 118 CMR 14(3)(b).

Is C.A. fit to provide services or supports to persons with intellectual or developmental disabilities?

No. See answers above to "Did C.A. apply an appropriate degree of physical force given the circumstances?" and "Could C.A.'s conduct reasonably be addressed through training, education, rehabilitation, or other corrective employment action?"

In addition to C.A.'s failures discussed above, C.A. failed to comply with the Safety-Care training he received.

The Core Curriculum Specialist Manual advises:

Physical management procedures must be used *only* when there is **no safe alternative**. **All three** of these conditions must be met in order to *consider* use of physical management:

....

- 1) There must be imminent risk of serious harm to the agitated person or someone else.
- 2) There must be no other practical way to prevent that harm without physical management.
- 3) The risk of not intervening must be greater than the risk of intervening.

(Ex. I, p. 148) (bold in the original; italics added)

However, imminent risk of serious harm to the victim did not exist. After the victim swung and slightly caught C.A.'s face, no risk of *serious* harm to C.A. existed.

Since such harm did not exist, it is not necessary to explore whether a "practical way to prevent that harm" existed.

Finally, the risk of intervening was not greater than the risk of not intervening. While predictions cannot be guaranteed to be accurate, the risk of C.A. not intervening further after a fist slightly caught his face, that is, the risk of what would have happened had he let the situation go and handled it other than placing the victim in a floor hold, seem low. The victim was not attacking other staffers or housemates. The victim did not seem to be attacking C.A.; the victim swung once at C.A. and that may have been it. In contrast to the risk of not intervening, the risk of intervening does not need to be predicted. We know that the victim was placed in a floor hold and injured, and the group home was placed in an uproar.

While the Core Curriculum Specialist Manual also advises that "it is always important to seek alternatives" to physical management (Ex. I, p. 148), C.A. did not do so.

The Core Curriculum Specialist Manual advises that physical management may be riskier for people with asthma (Ex. I, p. 149), such as the victim. (Ex. C, p. 16) However, no evidence exists that C.A. considered the victim's asthma before restraining him.¹³

While the Core Curriculum Specialist Manual advises staff members conducting physical management to "[c]heck for breathing at least every 30 seconds" (Ex. I, p. 149), no evidence exists that C.A. ever checked the victim's breathing during the 10 to 15 minute restraint.

While the Core Curriculum Specialist Manual advises staff members conducting physical management to "[w]atch for indicators of discomfort, such as verbal complaints" (Ex. I, p. 149), C.A. ignored the victim's complaints that C.A. was hurting him and was going to dislocate his shoulder. (Testimony of victim, L.C., housemate; Ex. C, p. 18; Ex. T)

The Safety-Care Advanced Skills Module, Specialist Manual states that a floor hold "should be used *only* when less restrictive interventions are not sufficient to manage imminent risk of harm during a severe behavioral crisis." (Ex. H, p. 80) (emphasis in original) However, C.A. did not try less restrictive interventions, and the victim's swinging at and slightly catching C.A.'s face did not constitute a *severe* behavioral crisis. It might not have constituted a crisis.

While the Safety-Care Advanced Skills Module, Specialist Manual recommends that floor holds "not be used unless the person has been assessed in advance by a licensed medical professional" (Ex. H, p. 80), no evidence exists that a licensed medical professional assessed the victim and that C.A. knew about such an assessment.

¹³ I am cognizant that CPPD has the burden of proof in this appeal. G.L. c. 19C, §15; 118 CMR 14.03(4). By asserting that "no evidence exists," here and elsewhere, I am not shifting the burden to C.A. Rather, I am pointing out that C.A.'s statement that he complied with training when he restrained the victim, which I discuss below, lack support in the record.

The Safety-Care Advanced Skills Module, Specialist Manual recommends that staffers implement floor holds on a padded gym mat, yoga mat, carpet, or towel, and not on a hard surface, such as tile. However, the victim might have been restrained on a tile or hardwood floor. (Ex. S, p. 300, 303, 305 (photographs))

C.A. told the investigator that he believed that he restrained the victim according to his training. (Ex. C, pp. 18) In his email of appeal to CPPD, C.A. called the restraint “a standard safety care restraint.” (Ex. L. p. 213) He further stated that the restraint “was executed within the bounds of my extensive training” and “adhered to all professional and ethical standards.” (Ex. L. p. 214) In his appeal to DALA, C.A. stated that the restraint was in “compliance with Safety Care protocol” and “I followed policy and acted in accordance with my responsibilities.” (DALA Appeal Form Pursuant to 801 CMR 1.01) (Ex. L, p. 214) C.A.’s post-hearing brief referred to his “proper execution of the supine stability hold.” (Pet. br. 31)

C.A. is incorrect. The restraint was none of those things. Thus, C.A. is not fit to provide services or supports to persons with intellectual or developmental disabilities for three separate but related reasons. One, the restraint did not comport with C.A.’s training. Two, he believed otherwise. And three, by maintaining that the restraint was proper, he did not take responsibility for his conduct. *C.M.J. v. DPPC*, DPPC-23-0143 (DALA Aug. 2, 2024) (petitioner’s refusal to accept responsibility was one reason to place him on the abuser registry).

