COMMONWEALTH OF MASSACHUSETTS

Middlesex, ss. Division of Administrative Law Appeals

E.A.,[1]
Petitioner

v. Docket No. DPPC-24-0520

Disabled Persons Protection Commission,
Respondent

Appearance for Petitioner:

E.A., *pro se*
Legenju Vitalise

Appearance for Respondent:

Kristyn D. Kelly, Esq.

Administrative Magistrate:

Kenneth J. Forton

SUMMARY

A direct service worker abused an adult resident of a state institution for individuals with intellectual and/or developmental disabilities by striking the resident on the head with a metal water bottle in response to the resident rushing towards the worker. This was also abuse per se under DPPC regulations. He may therefore be placed on the abuse registry.

DECISION

Petitioner E.A., a former relief staff and caretaker of individuals with disabilities, appeals a decision by Respondent Disabled Persons Protection Commission (DPPC) that

[1] In accordance with G.L. c. 19C, § 15, 118 CMR 9.03(1), and a protective order, this decision anonymizes the names of the appellant, the disabled person, the hearing witnesses, and the percipient witnesses.

he be placed on the abuse registry following a finding of physical abuse of a patient under his care in a long-term care facility. G.L. c. 19C, § 15 and 118 CMR 14.03. The incident which led to the finding of abuse occurred on October 10, 2023, at Hogan Regional Center (Hogan), which serves individuals with intellectual and/or developmental disabilities. E.A. appealed DPPC's decision and requested an adjudicatory hearing under G.L. c. 19C, § 15(c) and 118 CMR 14.02. In accordance with 801 CMR 1.01(6)(e), on September 4, 2024, DPPC filed its decision as its Answer to the Notice of Appeal. DPPC also moved DALA for a confidentiality order, which I now grant.

I conducted an evidentiary hearing at DALA by Webex video conference on April 14, 2025. The hearing was translated into Cameroonian Pidgin English for the benefit of E.A. I entered 17 documents into evidence, including one CD-ROM containing video footage of the incident. (Exs. A-Q). Investigator K.S. and Hogan staff member I.E. testified on behalf of DPPC. Dr. C.B., owner of the staffing agency where E.A. worked, testified on behalf of E.A., who also testified on his own behalf.

I ordered the parties to submit closing briefs no later than May 16, 2025. DPPC submitted a closing brief on May 16, 2025. E.A. moved DALA for extra time to submit his brief, which he ultimately filed on June 3, 2025. DPPC objected to the extra time and the brief. I hereby grant E.A.'s motion and accept his brief.

FINDINGS OF FACT

Based upon the documents and testimony presented at the hearing, I make the following findings of fact:

1. At the time of the incident in question, T.C. was a 41-year-old male residing at Hogan. (Ex. L at 1.)

2. T.C. resided briefly at Hogan prior to October 2003 and was readmitted to Hogan on August 20, 2012 following physical aggression toward a neighbor near his old group home. (Ex. D at 1.)

3. T.C. is legally blind in his left eye and is diagnosed with a traumatic brain injury (resulting from two instances of head trauma during infancy), seizure disorder, moderate intellectual disability, impulse control disorder, microcephaly, encephalomalacia, organic personality disorder, depression, and anxiety. (Ex. L at 1; Ex. D at 1; Ex. C at 3; Testimony K.S.; *see also* Ex. A at 4 and 11 and Ex. B at 1.)

4. T.C. requires total care assistance, including assistance with residential care, supervision, and personal care, such as bathing, toileting, dressing, and feeding. (Ex. L at 1.)

5. T.C. has an Intensive Positive Behavior Support Plan, a type of Coordinated Treatment Plan, that was last updated on March 14, 2023. (Ex. D at 1.)

6. According to his treatment plan, some of T.C.'s "problem behaviors (target behaviors to decrease)" include "Physical Aggression: . . . running/charging toward another, scratching, biting, grabbing, slapping, throwing objects (including food) at others, striking others with objects, pulling hair, punching, spitting, head butting, grabbing others' clothing, or other behavior that may harm others," along with being non-cooperative and destructive towards objects. T.C.'s frequency for physical aggression was approximately "22x/month." (Ex. D at 1.)

