WORKERS' COMPENSATION APPEALS BOARD

STATE OF CALIFORNIA

MICHAEL STEWART, *Applicant*

vs.

HODGES RESIDENTIAL FACILITY; REPUBLIC INDEMNITY COMPANY OF CALIFORNIA, *Defendants*

Adjudication Number: ADJ13531096
San Francisco District Office

OPINION AND ORDER DENYING PETITION FOR RECONSIDERATION

Applicant seeks reconsideration of the Findings of Fact and Orders (F&O) issued on May 20, 2026, by the workers' compensation administrative law judge (WCJ). The WCJ found, in pertinent part, that applicant, while employed on October 30, 2019, as a caretaker and counselor for defendant, Hodges Residential Facility, failed to meet the required burden of proof for increased compensation under Labor Code section 4553[1] for serious and willful misconduct against defendant.

Applicant contends that defendant had actual knowledge that a resident posed a dangerous condition and knew that keeping him at the facility would likely result in serious injury to an employee. Applicant asserts that defendant deliberately thwarted safety measures by unilaterally removing a professional behavioral support team from the Center for Autism and Behavior Analysis (CABA). Furthermore, applicant maintains that defendant prioritized financial incentives over worker safety by retaining the dangerous resident, which constituted a wanton and reckless disregard for employee safety. Finally, applicant alleges that the WCJ erred by improperly dividing the evidence and applying different legal standards to the removal of the behavioral support team versus the failure to evict the resident.

We have received an Answer from defendant. The WCJ filed a Report and Recommendation on Petition for Reconsideration (Report) recommending that we deny reconsideration.

We have considered the allegations of the Petition for Reconsideration, the Answer thereto, and the contents of the WCJ's Report and Recommendation. Based on our review of the record, and

[1] Unless otherwise stated, all further statutory references are to the Labor Code.

for the reasons stated in the Report, which we adopt and incorporate, and for the reasons stated below, we will deny reconsideration.

BACKGROUND

Applicant, while employed on October 30, 2019 as a caretaker/counselor, sustained an industrial injury to his right knee. (Minutes of Hearing and Summary of Evidence (MOH/SOE), 11/18/2025, 2:6-11.)

On October 29, 2020, applicant filed a petition for serious and willful misconduct by the employer, requesting increased benefits per section 4553[2].

On April 21, 2023, applicant resolved the case-in-chief by compromise and release for $100,000.00, excluding the claim for section 4553 benefits.

On November 18, 2025, the matter proceeded to trial on the issue of applicant's petition for violation of section 4553. (MOH/SOE, 11/18/2025, 2:23-28.) Applicant submitted into evidence the subpoenaed records of the Regional Center of the East Bay (RCEB). (App. Ex. 3.) Defendant submitted into evidence the clinical team summary dated June 20, 2019 (Def. Ex. C), the crisis team referral dated June 4, 2019 (Def. Ex. D), an eviction approval letter dated November 19, 2019 (Def. Ex. G), an eviction notice dated October 31, 2019 (Def. Ex. H), and RCEB vendor special incident reports (Def. Ex. I.)

Applicant testified at the trial that he commenced employment as a caretaker and counselor for Hodges Residential Facility in 2016. (MOH/SOE, 11/18/2025, 6:16-20.) He possessed prior professional training in physical and verbal de-escalation and intervention techniques from his employment within the New York State juvenile justice system. (MOH/SOE, 11/18/2025, 6:32-34.) He observed that a resident named Craig Barksdale exhibited severe physical aggression toward staff and other residents, which included breaking windows, destroying furniture, and scratching or biting care team members. (MOH/SOE, 11/18/2025, 8:25-29.) Mr. Barksdale required multiple admissions to John George Psychiatric Hospital in 2019 because he became inconsolable and excessively

[2] Section 4553 states: "The amount of compensation otherwise recoverable shall be increased one-half, together with costs and expenses not to exceed two hundred fifty dollars ($250), where the employee is injured by reason of the serious and willful misconduct of any of the following:

(a) The employer, or his managing representative.

(b) If the employer is partnership, on the part of one of the partners or a managing representative or general superintendent thereof.

(c) If the employer is a corporation, on the part of an executive, managing officer, or general superintendent thereof."

(Cal. Lab. Code, tit. 8 § 4553.)

violent. (MOH/SOE, 11/18/2025, 9:22-24.) Applicant sustained an ankle injury in January 2019 while attempting to separate Mr. Barksdale from another consumer during a violent altercation. (MOH/SOE, 11/18/2025, 7:14-18.) Applicant recounted that a specialized behavioral agency known as CABA began attending the facility five days a week between January and October 2019 to assist Mr. Barksdale with de-escalation, self-awareness, and socialization techniques. (MOH/SOE, 11/18/2025, 8:33-38, 8:46-47.) Anthony Hodges, the facility owner, unilaterally dismissed the CABA team on October 30, 2019. (MOH/SOE, 11/18/2025, 7:42-43, 8:11-12.) Applicant stated that, later that same day, Mr. Barksdale entered a bathroom bleeding from the neck. (MOH/SOE, 11/18/2025, 8:14-15.) Applicant applied a towel and attempted to calm Mr. Barksdale, but when other staff arrived to administer medication, Mr. Barksdale pushed applicant to go upstairs, causing applicant's leg to slip off a staircase injuring his right knee. (MOH/SOE, 11/18/2025, 8:16-17, 8:19-22.) He requested Mr. Hodges provide the facility staff with more assertive training regarding intervention and de-escalation techniques because the existing staff lacked the capacity to manage Mr. Barksdale safely. (MOH/SOE, 11/18/2025, 10:30-34.) During cross-examination, applicant acknowledged that during a separate violent incident, he used his walking staff to poke Mr. Barksdale in the armpit and chest area to halt an attack on other staff members. (MOH/SOE, 11/18/2025, 10:7-11.)

Mr. Hodges testified at trial that he operates Hodges Residential Facility, which provides care for adults with developmental disabilities but has no state medical licenses, medical training, or diagnostic authority. (MOH/SOE, 02/04/2026, 2:11, 2:28-32.) Instead, the facility relies on a defensive training certification called Pro-ACT. (MOH/SOE, 02/04/2026, 2:32-34.) He confirmed he submitted incident reports indicating Mr. Barksdale posed a danger because he continually attacked another client and assaulted staff members who intervened. (MOH/SOE, 02/04/2026, 4:5-7.) Mr. Hodges issued a 30-day eviction notice for Mr. Barksdale on June 12, 2019, but suspended the eviction when the RCEB advised Mr. Hodges to try utilizing the CABA behavioral team. (MOH/SOE, 02/04/2026, 4:9-13, 5:32-36.) He acted as the sole decision-maker in removing the CABA team from the facility because they crowded the residence and failed to identify the root cause of Mr. Barksdale's aggression. (MOH/SOE, 02/04/2026, 5:36-40.) Mr. Hodges confirmed he consulted no one other than Corinne Mahoney, a case manager from RCEB, regarding his decision to dismiss the behavioral support staff. (MOH/SOE, 02/04/2026, 5:17-18.) He admitted he retained the dangerous resident and implemented the CABA program largely due to an economic incentive, as he feared the RCEB would decline to place future residents at his facility if he rejected their

suggestions. (MOH/SOE, 02/04/2026, 8:16-20.) He disputed applicant's testimony, asserting that he never reported the October 30, 2019 right knee injury directly to him and never requested additional staff training to handle Mr. Barksdale. (MOH/SOE, 02/04/2026, 6:2-3, 7:15-16.) Mr. Hodges also claimed he personally trained applicant in Pro-ACT techniques. (MOH/SOE, 02/04/2026, 7:17-18.)

Applicant subsequently provided rebuttal testimony strictly denying that he received any training from Mr. Hodges during his employment at the facility. (MOH/SOE, 02/04/2026, 8:42-43.)

In a March 1, 2019 email, Tamar Meidav, M.D., documented that Mr. Barksdale, a member of the group home for 11 years, initiated rampages lasting up to six hours upon the return of other clients to Hodges Residential Facility. Dr. Meidav noted that these rampages involved assaulting individuals and destroying property. Mr. Hodges expressed fear regarding his staff's ability to manage Mr. Barksdale and transported the resident to John George Psychiatric Hospital for a psychiatric evaluation. Dr. Meidav subsequently facilitated Mr. Barksdale's hospital admission to adjust his medications and implement a psychosocial program. (App. Ex. 3, p. RCEB000018; Def. Ex. F.)