C.A. is not fit for yet another reason. He demonstrated “such poor judgment and control,” as CPPD put it. (Answer of CPPD)

C.A.’s argument in his post-hearing brief

I move on from answering questions that the relevant statute and regulations raise to one argument in C.A.'s post-hearing brief: The victim's injuries "could only have been caused by his struggling against [C.A.] during the supine restraint" and

The preponderance of the evidence indicates that any pain and/or injury on [the victim's] arm was caused by his own struggling against the supine restraint – not [C.A.'s] proper execution of the supine stability hold.

(Pet. br. 31) This argument is unavailing for a few reasons. It is a classic case of blaming the victim. The preponderance of the evidence neither indicates nor proves any such thing. It is unclear what the basis for the assertion of "only" is, which discounts the obvious possibility that C.A. kneeled or otherwise placed too much pressure on the victim's shoulder injured the victim, a possibility that I find by the preponderance of the evidence occurred.

Moreover, if one accepts C.A.'s argument both that he properly executed the supine hold and that the victim injured himself, one must accept that a problem exists with the supine hold, namely, that it can injure agitated people, among whom it is supposed to protect. I'm not ready to accept that a properly executed supine hold can injure a restrained person. And if it is so that a properly executed supine hold can injure a restrained person, then C.A. should not have restrained the victim after receiving a slight punch.

Conclusion and Order

CPPD has proved by a preponderance of the evidence that C.A. committed registrable abuse. DPPC may place A.C. on the abuser registry.

Dated: October 2, 2026

/s/ Kenneth Bresler

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APPENDIX

This appendix quotes or summarizes the various accounts of various witnesses of the incident on December 16, 2024 and its aftermath. The various accounts are from various sources, as identified. Compiling them in this appendix allowed me to compare a witness's accounts with (1) other accounts by the same witness, and (2) the accounts of other witnesses. After weighing these accounts, I made the factual findings about the incident, above. I have retained the appendix in the event that it is useful to a subsequent tribunal.

The following accounts are what various witnesses reported, not necessarily what I find happened on and after December 16, 2024. The numbering continues from the factual findings, above.

Debriefing interview of victim

56. On December 16, 2024, the same day as the incident, the Assistant Director interviewed/debriefed the victim about the incident. The handwriting on the interview form, a simple two-page form, is apparently that of the Assistant Director, recording the victim's answers. (Ex. W)

57. When asked what made him mad, the victim answered: When C.A. "pulled my bag." (Ex. W) (The form does not purport to quote the victim. This decision quotes the form, which presumably paraphrases the victim.)

58. When asked what happened, the victim answered: "I grabbed him and swung after he pulled my bag and pulled me down the stairs." (Ex. W)

59. When asked how the incident affected him, the victim answered: "I am very hurt. My shoulder hurts and my face."

Investigator's interview of victim

60. On December 19, 2024, the investigator interviewed the victim, who told him the following:

A. On December 16, 2024, he returned from his day program to the group home.

B. While walking up the stairs in the group home, C.A. said that he needed to search the victim's backpack.

C. The victim turned around in self-defense to get away from him [C.A.], and he picked me up and slammed me to the ground. My head hit the wall and the next thing I knew, I was in a restraint. (These indented words appear in the Investigation Report in quotations, presumably meaning that the investigator quoted the victim.)

D. C.A. “put his knee on me and I thought I was going to separate my shoulder.” (The investigator presumably quoted the victim.)

E. The victim did not know how long the restraint lasted.

F. He experienced shoulder pain and was unable to sleep because of the pain.

G. The investigator asked the victim to show him bruises; the victim pointed to several areas of his shoulder; but the investigator was unable to see bruises or marks.
(Ex. C, p. 17)

Victim’s hearing testimony

61. The victim testified at the hearing as follows:

A. C.A. drove the house van from the day program. In addition to the victim, two of his three housemates were in the van.