7. T.C. is uncomfortable when people "invad[e] his personal space" or when he is around unfamiliar people. (Ex. D at 2.) In describing T.C.'s behavior, the treatment plan states:

> [T.C.] has recently been observed aggressing against a peer, running towards him with his arms out and grabbing his shirt, which occurred just as he was exiting the timeout room. [T.C.] may have seen an opportunity to do so or acted impulsively. Another instance, [T.C.] may have felt startled when someone approached him from the side while he was working. As a result, he quickly stood and attempted to grab them. This appeared to be an impulsive, automatic reaction to a perceived threat of someone he felt was too close.

(Ex. D at 2.)

8. In addition to becoming aggressive in response to being around unfamiliar people or having insufficient personal space, staff have observed T.C. to be "highly aware of moments when staff or peers are vulnerable and that he can effectively seize these quick opportunities to aggress towards them (for example, hitting someone when they bend to tie their shoe) . . . ." (Ex. D at 5.)

9. However, most of T.C.'s physical aggression happens during transitions from walking to or from the bathroom and when exiting the timeout room. (Ex. D at 4.) E.A. was aware that this is when T.C.'s most aggressive behaviors occur. (Testimony E.A.)

10. While some experiences or environments are known to initiate an aggressive response from T.C., many times there are "no clear antecedents to T.C.'s behaviors." (Ex. D at 2; *see also id.* at 4-5.) Due to T.C.'s

> history of unpredictable aggression towards others, staff must keep [T.C.] within their sight at all times when he is in any area with other individuals, while also offering him space whenever possible. [T.C.] will often aggress towards others who invade his space, so unfamiliar staff and individuals must keep a distance from him to ensure their own safety.

(Ex. D at 2; *see also* Ex. A at 11.)

11. Examples of how staff can help T.C. avoid physical aggression are articulated in a flow-chart in his treatment plan, which shows that when T.C. is in close

proximity to others or when transitioning to and from different locations, staff are to initiate "Safe transitions procedures" or a "safe hands" procedure under which staff instruct T.C. to interlock his own fingers to prevent physical aggression. (Ex. D at 2-3; *see also* Testimony K.S.)

12. According to T.C.'s case notes, he had a goal to use his " 'safe hands' procedure during bathroom trips at least 80 times per month, for at least 3 of the next 6 months (Feb – July 2023) . . . supported by a behavioral incentive sticker chart . . . that reinforces his 'safe hands' transitions to the bathroom . . . ." (Ex. C at 6.)

13. If T.C. became physically aggressive or attempted to be aggressive towards others, despite the safe hands procedure, Hogan staff were instructed to firmly cue him to stop. If he did not stop and continued to aggress, staff would direct and escort him to the nearest timeout room available to follow the timeout procedure. If he did not respond to the verbal cue to go to timeout and became resistive to going, he could be physically escorted or, if staff were unable to safely get him to the timeout area due to the intensity of aggression, he could be restrained. (Ex. D at 6, 7, 8; *see also* Testimony K.S.; Testimony E.A.)

14. Like other staff at Hogan, E.A. was trained in T.C.'s treatment plan. (Exs. A at 5, M at 2.)

15. A staffing agency, ProPivotal, placed E.A. at Hogan, where he worked as "Relief Staff" and "Direct Care Staff," providing residential care and total care to individuals with disabilities. (Ex. L at 2; *see also* Ex. B at 2; Ex. A at 6.)

16. E.A. worked at Hogan for approximately 3 months prior to his incident with T.C. on October 10, 2023. (Ex. A at 6.)

17. E.A. has no previous documented abuse or criminal history. (Ex. L at 2.)

18. E.A. reports having a long history of dedicated service in caregiving and that his commitment to the caregiving profession is "deeply rooted in personal experiences, including caring for family members with disabilities." (Ex. O at 2.)

19. In addition to being trained in T.C.'s treatment plan, E.A. received training in "PABC (Positive Approaches to Behavioral Challenges)" as part of his orientation at Hogan. PABC is a "prevention and de-escalation [model] used by organizations that provide services to individuals with challenging behaviors; PABC training includes restraint training to teach caretakers how to safely restrain individuals." PABC training also teaches de-escalation techniques including verbal and gentle, physical redirections. (Exs. A at 6, M at 2; Testimony E.A., Testimony K.S.)