In a Crisis Team Referral Form dated June 4, 2019, generated by Ms. Mahoney, Mr. Barksdale exhibited severe aggression, self-injurious behavior, and property destruction. Ms. Mahoney recorded that facility staff required multiple individuals to handle Mr. Barksdale during emotional outbursts. The referral form further revealed that authorities placed him on involuntary psychiatric holds multiple times during the year for assaulting staff and peers. (App. Ex. 3, p. RCEB000016; Def. Ex. D.)

In a Clinical Team Summary dated June 20, 2019, Mr. Barksdale experienced an escalation in challenging behaviors beginning in February 2019. He specifically targeted another resident who possessed difficulty verbalizing. The team noted that his explosive behavior prompted other clients to intervene, which consistently caused him to attack the intervening clients. CABA determined it would forgo a functional assessment due to the recent escalation in his behavior and considered implementing a two-to-one staff-to-client ratio during problematic periods. (App. Ex. 3, p. RCEB000013; Def. Ex. C.)

Vendor Special Incident Reports documented that, between January 18, 2019, and November 21, 2019, Mr. Barksdale engaged in unprovoked physical assaults on co-residents and facility staff, destroyed facility property, and required repeated law enforcement interventions. (App. Ex. 3, pp. RCEB000093-RCEB000148; Def. Ex. I.)

On January 18, 2019, Mr. Barksdale attacked another consumer without apparent provocation. The consumer scratched Mr. Barksdale in the face, after which he bit and kicked facility staff and broke three windows and a television during an episode lasting four hours. (App. Ex. 3, p. RCEB000123.) The following morning, on January 19, 2019, he attacked staff members, attempted to bite other consumers, broke two additional windows, and required law enforcement intervention. (*Id.* at p. RCEB000127.) On March 11, 2019, he attacked a consumer who had just returned to the facility, kicked in a room door to pursue the consumer, and broke two windows before staff defused the incident two hours later. (*Id.* at p. RCEB000132.) On April 30, 2019, he attacked and attempted to bite a housemate and staff members, broke facility windows, and required contacting emergency services. (*Id.* at p. RCEB000095.) On May 13, 2019, he attacked a housemate in the facility kitchen, during which he slipped on a wet floor and sustained a cut under his left eyebrow. (*Id.* at p. RCEB000107.) On May 14, 2019, he entered another consumer's room in response to noise and attempted to bite the consumer. (*Id.* at p. RCEB000103.) On May 24, 2019, he attacked a housemate, attempted to bite staff members who intervened, and broke two windows, resulting in a call to emergency services. (*Id.* at p. RCEB000143.)

On August 19, 2019, he approached a housemate and bit their arm three times while CABA personnel witnessed the incident without intervening, prompting a call to emergency services. (*Id.* at p. RCEB000135.) On October 3, 2019, he entered the common area naked, screaming, and crying, before he attacked housemates eating breakfast and bit an intervening staff member, which required calling police. (*Id.* at p. RCEB000139.) On October 26, 2019, he attacked a housemate and attempted to bite staff members, resulting in facial scratches to both himself and the housemate. (*Id.* at p. RCEB000147.)

On November 6, 2019, he attacked a housemate, attempted to bite staff, and broke a window, leading a call to emergency services and a psychiatric hold placed on him at John George Psychiatric Hospital. (*Id.* at p. RCEB000115.) The following morning on November 7, 2019, upon returning from the hospital, he again attacked a housemate and attempted to bite both the client and staff members, prompting another emergency response and another psychiatric hold. (*Id.* at p. RCEB000119.) On November 21, 2019, he attacked a housemate entering the home, attempted to bite staff, and attempted to tear down a door, which resulted in police intervention and the facility issuing a three-day eviction notice. (*Id.* at pp. RCEB000099-RCEB000100.)

Between January 4, 2019 and November 25, 2019, RCEB service coordinators and personnel documented the care, behavioral incidents, and placement status of Mr. Barksdale at the

Hodges Residential Facility. (App. Ex. 3, pp. RCEB000051-RCEB000092; Def. Ex. O.) On January 29, 2019, Mr. Hodges and staff reported that Mr. Barksdale engaged in property destruction. (App. Ex. 3, p. RCEB000051.) On February 18, 2019, he began exhibiting escalating aggressive behaviors when he attacked a housemate without provocation, bit staff, and broke three windows, resulting in a psychiatric hold at John George Psychiatric Hospital. (*Id.* at p. RCEB000052.) Following this incident, the care team, including Dr. Meidav, evaluated and modified Mr. Barksdale's medication regimen. (*Id.* at p. RCEB000053.) Simultaneously, RCEB initiated a referral to CABA to provide in-home assessment and behavioral therapy. (*Id.* at pp. RCEB000054-RCEB000055.)

Despite medication adjustments, Mr. Barksdale continued to engage in targeted physical aggression against a specific housemate, often triggered when the housemate returned from their daytime program. (*Id.* at pp. RCEB000064, RCEB000066.) Documented physical altercations and property destruction occurred on subsequent dates including March 11, 2019, April 30, 2019, May 13, 2019, May 14, 2019, May 19, 2019, and July 11, 2019 frequently culminating in police intervention, calls to the Crisis Response Project, and additional psychiatric holds at Wilma Chan Highland Hospital Campus and John George Psychiatric Hospital. (*Id.* at pp. RCEB000057-RCEB000058, RCEB000062-RCEB000063, RCEB000066-RCEB000067, RCEB000075-RCEB000076.) In response to the escalating violence, Mr. Hodges' staff requested stronger medications for Mr. Barksdale. (*Id.* at p. RCEB000071.) RCEB coordinators supplemented the behavioral supports with additional speech and language therapy to improve Mr. Barksdale's functional communication utilizing a Nova-Chat device. (*Id.* at p. RCEB000069.)

On June 12, 2019, following an incident involving physical assaults and property destruction, the Hodges Residential Facility issued a formal 30-day notice of intent to discharge Mr. Barksdale. (*Id.* at p. RCEB000071.) The care team subsequently intensified behavioral interventions, launching direct services with CABA on August 5, 2019. (*Id.* at p. RCEB000078-RCEB000079.) These services initially provided comprehensive daily support before concentrating staffing ratios to two-to-one during the high-risk afternoon hours beginning on September 1, 2019. (*Id.* at pp. RCEB000086-RCEB000087.) However, Mr. Barksdale engaged in another severe physical altercation on August 8, 2019, leading to another psychiatric hold. (*Id.* at pp. RCEB000081-RCEB000082.) By November 12, 2019, the Hodges Residential Facility issued a three-day eviction notice. (*Id.* at p. RCEB000089.) On November 21, 2019, law enforcement transported Mr. Barksdale to John George Psychiatric Hospital following further behavioral

escalation at the facility. (*Id.* at p. RCEB000090.) Medical staff at John George Psychiatric Hospital determined Mr. Barksdale remained stable and did not meet the criteria for psychiatric admission, prompting them to attempt to discharge him on November 22, 2019 and November 25, 2019. (*Id.* at pp. RCEB000090-RCEB000091.) The Hodges Residential Facility explicitly refused to accept Mr. Barksdale back into their care, leaving him without a residential placement while RCEB staff initiated emergency searches for alternative group home accommodations. (*Id.* at p. RCEB000091.)

On May 20, 2026, the WCJ issued his F&O, finding applicant failed to sustain his burden of proving a serious and willful claim.

In his Opinion on Decision, the WCJ stated as follows:

> I am not persuaded that Anthony Hodges' removal of CABA from the home on October 30, 2019 was an act that he knew, or should have known, was likely to result in a serious injury to others, including the applicant.
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> * * *
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> I do not find that there is a link between the removal of CABA from the home on October 30, 2019 and the applicant's knee injury. Because there is not support in the evidence that the removal of CABA led to the applicant's October 30, 2019 injury, there also cannot be knowledge on the part of Anthony Hodges that removal of would lead to the applicant's injury.
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> * * *
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> In this matter, I am not persuaded that the failure to remove Craig from Hodges Residential constitutes an intentional act with knowledge that serious injury was probable . . . I do not find that the mere presence of Craig in the home created an unsafe work environment.
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> Additionally, I am persuaded that Anthony Hodges was taking reasonable steps to try to alleviate the danger posed by Craig.
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> * * *
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> Therefore, I do not find that the failure to remove Craig from Hodges Residential constitutes serious and willful misconduct by Hodges Residential.
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> * * *
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> For the reasons discussed above, I do not find that the applicant has met his burden to demonstrate by a preponderance of the evidence that Hodges Residential committed serious and willful misconduct in relation to the applicant's October 30, 2019 injury.