B. C.A. said that he needed to see what was in his bag, but the victim does not remember which items C.A. was interested in.

C. After they arrived at the group home, the victim entered the group home, followed by C.A. and his two housemates.

D. C.A. told the victim to let him see the inside of the victim’s bag. The victim told him: No; it’s not in my plan (meaning his behavior plan).

E. Their voices were raised. At one point, the victim swore at C.A.

F. The victim was on the first step going upstairs. C.A. put his hand on the victim’s shoulders to stop him and said that he needed to check his bag.

G. C.A. told the victim that the victim was not going upstairs, and grabbed the victim by his backpack. The victim turned around and punched C.A. in the face.

H. C.A. slammed the victim to the floor; his face hit the wall of the staircase.

I. The victim was restrained on his back. C.A. and S., a direct care staffer, each had one of the victim’s arms; L.C., a direct care staffer, restrained his legs.

J. C.A. had his knee on the victim’s shoulder. He told C.A. that C.A. was hurting him and that C.A. was going to dislocate his shoulder, and asked C.A. to stop.

K. S. said something about DPPC.

L. S. asked C.A. to step out of the room. The victim does not remember C.A.’s response.

M. The restraint lasted about 10 minutes.

N. After the restraint, the victim was bruised. *See* Ex. Q, p. 296 (photograph showing bruises on the alleged victim’s right inner arm and right under arm) (It is unclear when the victim’s bruises were photographed.) He did not have those bruises before being restrained.

O. The bruises are where C.A. applied pressure to the victim. He believes that the bruises are from the restraint.

P. The victim’s face was swollen. He does not remember how long the swelling lasted.

Q. The victim believed that the swelling resulted from his face hitting a wall.

R. The victim has a back condition, which sometimes hurt. After C.A. restrained him, his back hurt; he attributes the pain to the restraint. *See* Ex. R, p. 287 (photograph shows the victim’s back, including a scar from a medical procedure unrelated to the incident)

S. The victim was given an offer to go to urgent care (presumably by a supervisor or staffer at the group home). He declined because he wanted to attend the group home’s Christmas party that day, something that he had looked forward to. The victim eventually went to urgent care.

T. After the incident, the victim wore a sling for about two weeks. He went to physical therapy twice a week for six weeks.

U. The victim still experiences pain, which he ascribed to the restraint and C.A.’s acts. The pain comes and goes. He cannot sleep on his right side.

V. The victim does not want C.A. to return as house manager because he would not feel safe.

W. The victim was truthful when he spoke to the investigator. The victim reviewed his statement in the investigator’s report and would not change anything.

S.'s email to Assistant Director

62. On December 18, 2024 (two days after the incident), S., a direct care staff member at the group home who witnessed the incident, emailed the Assistant Director of the organization that ran the group home, at the Assistant Director's request, as follows:

- A. The victim opened the front door.
- B. The victim and C.A. discussed the victim's bag.
- C. C.A. asked the victim for his bag, but he refused.
- D. C.A. tried to take the victim's bag from his shoulder by force.
- E. The victim hit C.A.
- G. C.A. threw the victim on the floor without using any Safety-Care technique.
- H. S. came between the victim and C.A.
- I. C.A. and S. started using a Safety-Care technique to calm the victim.
- K. The victim was cursing C.A.
- L. S. asked C.A. to go upstairs because his presence did not help the situation, but C.A. refused.
- M. After the victim calmed down, S. decided to release him. (Ex. T)
- J. At a certain point, S. took control of the situation and the victim cooperated with S.

Investigator's interview with S.

63. On January 7, 2025, the DDS investigator interviewed S. (identified in the Investigation Report as I2), who told him the following:

- A. C.A. transported the victim and another resident of the group home from the day program to the group home.
- B. S. was in the group home when C.A. arrived.
- C. The victim opened the front door and went upstairs to his bedroom.
- D. C.A. grabbed the victim's bag.
- E. The victim turned around and hit C.A. in the face.
- F. C.A. grabbed the alleged the victim by his shirt and took him to the ground.
- G. S. did not see the victim strike his head on anything.
- H. S. told C.A. that he should step away so that victim could calm down, but C.A. refused.
- I. S. did not know how long the restraint lasted.
- J. The victim yelled while being restrained.
- K. S. did not help C.A. restrain the victim.
- L. After the restraint, S. followed C.A. into C.A.'s office and told him the following: C.A. was too aggressive; could have de-escalated the situation; and should have asked for help before restraining the victim.
- M. S. did not see injuries on the victim.