20. E.A. knew T.C. was "aggressive and attacks people all the time" and that staff should redirect T.C. or call for staff to assist if T.C. "is coming at you in an aggressive manner . . . ." (Ex. A at 6.)

21. T.C. previously aggressed against another staff member, I.E. I.E. reported the aggression occurred so quickly that I.E. did not have time to use his PABC training. (Testimony of I.E.)

22. There is a video recording of the following incident that led to this appeal. (Ex. I.)

23. On the evening of October 10, 2023, E.A. helped T.C. into the shower before returning to the adjacent common room to wait for T.C. to finish. E.A. drank from his own metal water bottle while he waited. (Testimony E.A.; *see also* Ex. M at 4.)

24. E.A. then moved his chair to give T.C. more space, in accordance with T.C.'s treatment plan. (Ex. M at 4.)

25. At approximately 1:23 a.m., T.C. left the bathroom and suddenly ran toward E.A. at a quick pace. (Exs. I, A at 5, L at 3; Testimony E.A.)

26. E.A. was standing alone in the common room as T.C. approached. E.A. turned to see T.C. "coming at him quickly with anger on [T.C.'s] face as if he were about to attack [E.A.]." (Ex. M at 4; *see also* Ex. I.)

27. As T.C. ran towards E.A., E.A. gripped his metal water bottle with both hands, pulled it behind his right shoulder, and then swung it as T.C. approached. E.A.'s arms were fully extended when he hit T.C. on the left side of the head. T.C. had not made any contact with E.A. before E.A. hit him. (Ex. I; Ex. Q at 5; Testimony K.S., E.A.; *see also* Ex. A at 5.)

28. As a result, T.C. fell to the ground, hitting a rocking chair with the right side of his face as he fell. (Exs. I, A at 4, 6.)

29. E.A. immediately bent down to check on T.C. and is seen leaning over T.C. in the video footage. (Ex. I; *see also* Ex. A at 4 and 6.)

30. The DPPC Investigator reported that her viewing of the video footage led her to believe E.A. was kneeling on T.C.'s chest after T.C. fell. (Ex. A at 4.) The Investigator also shared that a staff member recalled seeing T.C. on his stomach with E.A.'s knee on T.C.'s back once she arrived at the scene of the incident. (Ex. A at 5.) The Investigator included the chest and back allegations as "pertinent facts" in her report but omitted them in the multiple descriptions of her conclusions. (Ex. A at 6-8.) The DPPC also repeated both these allegations in the July 15, 2024 letter to E.A. in response

to E.A.'s appeal of the Investigation's Findings after explaining that the author of the letter reviewed the video footage herself. (Ex. M at 2.) T.C. never described E.A. as putting his knee on T.C.'s back or chest; however, T.C. reported that "he thinks he may have passed out for a little bit." (Ex. A at 5.) After reviewing the video footage, I find that E.A. did not put his knee on T.C.'s chest.

31. E.A. called out for staff to assist. Two other service workers responded. (Ex. A at 5; Testimony K.S.)

32. One observed T.C. bleeding from the mouth and lying on his back while E.A. was holding T.C.'s arms. The other got paper towels to clean the blood off T.C. and the floor. (Ex. A at 5; Testimony K.S.)

33. Shortly afterward, a Licensed Professional Nurse evaluated T.C. He observed swelling to T.C.'s right cheek, an abrasion to his left ear, and a laceration to the right side of his bottom lip and determined T.C. needed further medical attention. (Ex. A at 5.)

34. Accordingly, T.C. was taken to Beverly Hospital where he received sutures to the laceration on his lip. (Exs. L at 3, K at 1, B at 1; A at 1.)

35. Hogan reported the incident to DPPC and provided it a copy of the video footage. (Exs. A at 4, L at 1, 3; Testimony Investigator; *see also* Ex. A at 2.)