(Opinion on Decision, pp. 15-19.)

It is from this F&O that applicant seeks reconsideration.

DISCUSSION

I.

Up through July 1, 2024, petitions for reconsideration were subject to former section 5909, which provided that a petition for reconsideration was deemed denied unless the Appeals Board acted on the petition within 60 days from the date of filing. (Lab. Code, § 5909.)

During the period from July 2, 2024 through June 30, 2026, petitions for reconsideration were subject to former section 5909, which stated in relevant part that:

> (a) A petition for reconsideration is deemed to have been denied by the appeals board unless it is acted upon within 60 days from the date a trial judge transmits a case to the appeals board.
>
> (b)
>
> (1) When a trial judge transmits a case to the appeals board, the trial judge shall provide notice to the parties of the case and the appeals board.
>
> (2) For purposes of paragraph (1), service of the accompanying report, pursuant to subdivision (b) of Section 5900, shall constitute providing notice.

Under section 5909(a) (in effect from July 2, 2024 through June 30, 2026), the Appeals Board must act on a petition for reconsideration within 60 days after the district office transmits the case to the Appeals Board. Transmission is reflected in Events in the Electronic Adjudication Management System (EAMS). Specifically, in Case Events, under Event Description is the phrase "Sent to Recon" and under Additional Information is the phrase "The case is sent to the Recon board."

Here, according to Events, the case was transmitted to the Appeals Board on June 30, 2026 and 60 days from the date of transmission is Saturday, August 29, 2026. The next business day that is 60 days from the date of transmission is Monday, August 31, 2026. (See Cal. Code Regs., tit. 8, § 10600(b).)[3] This decision is issued by or on Monday, August 31, 2026, so that we have timely acted on the petition as required by section 5909(a) (in effect from July 2, 2024 through June 30, 2026).

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[3] WCAB Rule 10600(b) (Cal. Code Regs., tit. 8, § 10600(b)) states that:

> Unless otherwise provided by law, if the last day for exercising or performing any right or duty to act or respond falls on a weekend, or on a holiday for which the offices of the Workers' Compensation Appeals Board are closed, the act or response may be performed or exercised upon the next business day.

Section 5909(b)(1) (in effect from July 2, 2024 through June 30, 2026) requires that the parties and the Appeals Board be provided with notice of transmission of the case. Transmission of the case to the Appeals Board in EAMS provides notice to the Appeals Board. Thus, the requirement in subdivision (1) ensures that the parties are notified of the accurate date for the commencement of the 60-day period for the Appeals Board to act on a petition. Section 5909(b)(2) (in effect from July 2, 2024 through June 30, 2026) provides that service of the Report and Recommendation shall be notice of transmission.

Here, according to the proof of service for the Report and Recommendation by the workers' compensation administrative law judge, the Report was served on June 30, 2026, and the case was transmitted to the Appeals Board on June 30, 2026. Service of the Report and transmission of the case to the Appeals Board occurred on the same day. Thus, we conclude that the parties were provided with the notice of transmission required by section 5909(b)(1) because service of the Report in compliance with section 5909(b)(2) provided them with actual notice as to the commencement of the 60-day period on June 30, 2026.

II.

Pursuant to section 4553, an employee injured by the serious and willful misconduct of their employer may recover an award increasing their otherwise recoverable compensation by one-half, along with costs and expenses not to exceed $250.00. Depending on the employer's business structure, this liability can arise from the actions of a managing representative, a partner, an executive, or a general superintendent (Lab. Code, § 4553(a)-(c); Lab. Code, § 4453(a)).

An award for serious and willful misconduct is strictly a penalty, distinct from ordinary workers' compensation benefits that automatically follow an injury. Because it functions as a penalty for aggravated, quasi-criminal behavior against which an employer cannot purchase insurance, the proceedings and legal liability differ fundamentally from claims for normal benefits. (*Lambreton v. I.A.C.* (1956) 46 Cal.2d 498, 504 [citing Lab. Code, § 5407; Ins. Code, § 11661]; *Bigge Crane & Rigging Co. v. Workers' Comp. Appeals Board (Hunt)* (2010) 188 Cal.App.4th 1330, 1340 [75 Cal.Comp.Cases 1089].) The injured employee bears the burden of establishing the employer's misconduct. (*Central California Ice Co. v. I.A.C. (Montgomery)* (1944) 66 Cal.App.2d 339, 343-344 [9 Cal.Comp.Cases 276].) While issues of witness credibility and evidentiary weight are questions of fact, the minimum factual elements required constituting serious and willful misconduct, and the sufficiency of the evidence to that end, are strictly questions of law. (*Dowden v. I.A.C.* (1963) 223 Cal.App.2d 124, 128-129).

Courts heavily distinguish serious and willful misconduct from both ordinary and gross negligence (*Johns-Manville Sales Corp. v. Workers' Comp. Appeals Bd. (Horenberger)* (1979) 96 Cal.App.3d 923, 930-931 [44 Cal.Comp.Cases 878].) Gross negligence denotes a passive and indifferent attitude characterized by an absence of care, whereas willful misconduct requires a positive, active, and absolute disregard of consequences. (*Mercer-Fraser Co. v. I.A.C.* (1953) 40 Cal.2d 102, 117-118 [quoting *Meek v. Fowler* (1935) 3 Cal.2d 420, 425-426] (*Mercer-Fraser*). Misconduct requires proof of acts at least as culpable and deliberate as an intentional doing of something with the knowledge that it is likely to result in serious injury, or with a wanton and reckless disregard of its possible consequences. (*Id.* at p. 117 [quoting *Porter v. Hofman* (1938) 12 Cal.2d 445, 447-448]). Intent and knowledge of probable injury cannot simply be inferred from an act or omission that otherwise constitutes negligence, nor does the mere failure to perform a statutory duty elevate conduct beyond simple negligence. (*Ibid.*)

To impose liability, the evidence must show an affirmative and knowing disregard that is more culpable than a careless omission. (*Hawaiian Pineapple Co. v. I.A.C.* (1953) 40 Cal.2d 656, 663.) This requires demonstrating one of three alternatives: a deliberate act intended to injure another, an intentional act with knowledge that serious injury is a probable result, or an intentional act with a positive and reckless disregard of its possible consequences. (*Horenberger, supra,* 96 Cal.App.3d at p. 933.) Consequently, a culpable employer must know of the dangerous condition, know that its continuation will likely cause serious injury, and deliberately fail to take corrective action, demonstrating that the employer actually "turned its mind" to the hazard rather than merely failing to exercise prudent foresight. (*Mercer-Fraser, supra,* 40 Cal.2d at pp. 124-125; *Horenberger, supra,* 96 Cal.App.3d at p. 933). Finally, if the employee satisfies these rigorous elements, the employee must also prove that this intentional conduct was the proximate cause of the injury. (*Id.* at p. 934.)

In *Sauceda v. Fresno Unified School District* (2020) 85 Cal.Comp.Cases 903 (*Sauceda*)[4], the Appeals Board, in a majority decision, affirmed a finding of serious and willful misconduct where an employer deliberately ignored an explicit, documented threat of violence against a specific employee. In that case, a student with a known history of physical attacks on authority figures

[4] Unlike en banc decisions, panel decisions are not binding precedent on other Appeals Board panels and WCJs. (See *Gee v. Workers' Comp. Appeals Bd.* (2002) 96 Cal.App.4th 1418, 1425, fn. 6 [67 Cal.Comp.Cases 236].) However, panel decisions are citable authority and we consider these decisions to the extent that we find their reasoning persuasive, particularly on issues of contemporaneous administrative construction of statutory language. (See *Guitron v. Santa Fe Extruders* (2011) 76 Cal.Comp.Cases 228, 242, fn. 7 (Appeals Board en banc); *Griffith v. Workers' Comp. Appeals Bd.* (1989) 209 Cal.App.3d 1260, 1264, fn. 2 [54 Cal.Comp.Cases 145].) Here, we refer to these panel decisions because they considered a similar issue.

assaulted a special education teacher. The employee acquired the student's records, presented them to the administration, and explicitly warned the employer of the specific threats made against him. Despite actual knowledge of this precise danger and the probable consequence of serious injury, the employer deliberately failed to take corrective action, advising the employee that the situation was solely his problem while also failing to provide standard emergency communication equipment in the classroom. The Appeals Board concluded that the employer's refusal to act in the face of known, specific threats constituted a positive and reckless disregard for the employee's safety.