(Ex. C, p. 18)

S.'s hearing testimony

64. S. testified as follows:

- A. The victim came into the group home, followed by C.A.
- B. The victim refused to let C.A. check his backpack.
- C. S. did not see the victim hit C.A.
- D. C.A. pulled the victim to the floor by pulling the victim's hand and roughly dropped the victim to the floor.
- E. C.A. put the victim on the floor twice, once at the bottom of the stairs.
- F. S. asked C.A. to let the victim up. S. also asked C.A. to leave; when a person targets a staffer, Safety-Care training says that the targeted staffer should leave.
- G. S. participated in the restraint, which lasted for two minutes. He restrained the victim's arm; C.A. restrained the other arm; and L.C. restrained the victim's legs.

H. About three hours after the incident, C.A. called S. to the group home's office and asked him to sign a handwritten report about the incident. S. declined to sign because he had not seen the whole incident.

I. S. called the Assistant Director and emailed her; the order is unclear. His email to her was accurate. The Assistant Director did not ask him to email her.

J. S. denied that he told the investigator that he did not restrain the victim. He thought that the investigator asked about something else.

K. S. did not report the incident to CPPD because he relied on C.A. to report it.

L. The victim later told S. that he did not feel safe in the group home.

(S. testimony)

L.C.'s email to Assistant Director

65. On December 18, 2024 (two days after the incident), L.C., a direct care staff member at the group home who witnessed the incident, emailed the Assistant Director of the organization that ran the group home, as follows:

- A. L.C. heard the front door open, heard some of the residents' voices, and a loud thump.
- B. C.A. and the victim were arguing and scuffling in the dining room.
- C. The housemate was outside the group home, looking scared to come in.
- D. C.A. took the victim to the ground with excessive force and held him down.
- E. They moved to the living room, where the victim was restrained a second time.
- F. The victim told C.A. that he was hurting his arm and was going to dislocate his shoulder.

(Ex. T)

Investigator's interview with L.C.

66. On January 9, 2025, the DDS investigator interviewed L.C. (identified in the Investigation Report as I3), who told him the following:

- A. L.C. was in the group home when she heard the front door open, and then a bang and scuffling.
- B. She came down the stairs and saw the victim's backpack and some papers on the floor.
- C. She saw C.A. and the victim struggling and pushing each other.
- D. She did not see the victim strike C.A.
- E. C.A. aggressively grabbed the victim and pushed him to ground.
- F. C.A. told the victim to stand up, which he did. They walked toward the living room.
- G. The victim was very upset and agitated.
- H. C.A. told L.C. to help restrain the victim. She did not think that restraint was warranted, but C.A. was the manager and L.C. had to do what he said.
- I. L.C. held down the victim's legs while C.A. and S. each held an arm.
- J. The restraint lasted about 10 minutes until the victim calmed down and was released.
- K. C.A. was too aggressive during the incident and should not return to working with the victim.
- L. On the next day, L.C. saw some bruising in the area of the victim's right shoulder and upper arm.

(Ex. C, pp. 18-19)

L.C.'s hearing testimony

67. L.C. testified as follows:

- A. On December 16, 2024, C.A. brought residents from their day program to the group home.
- B. L.C. was in the bathroom when C.A. and the residents arrived. She knew they had arrived because, when the front door is opened, a high-pitched sound is emitted.
- C. She heard a loud thump, like something hitting a wall or the floor.
- D. When she went downstairs, she saw C.A. and the victim, pushing, shoving, and grabbing each other. They were arguing, with the victim saying: What are you doing? What are you doing? Are you crazy?

(Statements without quotation marks in this decision indicate paraphrases that the witness did not purport to be quotations.)

E. C.A. shoved the victim to the ground, hard. It was not consistent with the training that L.C. had received.

F. The victim ended up in a supine restraint, on his back. L.C. held his legs. S. held his arms. C.A. held the victim near his shoulder.

G. The victim said: You're going to dislocate my shoulder. You're hurting me. You're hurting me.

H. The victim was restrained a second time in a different room in the group home.

I. L.C. did not want to participate in the restraint but reluctantly complied. She feared that C.A. would yell at or report her.

J. The restraint lasted about 10 minutes. It came to an end when the victim slowly unclenched a fist.

K. C.A. had the victim sit on the couch and empty his backpack. L.C. did not see any items that the victim was not supposed to have.

L. The next day, the victim showed L.C. bruises on his shoulder in the area where C.A. had had his shoulder on the victim.

M. The victim told L.C. that he did not want C.A. coming back to the group home and that he would not feel safe if C.A. returned.