36. DPPC referred the case to the Essex County District Attorney's Office. (Ex. L at 6.)

37. DPPC Investigator K.S. was assigned to investigate the abuse report in conjunction with State Police Trooper C.P. (Ex. A at 1, 2, 6; Ex. K at 4.)

38. On October 19, 2023, the Investigator and the State Trooper conducted an in-person visit to Hogan. (Ex. K at 3; *see also* Ex. A at 3.) They conducted a face-to-face meeting with T.C. on October 19, 2023. (Ex. K at 2; Testimony K.S.; Ex. A at 2.) The Investigator also interviewed the service workers and LPN who were there that night. (Ex. A at 2; Testimony K.S.) Finally, the Investigator and Trooper C.P. interviewed E.A. (Ex. A at 2; Testimony K.S.)

39. The Investigator also reviewed relevant documents, including T.C.'s nursing notes, which revealed no pre-existing injuries to any of the body parts he injured during the incident. (Exs. L, A at 5, 13; *see also* Testimony K.S.)

40. T.C. reported to the Investigator: that he started "running toward [E.A.];" that E.A. hit T.C. across the face on the left side with a hard water bottle and he went down hard to the ground, hitting the right side of his face on the floor and a chair; and that the incident caused him pain on his lip and face. (Ex. A at 5; Testimony K.S.)

41. One of the workers who responded to the incident reported to the Investigator that he could tell T.C. was in pain. (Testimony K.S.; *see also* Ex. A.)

42. T.C. told the Investigator that he did not know E.A. well and that he did not know why E.A. would have hit him in the face. T.C. reported that he was in a lot of pain following the incident and that he was upset, sad, and scared. T.C. reported that he had not seen E.A. since the incident occurred and he was happy about that. According to the Investigation Report, when T.C. was interviewed on 10/19/23, T.C. was still upset about this incident and teary-eyed when talking about what had occurred. (Ex. A at 5; Testimony K.S.)

43. E.A. has inconsistently described the incident on several different occasions. During his interview with the Investigator, E.A. denied that he struck T.C. across the face with his water bottle, adding that "he threw the water bottle over his right shoulder as [T.C.] was approaching him." (Ex. A at 6.) In his appeal letter, E.A. stated that he raised his arms to protect himself and, as he did, the water bottle E.A. was holding came out of his hand and hit T.C. in the shoulder. E.A. also stated that, after his water bottle hit T.C.'s shoulder, T.C. fell on top of E.A. and they "struggled in a grappling fashion, with arms flailing. [E.A.] states that eventually he and [T.C.] fell to the ground . . . [and that] throughout the incident he was continuously yelling for other staff to come and help him . . . ." (Ex. M at 4.) Upon direct examination, E.A. stated he had the metal water bottle in his hands when he instinctively put up his hands to block T.C. E.A. stated that when he raised his hands, the water bottle slipped out of his hands, and he mistakenly hit T.C. with the water bottle. Finally, on cross-examination, E.A. could not identify when or how the water bottle fell out of his hands. (Testimony E.A.)

44. The Investigator concluded that there was sufficient evidence to conclude T.C. "sustained a serious physical injury" and is a victim of "abuse" and "abuse per se," as defined by G.L. c. 19C and 118 CMR. (Ex. A at 6-7; Testimony K.S.)

45. The Investigator further found that striking T.C. across the face with a metal water bottle was not an appropriate de-escalation technique and that, instead, E.A. could have put his hands up to block T.C., given T.C. more space, and/or called for help from other staff. (Testimony K.S.)

46. On March 28, 2024, the State Police filed an application for a criminal complaint with Salem District Court. E.A. was charged with assault and battery with a

dangerous weapon under G.L. c. 265, § 15A(b) and assault and battery on a person with a disability with injury under G.L. c. 265, § 13K(b). (Ex. N.)

47. After a hearing under G.L. c. 218, § 35A, a clerk-magistrate found no probable cause for the criminal charges and denied the application, effectively dismissing the charges. (Ex. N.)

48. On July 15, 2024, DPPC issued a decision determining that the appellant's name should be entered in the registry of care providers established by G.L. c. 19C, § 15. The appellant timely appealed. (Exs. J, Q.)