Applying these rigorous elements to the present evidentiary record, the instant matter is starkly inapposite to the factual matrix of *Sauceda*. Applicant has not established that defendant engaged in quasi-criminal conduct. The core of applicant's contention centers on the unilateral dismissal of CABA on the day of the injury. However, unlike the employer in *Sauceda* who refused to provide basic safety measures against a known violent threat, the evidentiary record here defines CABA as a therapeutic intervention designed to build Mr. Barksdale's self-awareness and socialization skills, rather than as a physical security detail tasked with shielding facility staff from sudden violence. Because CABA did not function as a physical safety mechanism, defendant's decision to terminate its services did not equate to deliberately dismantling a known safety barrier with a reckless disregard for applicant's welfare. Furthermore, the evidentiary record established no definitive causal chain connecting CABA's absence that specific day to Mr. Barksdale's sudden bathroom outburst. Applicant testified that he successfully calmed Mr. Barksdale upon arriving for work and the subsequent aggressive episode and resulting injury occurred without a clear trigger tying the event directly to the lack of CABA personnel. Consequently, applicant failed to prove that defendant dismissed CABA with actual knowledge that a serious injury would likely result.

Furthermore, defendant's decision to retain Mr. Barksdale at the facility does not satisfy the statutory threshold for serious and willful misconduct and further distinguishes this case from *Sauceda*. Rather than demonstrating an affirmative and knowing disregard for safety or dismissing the danger as applicant's problem, the documentary evidence illustrated defendant actively attempted to manage and mitigate a complex behavioral challenge. Defendant consistently documented Mr. Barksdale's aggressive episodes, reported these incidents to RCEB, and repeatedly sought professional intervention. Defendant facilitated psychiatric hospitalizations to adjust Mr. Barksdale's medication regimen and engaged the very behavioral specialists applicant claims were essential. When these interventions failed to yield immediate improvements, defendant issued multiple eviction notices, which were only paused upon RCEB's recommendation to attempt further

therapeutic strategies. While defendant acknowledged an economic incentive in retaining Mr. Barksdale, their concurrent documented, continuous efforts to seek medical and behavioral solutions directly contradict applicant's assertion that defendant exhibited a passive, indifferent attitude toward staff well-being or recklessly abandoned workplace safety.

While Mr. Barksdale's behavioral escalations clearly presented difficulties for the facility's personnel, defendant implemented standard de-escalation protocols and continuously collaborated with state and medical agencies to find a solution. While defendant's actions may warrant scrutiny for their effectiveness, they do not rise to the level of a positive, active, and absolute disregard of consequences seen in *Sauceda*. Ultimately, the evidentiary record lacks proof that defendant turned his mind to the hazard and deliberately chose inaction. Therefore, applicant has failed to meet his burden of proving by a preponderance of the evidence that defendant's conduct proximately caused the October 30, 2019 injury through intentional, reckless, or deliberate omission.

Finally, we have given the WCJ's credibility determination great weight because he had the opportunity to observe the demeanor of the witnesses. (*Garza v. Workmen's Comp. Appeals Bd.* (1970) 3 Cal.3d 312, 318-319 [35 Cal.Comp.Cases 500].) Moreover, following our independent review of the record, we conclude that the record contains no evidence of sufficient substantiality to warrant rejecting the WCJ's credibility determination. (*Id*. at p. 319.)

Accordingly, we affirm the F&O.

For the foregoing reasons,

IT IS ORDERED that applicant's Petition for Reconsideration of the Findings of Fact and Orders issued on May 20, 2026 is **DENIED**.

WORKERS' COMPENSATION APPEALS BOARD

/s/ JOSÉ H. RAZO, COMMISSIONER

I CONCUR,

/s/ KATHERINE WILLIAMS DODD, COMMISSIONER

/s/ PAUL F. KELLY, COMMISSIONER

DATED AND FILED AT SAN FRANCISCO, CALIFORNIA

AUGUST 31, 2026

SERVICE MADE ON THE ABOVE DATE ON THE PERSONS LISTED BELOW AT THEIR ADDRESSES SHOWN ON THE CURRENT OFFICIAL ADDRESS RECORD.

MICHAEL STEWART
BOXER & GERSON, LLP
D'ANDRE LAW, LLP

DLP/md

I certify that I affixed the official seal of the Workers' Compensation Appeals Board to this original decision on this date.
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REPORT AND RECOMMENDATION ON PETITION FOR RECONSIDERATION AND NOTICE OF TRANSMISSION TO WCAB

I. INTRODUCTION

Applicant seeks reconsideration of my Findings of Fact and Orders, dated May 20, 2026, that the applicant failed to meet his burden of proof for benefits for Serious and Willful Misconduct of Employer pursuant to Labor Code section 4553. The applicant's Petition for Reconsideration was timely filed on June 15, 2026 (the "6/15/2026 Petition") and was verified. The defendant filed an Answer on June 26, 2026 (the "6/26/2026 Answer") arguing that applicant's 6/15/2026 Petition be denied. The evidence section which follows is taken largely from the May 20, 2026 Opinion on Decision with modifications for clarity and to address the 6/15/2026 Petition. I recommend that the 6/15/2026 Petition be denied.

II. FINDINGS OF FACT AND ORDERS – MAY 20, 2026

After consideration of all the evidence I concluded that the applicant failed to meet his burden of proof for benefits for Serious and Willful Misconduct of Employer pursuant to Labor Code section 4553. (5/20/2026 Finding of Fact no. 5.) Because I did not find that the applicant was entitled to additional benefits, my decision was silent on the applicant's attorney was entitled to reimbursement for costs in relation to the applicant's claim for additional benefits. There were additional findings, and orders regarding evidentiary issues and defendant's petition for contempt, sanctions and request for replacement evaluator, that are not appealed by the applicant.

III. CONTENTIONS ON RECONSIDERATION

The applicant contends that the evidence does not support the findings of fact and that the findings of fact do not support the May 20, 2026 orders. (6/15/2026 Petition, p. 1.) Applicant is not challenging my orders regarding exclusion of deposition transcripts, my order denying defendant's request to admit additional exhibits, or denial of defendant's Petition for Contempt, Sanctions, and Request for Replacement Evaluator filed on December 7, 2022. Regarding the assertion that the findings of fact do not support May 20, 2026 orders, the applicant appears to be challenging my lack of an order that the applicant is entitled to

additional compensation, and that the applicant's attorney is entitled to reimbursement of costs related to the serious and willful claim. (6/15/2026 Petition, p. 9, line 13 – p. 10, line 27.)

The applicant asserts that serious willful conduct existed because Hodges Residential represented an unsafe workplace in that: 1) Hodges Residential knew Craig[1] posed a dangerous condition to residents and staff, 2) Hodges Residential knew that keeping Craig at the facility would result in a serious injury to another resident or employee, 3) Hodges Residential acted to thwart safety measures and failed to take corrective action. (6/15/2026 Petition, p. 5, line 17 – p. 9, line 12.)

IV. EVIDENCE AT TRIAL WITNESS TESTIMONY

Both the applicant and Anthony Hodges, the owner of Hodges Residential, provided extensive testimony. The testimony of both witnesses is more fully summarized ii the Minutes of Hearing and Summaries of Evidence (MOH/SOE) for November 18, 2025 and February 4, 2026. I did not find either witness especially persuasive. In large part I believe that this was the result of the amount of time that has elapsed since the events discussed, and each witness seeking to justify their actions rather than focusing on the question that was asked. I did not feel either witness was intentionally making misrepresentations. The result of this is that I generally find the testimony of the witnesses to be unpersuasive except where supported by the other witness or documentary evidence. I will briefly summarize the testimony of Michael Stewart to provide an outline of events and context to the documentary evidence, as well as the applicant's opinion on his own actions at the relevant times. I am not summarizing Mr. Hodges testimony, as I did not find it persuasive, except where it was supported by documentary evidence. As that documentary evidence is discussed below, his testimony would be duplicative.