N. L.C. did not report the incident to CPPD, even though she's a mandated reporter. She thinks the reason is that she thought the Assistant Director would take care of it.

O. L.C.'s email to the Assistant Director was accurate.

P. The investigator recorded her account accurately except that she wasn't upstairs at the beginning of the incident. (L.C. testimony)
(L.C. testimony)

B.B.'s email to Assistant Director

68. On December 18, 2024 (two days after the incident), B.B., a direct care staff member at the group home who witnessed the incident, emailed the Assistant Director of the organization that ran the group home, as follows:

A. The victim rushed into the group home and climbed the stairs.

B. C.A. rushed in too and told the victim three times to come down. The victim refused, saying that he was going to his room.

C. C.A. "redirected" the victim "to come down by pulling [him] from the stairs."

D. The victim was very upset and yelled at C.A. to leave him and not touch him again.

E. The victim managed to stand up and hold C.A. by the neck.

F. C.A.'s coffee spilled, C.A. and the victim "started dragging," and C.A. pulled the victim to the floor to restrain him. (B.B. may have meant "struggling.")

G. A staffer asked for the on-call supervisor to be called, but C.A. instructed the staffer not to do so and to go upstairs. (B.B. told the DDS investigator that this staffer was S.)

H. C.A. dragged the victim from the front door to the living room.

I. Other staffers went upstairs to be with other residents.

(Ex. T)

Investigator's interview with B.B.

69. On January 8, 2025, the DDS investigator interviewed B.B. (identified in the Investigation Report as I4), who told him the following:

A. B.B. was in the group home when C.A. and the victim returned there.

B. The victim entered the group home and walked up the stairs.

C. C.A. entered closely behind the victim, holding coffee and items.

D. C.A. told the victim to stop so that he could check the victim's bag. The victim refused.

E. C.A. grabbed the victim's hand, dragged him down the stairs, and put him on the floor. B.B. did not see C.A. grab the victim's backpack.

F. C.A. asked S. to help with restraining the victim; S. did so.

G. The victim was very upset and yelled that it hurt.

H. S. told B.B. to call the on-call supervisor, but C.A. said not to.

I. B.B. then went upstairs with other residents and did not see anything else.

J. B.B. did not see the victim strike his head on anything and did not see any injuries on the victim.

K. B.B. believed that C.A. was too quick and aggressive in taking the victim to the floor.

(Ex. C, p. 19)

B.B.'s hearing testimony

70. B.B. testified as follows:

A. On December 16, 2024, C.A. picked up residents from the day program and drove them to the group home.

B. When C.A. and the residents arrived at the group home, B.B. was sitting in a chair near the front door.

C. The victim entered the group home and went up the stairs. C.A. followed.

D. C.A. said: Come down. The victim said: I'm going to my room. C.A. told him to calm down and said: You don't want me to drag you down.

E. C.A. dragged the victim down the stairs by holding one of the victim's hands.

F. The victim put his hands around C.A.'s neck.

G. At some point around then, C.A. spilled his coffee.

H. Other staffers told B.B. to call the Assistant Director, but C.A. said not to call anyone. B.B. went upstairs.

I. C.A. dragged the victim to the living room.

J. B.B. did not call the CPPD because managers were already involved. (Presumably, she meant that managers would take care of reporting the incident to CPPD.)

K. The investigator's report of her account of the incident was accurate.

L. B.B.'s email about the incident to the Assistant Director was accurate.

(B.B. testimony)

Investigator's interview with housemate

71. On January 23, 2025, the DDS investigator interviewed one of the victim's housemates (identified in the Investigation Report as I5), who told him the following:

A. C.A. picked up the victim and housemate from the day program. During the ride to the group home, C.A. said that he believed that the victim might have taken hot sauce from the day program, which she was not allowed to do, and he wanted to check the victim's bag.

B. At the group home, the victim entered with C.A. right behind. As the victim went upstairs inside the home, C.A. asked to look in the victim's bag. The victim said no, because a protocol did not exist for C.A. to look in his bag. C.A. grabbed the victim's hood from behind and threw him into a wall. The victim yelled: Get off me. C.A. restrained the victim on the ground. The victim kept yelling: Get off me, get off me.

C. The victim did not strike C.A.

D. C.A. called for S. to help with the restraint.

E. The housemate left the vicinity at this point.

(Ex. C, p. 19)

Housemate's hearing testimony

72. The housemate testified as follows:

A. C.A. picked up her and two other residents from the day program.

B. In the van ride, the conversation was about the victim's having in his backpack things that he was not supposed to have: hot sauce and energy packets containing caffeine.