CONCLUSION AND ORDER

DPPC is responsible for maintaining a registry of care providers who have committed "registrable abuse." G.L. c. 19C, § 15(b)-(c). An individual whose name appears in the registry cannot be hired as a care provider to disabled persons. *Id.* § 15(d). The commission bears the burden of proving registrable abuse by a preponderance of the evidence. *Id.* § 15(c).

Overlapping provisions define "abuse" as an act or omission that "results in serious physical or emotional injury to a disabled person." *Id.* § 1. *See id.* § 15(a); 118 CMR 2.02. Serious physical or emotional injury is defined as an "impairment of the physical condition of a [p]erson with a [d]isability including, but not limited to: . . . (d) any significant: bleeding; bruising; burn; sunburn; abrasion; laceration; or puncture of the skin." 118 CMR 2.02. In determining whether an injury meets this definition, its significance in the totality of the circumstances is to be examined, including the "shape [and] size . . . of the injuries, including indicators that the injuries may have been sustained by the application of force from an identifiable object, . . . the location of the

injury on the [p]erson with a [d]isability, . . . and the nature and extent of any medical treatment needed to address the injury." 118 CMR 2.02.

DPPC has established that E.A. abused T.C. T.C. had no documented injuries prior to the October 10, 2023 incident. As a result of being hit, he suffered a laceration to his face, which required stitches. He received multiple other injuries to his face and head. These injuries obviously required the application of force. The metal water bottle was the identifiable object. *See* 118 CMR 2.02. Hitting T.C. in the head was particularly egregious because T.C.'s disability was largely caused by several traumatic brain injuries when he was younger.

Even if no injury is "manifested," abuse includes several forms of "abuse per se." *See* G.L. c. 19C, § 15(a); 118 CMR 2.02. The form of abuse per se alleged here is "the intentional, wanton or reckless application of physical force in a manner that inflicts physical pain or [s]erious [e]motional [i]njury." 118 CMR 2.02.

DPPC has also established that E.A. committed abuse per se because his conduct was reckless. E.A. acted recklessly when he pulled back the water bottle to swing hard at T.C., rather than even attempting to follow T.C.'s care plan. He could have blocked T.C. with the water bottle. He could have blocked T.C. with his arms. He could have taken a defensive posture while he called for help. E.A. was familiar with T.C.'s care plan. He knew not to hit T.C. in the head because of his history of traumatic brain injury. But, he did it anyway.

E.A. asserts he reacted to T.C.'s aggression in self-defense when he "acted instinctively to protect" himself. As DALA has concluded previously, "there is no self-defense exception in the statute or the regulations that would preclude a determination of

abuse or abuse per se." *S.S. v. Disabled Pers. Protection Comm'n*, DPPC-22-0537, at *5 (Div. Admin. L. App. Oct. 26, 2023). Perhaps in settings where he is not employed to care for disabled persons, E.A.'s response to sudden aggression may be an understandable and instinctive reaction that may not rise to the level of recklessness. However, at Hogan, E.A. knew T.C. was prone to aggress towards people without warning but especially when transitioning from one room to another, as happened the night of the incident. E.A. may not have acted with the "purpose" of hurting T.C., but he did act recklessly when he intended to apply physical force in his response to T.C.'s aggression without following his care plan or behavior plan, as clearly seen in the video footage.

E.A. also insists that he could not have abused T.C., or at least that his behavior was excusable, because the Salem District Court dismissed the charges against him. This argument is inapposite. First, the definitions of the crimes E.A. was charged with are not the same as the definitions of abuse or abuse per se. Second, "clerk-magistrates may deny the complaint even if they conclude that the application is supported by probable cause, if prosecution of the underlying charge is unlikely."[2] *Cabrera v. Commonwealth*, 496 Mass. 179, 184 (2025) (citations omitted). Moreover, it is impossible to evaluate,

[2] "We recognize that under standard 3:08 of the Complaint Standards, a clerk-magistrate need not assume that a prosecutor intends to prosecute every criminal complaint sought by a law enforcement officer. Where a prosecutor's office has not communicated a decision to pursue a criminal complaint brought by a law enforcement officer and where the clerk-magistrate determines -- perhaps after discussing the matter with a prosecutor -- that prosecution is not likely despite the existence of probable cause, the clerk-magistrate may decline to authorize the complaint even though it was brought by a law enforcement officer." *Boston Globe Media Partners, LLC v. Chief Just. of Trial Ct.*, 483 Mass. 80, 86 & n.10 (2019).

based on the mere docket sheets in evidence, why the clerk-magistrate denied the criminal complaint.