TESTIMONY OF APPLICANT MICHAEL STEWART.

The applicant began employment with Hodges Residential in 2016. Hodges Residential acts as caretakers of five to six autistic and disabled men who are known as clients or consumers. Some of the men are capable of going outside the home, while others are in the home full-time. His title was caretaker/counselor. He provided daily support to the consumers by cooking for them, helping them dress for appointments, spending time with them, and making sure they are safe.

He had many years of training. In New York State, he worked for the juvenile justice system and is trained in de-escalation and intervention techniques, both verbal and physical. The witness is trained in the administration of physical restraint. He was trained in New York State regarding restraint and became a trainer on the restraint of patients or individuals. The applicant did not receive any training from Mr. Hodges and did not receive any training while employed at Hodges Residential.

The consumers had frustrations and sometimes didn't get along, and it was his job to de-escalate situations by talking to them. He would speak with them verbally if there was an argument, and, if necessary, he would get in the middle of physical fights where clients were pushing each other. He would sometimes have to stagger mealtimes so that certain consumers were not together.

There was a consumer by the name of Craig. After he figured out some of Craig's triggers, he feels that they had a good relationship. He took a lot of time with Craig. Craig would be agitated by his inability to go outside the home while others were able to do so. One of Craig's de-escalation tools was that he liked to listen to classical music, so the witness made sure that Craig's tablet was always plugged in. Craig was physically strong, perhaps five-foot-nine or five-foot-ten and between 180 and 190 pounds. Craig was nonverbal and had to use a tablet to communicate. He also used simple signs to communicate. Craig had flashes of violence and was hard to maintain at times. Craig was a resident there when the witness began working at Hodges in 2016.

Before a January 2019 incident where the applicant was injured, when a particular consumer would be returning from off-site, the witness would often delay that consumer's entry into the home by giving him snacks on the porch until Craig settled down. This was because Craig would stalk the returning consumer, get upset, and they would fight immediately. Craig was usually the aggressor.

Between January and October 2019, there were between 10 and 12 incidents with Craig. Craig would be removed from the home for biting or wrestling with a client and for breaking property. John George Hospital has a mental health capacity to support and rebalance patients. Craig had multiple admissions to John George Hospital in 2019. Craig was admitted to the hospital because he was too violent to be at Hodges. He would sometimes self-harm when

he was frustrated. The witness heard of proceedings to remove Craig from Hodges, but those occurred after he had stopped working at Hodges.

The applicant sustained three injuries at Hodges. The first time was in the witness's first month when he was feeding Craig and another consumer. Craig was reaching for the other consumer's plate and scratched the witness's hand as the witness was taking the plate off the table. The second incident occurred when Craig was attacking another consumer in January 2019. When the witness went to separate them and pull Craig off, he hurt his ankle.

The third date was October 30, 2019, when the witness suffered an injury when Craig pushed him. Craig had become agitated to a state of extreme frustration and was screaming with another staff member. On that date, the witness had noticed that Craig was agitated but not to an extreme when he first entered the house. Craig was fidgety, nodding, and holding his hands to his head like he had a headache. The witness started talking to Craig, knowing that his other care team, CABA (Center for Autism and Behavior Analysis), would not be there anymore that day.

CABA was helping Craig to socialize and self-monitor his behavior. The witness had heard that CABA was told to go home on October 30, 2019, and believes it was Anthony Hodges who sent the CABA team away that day. He also heard CABA were writing things up about what they were seeing at the home. When the applicant came on shift on October 30, 2019, he saw that Craig was upset. The applicant had mentioned to Craig that day that his friends were not going to be there today, and Craig nodded. Craig viewed the CABA team as his friends because they would play games with him. The witness had no other discussion with Craig about what had happened before the witness arrived that may have gotten Craig agitated. He talked to Craig about why he was upset, and it seemed like Craig's energy relaxed some.

Later that day, Craig came into the bathroom the applicant was using. Craig was bleeding from his neck, and the witness put a towel on his neck. Craig kept trying to get past the witness to go back upstairs. When this was initially occurring, there was no additional staff that had yet come down. The witness was in front of Craig trying to calm him down when other staff came down and tried to give Craig a pharmaceutical, and Craig pushed the witness and his leg slipped off the staircase, injuring his knee.

The applicant did not observe any change in Craig's behavior between January and October of 2019. Craig would cycle in and out of aggressive behavior. Craig had bitten a member of his care team. Other staff would avoid Craig because he would attack them, including breaking windows, breaking furniture to get at them, and trying to scratch and bite them. Craig had broken windows before January 2019. Craig's aggressive actions did not become more frequent after 2019.

The CABA care team were working with Craig. They didn't really work with clients other than Craig. They would ask the staff about his behavior and what was successful with Craig, but they didn't work directly with the staff. CABA works with clients on de-escalation and socialization techniques and self-awareness. There were approximately five CABA staff members who came in to assist with Craig by playing interactive games with him, working on how to ask for things, and engaging him in fun activities that were also learning techniques. CABA's goals were to assist Craig to self-recognize and modulate his aggressive behavior, to increase his patience, and to allow him to communicate better on how to ask for things. CABA came five days a week, Monday through Friday.

He believes that CABA first was on site at Hodges to work with Craig in July 2019. Between when CABA started in July and CABA's dismissal in October 2019, Craig was still having outbursts, and there was no change in his behavior. If a violent incident occurs at Hodges Residential, adjustments are made. When the witness had extra staff, he would position one in the hallway, and the witness would be in the front room, and they would navigate how the clients are moving through the house. This was done to intercept Craig, when he was coming up from the downstairs bedroom area, before he could get to the front room to attack another client. If Craig is breaking windows and unable to de-escalate, they are often calling 911 and he’s getting picked up.

When he began working for Hodges, he was advised that he would have to restrain consumers. The witness never went to Anthony Hodges to suggest that Craig be removed from the house. He would go to Anthony Hodges to speak about making adjustments to make things safer.

There was an incident at Hodges Residential when Craig directly attacked the witness. This occurred when CABA and Hodges’ staff phoned the witness to come in urgently. When he arrived, Craig was on the ground and sobbing. Craig's attention shifted to the witness, and he

growled at the witness. The witness noticed at this point that a CABA staff member had been bitten. The witness told Craig to go downstairs, and Craig ran at him. He poked Craig in the armpit with his walking staff, which he was using after the January 2019 injury. Craig went to run around the table to attack other staff members, and the witness again poked Craig with the staff, this time in the shoulder or chest area. Craig then went downstairs. The applicant believes a report was written, but 911 was not called. A CABA staff member told the applicant that they had never experienced that level of violence with Craig before.

The applicant has no personal knowledge of what CABA staff reported. He was just told by one of the Hodges' staff that CABA was making reports.

There were five residents at Hodges. The witness feels that he is qualified to handle situations similar to that at Hodges Residential and Craig's residence there. However, it is a team effort, and he found a lot of the Hodges' staffers were not trained to a sufficient level to deal with Craig and his level of strength and violence. The witness could not handle Craig on his own. It required a team, and there was not that level of staff at Hodges.

The witness suggested to Anthony Hodges to have more training of the staff on working together when doing interventions. He requested more detailed instruction on triggers for Craig and the other clients. He feels that the staff at Hodges needed more assertive training to deal with de-escalation.

DOCUMENTARY EXHIBITS.

All exhibits were reviewed in consideration of this opinion, but the exhibits are summarized in the discussion below only insofar as they are relevant and probative. Many of the exhibits were duplicative such as applicant's exhibit 3 containing the records in several of defendant's exhibits. Because of my findings in this matter, several exhibits were not relevant and are not summarized.

DOCUMENTARY EXHIBITS SUMMARY.