C. The victim walked into the group home and C.A. followed.

E. At one point, C.A. grabbed the victim's backpack by a loop on the back of it.

D. The victim said to C.A.: I don't have a bag protocol. Why are you checking my bag?

E. At some point, C.A. pushed the victim's head into the wall.

F. C.A. brought the victim to the ground. The housemate did not see other staffers help restrain the victim.

G. C.A. put a knee on the victim. The victim screamed.

H. A staffer told C.A. to go upstairs to calm the situation, but C.A. refused.

I. The housemate got scared at C.A.'s restraint of the victim and left the group home for about three minutes.

J. Later, the housemate saw abrasions on the victim's forehead and arm, and bruises on his arm and leg.

Incident report

73. On December 16, 2024, C.A. wrote in an Incident Report for the Home and Community Services Information System (HCSIS), which the Executive Office of Health and Human Services (HHS) maintains: [The victim] was restrained today at 3:40pm. I picked [three residents] including [the victim] up from the [day program] and the drive back to the program was fairly routine. I had a discussion with the [residents] about not taking each other's property or pressure their housemates into buying something for them. In conversation, it came up that [the victim] had been bringing [the housemate]'s hot sauce to the [day program]. Shortly before we arrived back at the program [that is, the group home], I informed [the victim] that I would like to check [his] school bag so [he] didn't have things like hot sauce. When we arrived at the program [that is, the group home], [the victim] got in first and I came in right after with the other [residents] right behind me. I asked [the victim] to either wait downstairs or meet me in the office for a quick check away from [his] housemates. [The victim] responded saying 'I don't give a fuck. you are not searching my bag.['] [The victim] was prompted again to hold on and not go upstairs yet as I would like to meet [him] in my office and this made [the victim] upset. [The victim] then swung at me with a clenched fist slightly catching my face. I didn't expect the aggression but I swiftly secured the same right arm and guided [the victim] to the floor until staff joined. Staff [S.] and LC were on shift and immediately assisted. [The victim] was put in a three man supine restraint with [the victim]'s arms out by [his] side. I maintained [his] right arm while staff CS secured the left arm with one hand on [his] shoulder. Staff LC was called in to secure [the victim]'s legs and this lasted for about 15 minutes. [The victim] deescalated and followed all safety prompts[,] including taking deep breaths and staff disengaged one after another after each safe prompt. [The victim] is currently on regrouping and continues to be monitored but [he] is back to baseline at least for now.

(Ex. V) (This account also appeared in the General Events Report. (Ex. U))

Restraint report

74. On December 16, 2024, C.A. wrote in a Restraint Report (which is less detailed than the Incident Report) that the victim "swung at me with a clenched fist[,] slightly catching my face." (Ex. G, p. 52) See Ex. C, pp. 18 (C.A. told investigator that he filed a restraint report on the day of the incident).

75. The report categorized the emergency as "Substantial Risk of Serious Physical Assault." (Ex. G, p. 52) (The record does not reveal whether C.A. was the person who categorized the emergency, but this categorization appears in the same box, Restraint Basic Information, as C.A.'s brief first-person account.)

76. When asked for the antecedents to emergency, the form states:

I asked [the victim] to either wait downstairs or meet me in the office for a quick check away from [his] housemates. [The victim] responded[,] saying 'I don't give a fuck. you are not searching

my bag.['] [The victim] was prompted again to hold on and not go upstairs yet as I would like to meet [him] in my office and this made [the victim] upset.

(Ex. G, p. 52-53) (The office was on the second floor. (C.A. testimony))

77. When asked "Less Restrictive Methods Used Prior to Restraint," the report states that the victim "was prompted." (Ex. G, p. 52) (C.A. almost certainly wrote this. It appears in the same box, Restraint Information II, as C.A.'s longer first-person account, and both statements (the victim "was prompted" and the longer first-person account) refer to the victim having been prompted. Thus, it was almost certainly C.A. who stated that the less restrictive method that he used before restraining the victim was to tell the victim that he wanted to talk to him.)

78. The report stated that the restraint did not physically injure the victim or any staffer. (Ex. G, p. 53) (C.A. may or may not have written this.)

79. For "Describe Individual's Behavior and Condition During Restraint..," the report stated that the victim "was yelling and resisting and swinging [his] arms and legs." (Ex. G, p. 53) (C.A. may or may not have written this.)

Investigator's interview of C.A.

80. On December 31, 2024, the DDS investigator interviewed C.A., who told him the following:

A. The victim had a pattern of taking other residents' possessions, including hot sauce. He had been taking hot sauce to the day program, even though he had been asked not to. He had pressured housemates to buy items for him and concealed them in his backpack.