The analysis does not end there, however. Conduct that otherwise would qualify as "abuse" is excluded from that category in the case of certain types of "accidents," including where the harm to the disabled person: (1) is not the result of the caretaker's reckless act, (2) was "caused by [an] application of an appropriate degree of physical force given the circumstances," or (3) "is caused by a [c]aretaker's good faith attempt to prevent physical injury, pain or serious emotional [i]injury to the [p]erson with a [d]isability." 118 CMR 2.02. E.A. asserts that the water bottle fell out of his hands and accidentally came into contact with T.C.'s face. It is unlikely that "dropping" a metal water bottle would cause T.C. to fall as hard and as quickly as the video footage depicts. More importantly, the clear video footage does not support this version of events. I therefore do not credit E.A.'s description of what happened. Not only was E.A.'s use of a metal water bottle to strike T.C. reckless, as discussed above, E.A.'s application of physical force was not an "appropriate degree of physical force" in light of T.C.'s care plan and behavior plan, T.C.'s history of head injuries, and E.A.'s training. Finally, nothing in the video or E.A.'s testimony indicates E.A. was making a good faith attempt to prevent physical injury, pain, or serious emotional injury to T.C. Rather, E.A. was trying to protect *himself* from T.C.

Now, even though I have determined that E.A. has committed abuse and abuse per se, it is still possible he can avoid being placed on the registry. To do so, he must "provide information that demonstrates, based upon the totality of the circumstances, the incident was isolated and unlikely to reoccur, and that [he] is fit to provide services or

supports to persons with intellectual or developmental disabilities." 118 CMR 14.02(3). Factors that I may include in my analysis include "the nature and extent of the serious physical injury . . . or abuse *per se* sustained by [T.C.];" and

> relevant details about [E.A.], such as whether [he] received training relevant to the incident at issue; [his] employment history in working with individuals with disabilities; prior instances of similar conduct; any statements or communication regarding [E.A.'s] work history and fitness to provide services and supports to persons with disabilities; and whether [his] conduct could reasonably be addressed through training, education, rehabilitation, or other corrective employment action and [his] willingness to engage in said training, education, or other corrective employment action.

Id.; G.L. c. 19C, § 15(a); *see also* 118 CMR 2.02.

E.A. does not qualify for this exception to registerable abuse. On the plus side, E.A. has no criminal record, no documented employee discipline, or any other registered findings of abuse; this supports the conclusion that the incident was isolated. His former employer, C.B., also vouched for him. However, there is insufficient evidence for me to conclude that an incident like this is unlikely to reoccur or that E.A. is fit to provide services to developmentally disabled persons. E.A.'s continued reliance on a self-defense theory and his inability to acknowledge his actions, *even when confronted with clear video evidence*, forces me to conclude that he cannot be trusted to restrain himself with this vulnerable population. T.C. and other residents are likely to aggress again. They need a caregiver who can follow their care plans and reliably avoid violence.

E.A. may petition for removal from the registry five years after his name is placed there. 118 CMR 14.04. Removal would require E.A. to show that, "in considering the totality of the circumstances it is no longer in the interest of persons with intellectual or developmental disabilities and it is no longer in the public interest to exclude [E.A.] from

working as a care provider." 118 CMR 14.04(1). To do so, he would need to make efforts at rehabilitation, such as education, training, or counseling. 118 CMR 14.04(2).

For the above-stated reasons, DPPC's decision is AFFIRMED. E.A.'s name may be entered in the registry of care providers established by G.L. c. 19C, § 15, in connection with the incident litigated in these proceedings.

SO ORDERED.

DIVISION OF ADMINISTRATIVE LAW APPEALS

/s/ Kenneth J. Forton

Kenneth J. Forton
Administrative Magistrate

DATED: August 28, 2025