On January 2, 2019[2], the applicant texted Anthony Hodges that when attempting to pull Craig off a gate that he was banging on, Craig tried to bite the applicant and they both fell, and the applicant hurt his ankle. (App. Ex. 10.) A Regional Center of the East Bay (RCEB) Quarterly Monitoring Reviews dated January 29, 2019, April 23, 2019, indicated that Craig's

living arrangements met his needs and there had not been a medical status changes since the prior quarterly review. (App. Ex. 3, Bates page nos. 47-48.) There are incident reports prepared by Anthony Hodges reflecting incidents where Craig was aggressive to himself, staff, and/or other consumers as well as several incidents of property damage including the breaking of windows. (Def. Ex. I.) The incidents occurred in 2019 on January 18, January 19, March 11, April 30, May 13, May 14, May 24, August 19, October 4, October 26, November 6, November 7, and November 21. (Def. Ex. I.) There is no incident report for October 30, 2019. The incident note for the January 18, 2019 incident noted that Hodges Residential wished to keep working with Craig but believed that his medications needed adjustment. (App. Ex. 3, Bates page no. 124.) In the report for the January 18, 2019 incident, Mr. Hodges wrote that "… the property destruction is way out of hand. Craig at this point cannot be around other clients or my staff. He is to [sic] dangerous." (*Ibid*.) The home was considering a 30-day notice if there was no change in Craig's medication. (*Ibid*.) After another incident on January 19, 2019, the applicant was committed to John George Hospital. (*Id*. at p. 128.)

The RCEB client notes, authored largely by case manager Corinne Mahoney, documented additional behavioral incidents with Craig destroying property, attacking staff, and other consumers in 2019 that were not reflected in the incident reports. (Def. Ex. O.) These include February 18, May 19, June 12, the weekend before July 8, July 11, August 8, August 30, September 5, (App. Ex. 3, Bates page nos. 52, 67, 70, 75, 81, 88.) There is a significant time jump in the notes from September 5, 2019 to November 12, 2019. (*Id*. at pp. 88-89.) When the notes resumed on November 12, 2019, they were authored by Phu Nguyen, program manager. (*Id*. at p. 89.)

A February 25, 2019 client note indicates that Hodges Residential were willing to try CABA and hoped that it would help Craig, combined with medication changes. (App. Ex. 3, Bates page no. 54.) Hodges Residential believed that the behavioral center was too far to transport Craig, and thus they preferred to go with CABA. (*Id*. at pp. 54-55.) On March 11, 2019 CABA indicated that they would likely be able to take on Craig's case with the assessment beginning May 1, 2019. (*Id*. at p. 57.) Anthony Hodges informed the case manager that there had been at least three incidents of aggression between his hospital discharge on February 27, 2019 and March 11, 2019. (*Id*. at pp. 55, 58.) On May 1, 2019, Anthony Hodges told the case manager that Craig's behavior had been getting progressively worse. (*Id*. at p. 62.)

On March 1, 2019, an email was sent by Tamar Meidev, M.D., a member of Craig's clinical team,[3] discussing recent behavior by Craig including his "going on a rampage" lasting up to 6 hours, destroying property and assaulting people. (Def. Ex. F.) Dr. Meidev had recently spoken with staff at both Hodges Residential and the John George Hospital. (*Ibid*.) Mr. Hodges stated that Craig may have been jealous and upset because he did not have a program to participate in during the days. (*Ibid*.) Dr. Meidev spoke with psychiatrist Dr. Andara who agreed to admit Craig to John George Hospital where adjustments were made to Craig's medication. (*Ibid*.)

In a March 12, 2019 incident report, which appears to be for a March 11, 2019 incident[4], Mr. Hodges wrote that Craig had been attacking a housemate for 2 years. (App. Ex. 3, Bates page no. 130.)

There was a CRISIS Team Referral Form date June 4, 2019, that lists "1:1 Supports through CCG CABA Center for Autism & Behavior Analysis Assessment" as a current Regional Center funded support and program. (Def. Ex. D. In describing Craig, the referral form stated:

> "Craig can become very aggressive, display SIB, become very hyperactive, resistive, easily frustrated, and may AWOL. Craig has not had any incidents of AWOL in over a year. Craig usually destroys property when agitated; ex. kicking a hole in the door and breaking windows; Usually there is no antecedent to Craig's behaviors. When he has his emotional outbursts, it may take several staff to handle him. He needs close supervision when he is out socially. Craig needs supervision when he is out in the community because he has few safety awareness skills.
>
> Craig was 5150-ed several times this year for assaulting staff/peers and property destruction. Craig can get easily fixated on something, and until he is done engaging in his activity, he may become resistive to do anything else. Craig is usually successful when he has 1:1 support. Staff express that he usually responds better to male staff. Staff will usually try to calm Craig down by discussing things that he likes." (Def. Ex. D.)

On June 12, 2019, Hodges Residential prepared a 30-day notice to inform Craig Barksdale that he would no longer be able to live at Hodges Residential. (Def. Ex. A.)

The reason stated for the removal was, "… continuous loud screaming and dangerous propensities toward other clients, staff and neighbors." (*Ibid*.)

A June 13, 2019 client note indicated that if Hodges residential refused to have Craig back following a hospitalization, it would be considered abandonment and Hodges Residential would be fined. (App. Ex. 3, Bates page no. 72.) On June 19, 2019 there was a clinical team referral form requesting CABA assessment and staffing. (*Id*. at p. 12.) The referral form noted that Craig could become aggressive, but unlike many other comments on Craig's behavior, the form stated that there was usually no antecedent to Craig's behavior. (*Ibid*.) There is a clinical team summary for a June 20, 2019 telephone meeting for those associated with Craig's care. (Def. Ex. C; App. Ex. 3, Bates page no. 74.) The summary identified the clinical team for the applicant consisting of two psychologists and psychiatristTamar Meidev, M.D. with Mr. Hodges, Craig's mother, and Craig's case manager Corinne Mahoney, and Jesslyn Farros, PhD of CABA also in attendance. (Def. Ex. C.) The clinical team summary appears to be incomplete as the last line on the page appears to end mid-sentence.[5] (*Ibid*.) The summary stated that:

> "Craig has had an increase in challenging behaviors since February. According to the Hodges, he has one person who he tends to target, and this is generally a person who has difficulty verbalizing. It gets so explosive with this client that other clients will get involved to try to redirect Craig and then he will have to go after them.
>
> Most behaviors occur at 2:30pm almost every day." (Def. Ex. C.)

The summary also stated that CABA was in the midst of doing an assessment and would forgo a functional assessment due to the "… escalation in behaviors over the past few weeks." (Def. Ex. C.) Jesslyn Farros, PhD of CABA stated that, "… CABA will need to be there during the problematic times in order to address the challenges when they are occurring and will need[.]" (*Ibid*.) That is the final line on the exhibit.

CABA produced an assessment report dated June 28, 2019 following three assessment dates over slightly more than a month[6]. (App. Ex. 3, Bates page no. 14.) The purpose of the assessment was to identify interventions to reduce the challenging behaviors and increase functional skills. (*Ibid*.) The assessment stated:

> "Craig's caregivers report that he engages in aggression daily and these behaviors are typically directed at a specific consumer in his

> home. Therefore challenging behaviors typically occur at the time of waking (08:00am) and/or at the time the targeted consumer arrives home from school (02:30pm). Caregivers report these instances are of high intensity and can last 1-3 hours in duration. Additionally, if the staff cannot calm Craig down they will call 911 - Craig has been 5150'd three times this year (05/01-05/06, 05/24-05i28, and 06/12-06il 8) due to an inability to calm him down and keep Craig, his staff, and house1nates safe. These behaviors serve as a barrier for Craig to access his community (e.g., the group home does not take him on any outings due to a history of challenging behaviors) and are very concerning for his safety (e.g., injury and/or potential incarceration). He has an AAC device to communicate, however, he uses it as a leisure activity rather than to functionally communicate. Craig also uses a variety of modified signs/hand signals to communicate with his caregivers." (App. Ex. 3, Bates page no. 14.)

A July 15, 2019 Individual Program Plan update indicated that Craig's placement at Hodges Residential was stable, and they worked to reduce behavioral problems with assistance from Craig's clinical team, and RCEB psychiatrist. (App. Ex. 3, Bates page no. 49.) A December 13, 2019, update indicated that after a hospitalization, Hodges did not want Craig back but that he was doing well in a home.

Craig had a successful overnight visit with his mother on or shortly before July 15, 2019. (App. Ex. 3, Bates page no. 72.) CABA's services began August 5, 2019. (*Id*. at p. 79.) An August 15, 2019 note indicated that CABA felt the staff at Hodges Residential were hesitant regarding the CABA services. (*Id*. at p. 82.)