B. On December 16, 2024, during the ride from the day program to the group home, C.A. mentioned that the victim had been taking hot sauce from the group home. The victim became defensive, leading C.A. to believe that victim had hot sauce in his backpack.

C. At the group home, C.A. followed the victim and his housemate into the home. C.A. held papers and coffee. As the victim was going upstairs, C.A. asked the victim to hold up because C.A. wanted to check his backpack for hot sauce and other items that victim wasn't supposed to have.

D. The victim became enraged, turned around, and punched C.A. in the left side of the face.

E. C.A. dropped the papers and coffee that he had held, and grabbed the victim's backpack to stop him from striking C.A. again.

F. C.A. used the victim's backpack to control him. The victim continued to swing at C.A.

G. C.A. guided the victim to the floor and asked S., another group home staffer, to help restrain the victim. C.A. held one of victim's hands; S. held another.

H. Another staffer, L.C., also helped by holding victim's legs, as the victim continued to try to fight.

I. During the restraint, C.A. spoke to the victim, trying to calm him.

J. S. tried to diffuse the situation and asked C.A. to leave but C.A. thought he needed to stay and maintain the restraint for everyone's safety.

K. The restraint lasted about 15 minutes until the victim was calm.

L. The victim did not strike his head on any surface, did not sustain any apparent injury, and did not complain of pain.

M. The victim later apologized to C.A. for his actions leading to restraint.

N. C.A. believed that he restrained the victim according to his training.

(Ex. C, pp. 17-18)

C.A.'s responses to Abuser Registry Notification

81. On March 5, 2025, CPPD sent C.A. an Abuser Registry Notification, stating that CPPD had determined that sufficient evidence existed that he had committed abuse or abuse *per se*, which is registrable abuse. (Ex. K, p. 186)

82. C.A. had two substantive responses. The first was on March 30, 2025 with an email whose subject line was "Formal Appeal of DPPC Finding...." and beginning, "I am formally appealing the finding...." (Ex. L, p. 213) The second response was on April 7, 2025, titled, "Official Petition for Review." The cover email to the petition stated that the petition was "a follow-up to [his] previous appeal." (Ex. L, p. 217)

C.A.'s email of appeal

83. C.A.'s email of March 30, 2025, asserted that the allegations against him were "based on a mischaracterization of events" and did "not align with the factual record." (Ex. L, p. 213)

84. C.A. called the restraint "a standard safety care restraint" that "was executed strictly to ensure safety." He asserted that he had "adher[ed] to established protocols." The restraint was "wrongly portrayed as abuse...seemingly driven by a supervisor's bias." (Ex. L. p. 213) (He did not identify the supervisor or specify the bias.)

85. C.A.'s email stated:

A. Before the incident, the housemate and another resident "had raised concerns about [the victim]'s coercive behavior, particularly pressuring them into financial transactions." (Ex. L, p. 213)

B. After picking up residents at the day program, C.A. wrote, he facilitated a discussion in which [the victim] admitted [his] actions and apologized. To mitigate further conflict, I proposed temporary adjustments to community outings, which the residents accepted without issue.

Upon returning to the residence, I requested to check [the victim]'s bag in the office, as was customary due to prior incidents involving restricted items. [The victim] became visibly agitated and, without warning, struck me in the jaw.

Justification for the Restraint

Given the suddenness of the attack and the need to regain control of the situation, I applied a safety care restraint with the assistance of two staff members. The response was executed within the bounds of my extensive training and solely for the protective purposes. At no point was excessive force used, nor was there any intent other than ensuring the safety of all individuals present.

....

The conclusion that this restraint constituted abuse is both factually and procedurally flawed. The intervention adhered to all professional and ethical standards, and the claim against me appears to be driven by ulterior motives....

(Ex. L, p. 213-14)

C.A.'s Petition for Review

86. C.A.'s petition for review detailed the group home residents' complaints about the victim. (Ex. L. pp. 217-18) It stated:

I asked [the victim] if [he] still had the hot sauce or any caffeine drink in [his] possession, [he] kept quiet. I asked a second time and it was the [same] response. This prompted me to politely ask [the victim] to please submit to a bag search once we returned to the program.

(Ex. L. p. 218)

87. C.A.'s petition for review also stated:

Arrival at Residence

- [The victim] entered first[,] while I carried coffee in one hand and program mail in the other. [The housemate and another resident] followed closely behind me.