In the incident report for August 19, 2019, Mr. Hodges wrote that Craig attacked a housemate including biting him on the arm. (App. Ex. 3, Bates page no. 135.) Mr. Hodges wrote that CABA staff were present at the time but, "… stood their [sic] and watched the incident." (*Ibid*.) He went on to write that:

> "We have had a team from CABA in the house for two weeks. Nothing has changed with Craig [sic] behavior. I was under the impression [sic] to try and get Craig in a program away from the house and find out why Craig attacks his housemate. I see nothing that they are doing to work toward those goals. […] CABA is only doing [sic] playing games with Craig and trying to keep Craig downstairs away from his housemate. The exact thing that the home was doing to

> no avail as you can see from the past 2 weeks." (App. Ex. 3, Bates page no. 136.)

On August 23, 2019 there was a collaborative meeting with the case manager, representatives from CABA, and Carleene from Hodges Residential, but it is not clear from the note if Anthony Hodges was present or just staff of Hodges Residential. (App. Ex. 3, Bates page no. 86.) An August 30, 2019, note indicates he likely was present at that meeting and requested that CABA focus on the afternoon hours, and CABA indicated that would provide two staff from 1-6 p.m. every day. (*Id*. at p. 87.) Mr. Hodges continued to express frustration with the progress with CABA working with Craig in the incident report for October 26, 2019. (*Id*. at p. 148.) He wrote that, "CABA has been in the home for almost 3 months. No results concerning Craig and his housemates." (*Ibid*.)

Another 30-day eviction notice is dated October 31, 2019. (Def. Ex. H.) Again, the reason given was Craig's, "… continuous loud screaming and dangerous propensities toward other clients, staff and neighbors." (*Ibid*.)

On November 19, 2019, the acting regional manager of the State of California's Department of Social Services approved Mr. Hodges request for a three-day eviction notice for Craig. (Def. Ex. G.) The Department of Social Service determined, after reviewing documentation provided by Hodges Residential, that Craig was, "… a danger to himself and others as he has escalating attempts to injure staff and other consumers, engaged in property destruction, and has required multiple 5150 holds," and thus there was good cause to issue a three-day eviction notice. (*Ibid*.) Hodges Residential was also required to assist in the relocation of Craig and was required to continue caring for him until he could safely be relocated. (*Ibid*.) In a client note from November 22, 2019, it was indicated that Craig was ready for discharge from John George Hospital but that Hodges residential did not want him back in the home. (App. Ex. 3, Bates page no. 90.)

V. DISCUSSION

At trial, the applicant asserts that Anthony Hodges removal of the CABA team was serious and willful misconduct that led to, and that Mr. Hodges knew would lead to, the applicant's October 30, 2019 injury. (Applicant's Trial Brief, filed February 17, 2026, p. 2, lines 13-16.) It was additionally argued that the failure to remove Craig from

Hodges Residential was also serious and willful misconduct that led to, and that Mr. Hodges knew would lead to, the applicant's October 30, 2019 injury. (*Id*. at p. 4, lines 1-11.) Those contentions were addressed in the May 20, 2026 Opinion on Decision, In the 6/15/2026 Petition the applicant similarly asserted that 1) Hodges Residential knew Craig posed a dangerous condition to residents and staff, 2) Hodges Residential knew that keeping Craig at the facility would result in a serious injury to another resident or employee, 3) Hodges Residential acted to thwart safety measures and failed to take corrective action. 6/15/2026 Petition, p. 5, line 17 – p. 9, line 12.) I will address those assertions here, although there will be significant overlaps with the discussion in the May 20. 2026 Opinion on Decision.

The basis for increased compensation is found in Labor Code section 4553 which states in relevant part that:

> "The amount of compensation otherwise recoverable shall be increased one-half, together with costs and expenses not to exceed two hundred fifty dollars ($250), where the employee is injured by reason of the serious and willful misconduct of any of the following:
>
> (a) The employer, or his managing representative.
>
> (b) If the employer is a partnership, on the part of one of the partners or a managing representative or general superintendent thereof.
>
> (c) If the employer is a corporation, on the part of an executive, managing officer, or general superintendent thereof." (Labor Code §4553.)

The Supreme Court of California in *Mercer-Fraser Co. v. Industrial Acci. Com.*, (1953) 40 Cal. 2d 102 discussed what constitutes willful misconduct:

> " 'Wilful misconduct . . . necessarily involves deliberate, intentional, or wanton conduct in doing or omitting to perform acts, with knowledge or appreciation of the fact, on the part of the culpable person, that danger is likely to result therefrom.' [quoting *Porter v. Hofman* (1938) 12 Cal.2d 445, 447 [85 P.2d 447].]
>
> " 'Wilfulness necessarily involves the performance of a deliberate or intentional act or omission regardless of the consequences.' [quoting *Porter* at p. 448.]
>
> […]

> While the word 'wilful' implies an intent, the intention referred to relates to the misconduct and not merely to the fact that some act was intentionally done. In ordinary negligence, and presumably more so in gross negligence, the element of intent to do the act is present and any negligence might be termed misconduct. But wilful misconduct as used in this statute means neither the sort of misconduct involved in any negligence nor the mere intent to do the act which constitutes negligence. Wilful misconduct implies at least the intentional doing of something either with a knowledge that serious injury is a probable (as distinguished from a possible) result, or the intentional doing of an act with a wanton and reckless disregard of its possible result." (*Mercer-Fraser Co. v. Industrial Acci. Com*., 40 Cal. 2d 102, 116 and 118 [emphasis in original].)

An employer is guilty of serious and willful misconduct where they: "know of the dangerous condition, know that the probable consequences of its continuance will involve serious injury to an employee, and deliberately fail to take corrective action." (*Johns-Manville Sales Corp. v. Workers' Compensation Appeals Bd*. (*Horenberger*) (1979) 96 Cal.App.3d 923, 933.) "There must be knowledge or the equivalent of knowledge, from all the surrounding circumstances, that the act or omission to act is likely to result in serious injury to others." (*Henry J. Kaiser Co. v. Industrial Acci. Com*., 12 Cal. Comp. Cases 246, 250.)

The applicant's argues that the actions, or lack of actions, undertaken by Anthony Hodges created an unsafe work environment that he knew would result in serious injury. (6/1/2026 Petition, p. 4, lines 5-12.) The applicant also argues that failing to remove Craig from the home, or to provide adequate training to the applicant to deal with Craig's outbursts created an unsafe work environment and constituted serious and willful misconduct. Indeed, the defendant has a statutory duty to provide a safe workplace for its employees. (Labor Code sections 6400, 6402, 6403, and 6404.) A "safe" workplace is, "… freedom from danger to the life, safety, or health of employees as the nature of the employment reasonably permits." (Labor Code section 6306.)

As explained in *Bonner v. Workers' Comp. Appeals Bd*. (1990) 225 Cal.App.3d 1023, a case considering the employer's negligence in a claim for third-party credit, but illustrative of employer responsibility under Labor Code sections 6400, et seq.:

> "The duty to maintain a safe workplace encompasses many responsibilities, including the duty to inspect the workplace, to discover and

> correct a dangerous condition, and to give an adequate warning of its existence. Here, it was Moodie's [the employer] duty to maintain a workplace free "from danger to the life, safety, or health of employees as the nature of the employment reasonably" permitted, and to utilize "any practicable method of mitigating or preventing a specific danger ...."
> (§ 6306.)" (*Bonner v. Workers' Comp. Appeals Bd*. (1990) 225 Cal.App.3d 1023, 1034 [275 Cal.Rptr. 337].)

However, *Bonner*, *supra*, also held that an employer is liable for contributory negligence, a lower standard than that required for serious and willful misconduct allegation in the case at issue, only where the employer "… fails to take reasonable steps either to alleviate the danger or to give an adequate warning in order to prevent injury to employees…." (*Bonne v. Workers' Comp. Appeals Bd*. (1990) 225 Cal.App.3d 1023, 1028.)

REMOVAL OF CABA ON OCTOBER 30, 2019 AND INTERFERENCE WITH CABA.

The applicant, "… primarily [contends] that Mr. Hodges deliberately removed CABA from Hodges Residential thereby removing the safety measure designed to protect the residents and staff from Craig's violent outbursts." (6/15/2026 Petition, p. 7, lines 10-12.) Besides the use and presence of the CABA Team, the 6/15/2026 Petition does not identify what other safety measures Mr. Hodges acted to thwart. I disagree with applicant's assertion that, "Mr. Hodges engaged in a deliberate course of conduct that undermined and ultimately eliminated these protective measures." (*Id*. at p. 7, lines 14-15.)