- [The victim] began walkin[g] up the stairs, at which point I politely asked [him] to either wait for me and could go to the office or just come back downstairs to do the bag search. [The victim] immediately got agitated and escalated into yelling at me saying[,] 'eff you [C.A.'s first name], I won'[t] let you search my bag.'

- I explained to [him] that I wasn't going to search it myself, [he] knew [he] just had to comply by just showing the contents of [his] bag by [himself].

- I was still by the entrance and observed [the victim] get to the first step, then I backed up to give [him] space and also allow [the housemate and other resident] to get in the house when I turned around and felt [the victim] strike me.

Assault & Restraint

1. [The victim] punched my jaw without warning (coffee spilled, proving my hands were occupied) - I immediately grabbed [the victim]'s bag with my right hand with arm straight and elbows locked to keep [him] at bay and avoid punches while I waited for support. I still had mail in my other hand because I didn't get a chance to settle nor did I plan for a restraint. [The victim]'s attack was unprovoked.

2. I immediately summoned staff [S.] and [L.C.]

3. Conducted 3-person supine restraint: I did this because I remembered [the victim] had history of a rod in [his] back, and I wanted to keep [him] safe while de-escalating [him].

- Myself: I secured [the victim] right arm with my left hand slightly above the wrist and my right hand *above* the shoulder

- [S.]: Left arm (confirmed by [L.C.], even though he denied helping)

- [L.C.]: Leg control

4. I instructed [B.B.] to bring the other three housemates to a private area upstairs.

5. Restraint concluded when [the victim] demonstrated de-escalation (10 deep breaths)

6. Restraint lasted about 15 minutes

Aftermath

- [The victim] voluntarily unpacked bag (only books present)

- Offered unprompted apology ("*I should have kept my hands to myself*") witnessed by [the housemate]

- I responded saying [he] just had a bad day and we all do sometimes. I left the program asking [him] to write what [he] thought [he] could have done better. [He] agreed to this.

....

(Ex. L, pp. 218-19)

C.A.'s hearing testimony

88. C.A. testified as follows:

A. The victim entered the group home first. C.A. entered second. Inside the group home, the victim started going up the stairs.

B. C.A. told the victim that he wanted to check the victim's bag.

C. At the time, C.A. held a coffee in one hand and papers in his other.

D. The victim said: Fuck you, [nickname of C.A.'s first name]. I'm going to fuck you up.

E. C.A. backed down the stairs to create more space between him and the victim, and engaged in actively ignoring the victim, a technique to avoid escalating a situation that entails monitoring a person and a situation but not responding to what a person is saying.

F. C.A. interacted with other residents and felt a punch on his face. The victim had punched him. C.A. dropped his coffee.

G. The victim was still swinging his arm, so C.A. grabbed his backpack with a straight arm and a locked elbow to keep the victim away from him. He called for other staff members to assist him.

H. The victim dropped to the floor, as people typically do when trying to escape being controlled.

I. C.A. felt that the victim was engaged in an ongoing attack, not a single isolated punch.

J. At some point, the victim's backpack came off or was taken off.

K. C.A. restrained the victim with his palm slightly above the victim's shoulder and his other palm slightly above his wrist.

L. The victim spit, cursed, and tried to get his hands free.

M. The supine restraint is the most restrictive restraint. After having read the victim's plan and knowing that he hoped to have back surgery, C.A. decided that a supine restraint would not put pressure on the victim's back.

N. At some point, C.A. instructed B.B. to move the other residents to their rooms.

O. It took 10 or 11 minutes for the victim to calm down and be released from the restraint.

P. The victim stood, went to a couch, opened his backpack, and removed items, which did not include anything significant, such as hot sauce, beverages containing caffeine, or items that he had stolen from fellow residents. C.A. asked: What was that for [presumably referring to his refusal to open his backpack]? The victim answered: I don't know.

Q. At a certain point, members of the staff conducted a body check on the victim. C.A. did not see any bruises.

R. After the incident, C.A. spoke with the Assistant Director by telephone. He did not remember who called whom.

S. As C.A. left the group home at the end of his work day, the victim apologized to C.A. and said that he should have kept his hands to himself. The victim was writing a letter of apology to C.A., who said that he would read it the next day.

T. The next day, the victim said that he was almost done with his letter to C.A. C.A. said that he had to go grocery shopping and would read the letter when he got back. C.A. never got the letter. (He was placed on administrative leave before he could get it.)

U. C.A. did not need medical attention for the punch he received. He did not experience pain or swelling. He did not take aspirin, acetaminophen, or ibuprofen.
(C.A. testimony)