I have a different view of some of the evidence the applicant cites to in support of his contention that Mr. Hodges was undermining CABA. Applicant's Petition states that, "The record reflects Mr. Hodges' reluctance to cooperate with CABA, delayed meetings, cancellation of services, and even the blocking of a treating therapist's phone number. *See Exhibit 3, Pages 82, 85, and 86*." (6/15/2026 Petition, p. 7, lines 16-18.) I believe this to misrepresent the evidence. The record does not reflect an intentional blocking of a phone number, but instead reflects that, "Hodges have mistakenly blocked Martha's number." (App. Ex. 3, p. 86.) While Mr. Hodges did request to cancel a meeting on August 26, 2019, and cancelled CABA services on that date, the record shows that was due to an annual inspection at the home. (*Id*. at p. 85.) To interpret the actions on August 26, 2019 as an effort to thwart the efforts of CABA is not supported by the evidentiary record.

I also do not agree with the characterization that the role of CABA was to be a "… safety measure designed to protect the residents and staff from Craig's violent outbursts." 6/15/2026 Petition, p. 7, lines 10-12.) This implies that CABA would step in to physically protect staff during an outburst. CABA's role was to identify interventions to reduce Craig's challenging behaviors and increase his functional skills. (App. Ex. 3, Bates page no. 14.) The June 20, 2019 Clinical Team Summary does state that CABA would need to be at Hodges Residential "… during the problematic times in order to address the challenges when they are occurring," but this statement is made in the context of doing an assessment. (Def. Ex. C.) It appears indisputable that CABA were engaged to reduce the number of Craig's outbursts. However, that is not the same as CABA being engaged to protect the residents and staff from the violent outbursts when they were occurring. CABA were engaged to reduce the frequency of those outbursts, which would have the logical outcome of preventing harm due to Craig's outbursts, but the evidence does not support that CABA had a role in protecting residents and staff once an outburst was occurring. Instead, that was the responsibility of staff and, if necessary, the police.

In this matter I was not, and am not, persuaded that Anthony Hodges removal of CABA from the home on October 30, 2019 was an act that he knew, or should have known, was likely to result in a serious injury to others, including the applicant. It is clear that Craig was having numerous and consistent violent outbursts in 2019. These outbursts included property destruction as well as attacks on staff and other consumers in the home. The introduction of CABA staff on August 15, 2019 did not result in a cessation or even a significant reduction in the incidents, as there were incidents on August 19, August 30, September 5, October 4, October 26, November 6, November 7, and November 21. This is not a significant reduction in the frequency of incidents compared with those prior to the presence of CABA in 2019. The applicant seemed to agree that CABA was not having an effect in reducing the applicant's outbursts as he testified that he did not observe any change in Craig's behavior between January and October of 2019.

I also did not see evidence in the record that supported the applicant's testimony that Craig was upset on October 30, 2019 because CABA had been sent away. The documentary record is entirely silent on what occurred on October 30, 2019. This is despite the applicant's testimony that Craig was bleeding. It is not understood why there is nothing in the client notes or an incident report to reflect this incident. The applicant testified that when he arrived at the home on October 30, 2019, Craig was upset because CABA were not coming that day.

However, the applicant testified that after he talked to Craig, his energy relaxed. It was only later that Craig burst into the bathroom being used by the applicant. There is not testimony about whether the renewed increase in Craig's agitation was still a result of CABA not being present, or due to some other factor such as being angered by another consumer. So, while the injury certainly seems to have been the result of a push from Craig, there is not substantial evidence supporting that the push by Craig was the result of anger over the CABA removal.

There is also not evidence that CABA would have otherwise been present when the incident occurred since the time of the push is not clear. Nor is there evidence that CABA would have actively intervened to de-escalate Craig's agitation. Although Mr. Hodges noted an incident where CABA did nothing during an outburst by Craig, I am not persuaded by that statement as it may have been influenced by Mr. Hodges growing frustration at what he considered a lack of progress from the CABA team in addressing Craig's outbursts. However, there is also no evidence that CABA had previously been able to intervene and de-escalate Craig during prior or subsequent incidents.

I do not find that there is a link between the removal of CABA from the home on October 30, 2019 and the applicant's knee injury. Because there is not support in the evidence that the removal of CABA led to the applicant's October 30, 2019 injury. Therefore, I did not, and do not, find that the removal of CABA from the home on October 30, 2019 constitutes serious and willful misconduct by Hodges Residential.

I also am not persuaded that Anthony Hodges intentionally undermined the work of CABA throughout their time working with Craig. As early as February 2019, Hodges Residential were willing to have CABA come to assist in Craig's care. It appears that it may not have been until May or June 2019 that CABA was authorized by the case manager. I do not find sufficient evidence to support that Anthony Hodges was undermining the work of CABA after that authorization, as may have been implied by some testimony and is alleged in the 6/15/2026 Petition. However, it is clear Mr. Hodges was frustrated by a lack of progress in reducing Craig's outbursts. Mr. Hodges, and Hodges Residential staff, may have been not fully in sync with CABA as to their role in working with Craig, and in educating the Hodges staff. Nevertheless, I do not see sufficient evidence that Hodges Residential were preventing the work of CABA. Additionally, Mr. Hodges requested that CABA focus their efforts on the afternoon hours when Craig's violent outbursts and interaction with the other consumer were most common. I find that Hodges was taking efforts to address Craig's outbursts with doctors,

and with CABA. I do not find that Mr. Hodges was interfering with the work of CABA sufficiently to represent serious and willful misconduct.

FAILURE TO REMOVE CRAIG FROM HODGES RESIDENTIAL.

The applicant asserts that the January 2, 2019 injury, Anthony Hodges communications with RCEB, and Craig's pattern of violence established a knowledge on the part of Hodges Residential that the mere presence of Craig in the home constituted a dangerous condition. (6/15/2026 Petition, p. 5.) In this matter, I remain unpersuaded that the failure to remove Craig from Hodges Residential constitutes an intentional act with knowledge that serious injury was probable. Craig had been acting out repeatedly throughout 2019, but his outbursts against people were largely directed at another consumer in the home. There were certainly incidents where Craig would attack Hodges Residential staff, but aside from the applicant's January 2019 ankle injury, there had not been serious injuries before the October 30, 2019 injury to the applicant.

The January 2, 2019 injury is not glossed over as inconsequential, but there is little in the evidentiary record regarding the January 2019 ankle injury. There are no medical records related to that injury, and the Joint Compromise and Release indicates $913.03 in medical bills were paid related to that claim. (App. Ex. 1, PDF p. 7.) The benefit printout for that date of injury shows medical treatment payments of at least $1,036.10, and no temporary disability payments. (Def. Ex. B, p. 2.) While there is evidence of the January 2, 2019 ankle injury, I do not believe that the evidentiary record supports applicant's classification of that injury as a "significant" injury. (6/15/2026 Petition, p. 8, lines 18-19.) I am not persuaded that Anthony Hodges repeated statements, such as one on or about May 21, 2019 that, "Craig is to [sic] dangerous to be around the other consumers and to [sic] dangerous for the staff and himself. Someone is going to get hurt seriously," constitute knowledge, as opposed to a suspicion, that Craig's continued presence would result in an injury. (App. Ex. 3, p. 67, cited by the 6/15/2026 Petition, p. 9, lines 3-5.) That statement was made in the context of saying that Craig would get a 40-day eviction notice, "… if we cannot address this situation." (App. Ex. 3, p. 67.) The statement was made in an effort to have Craig's behavior addressed. It does appear that there was at times a less urgent response to Craig's behavior by the RCEB. This is evidenced by the several months between Hodges Residential's February agreement to use CABA, and the May 2019 beginning of the assessment process. I therefore do not agree that Anthony Hodges statements constitute knowledge that Craig's continued presence would likely result in an injury.

Additionally, I am persuaded that Anthony Hodges was taking reasonable steps to try to alleviate the danger posed by Craig. Mr. Hodges was routinely informing Craig's case manager, who appears to be the one responsible for directing the overall care of Craig, of the dangers Craig posed to himself and others. Additionally, Mr. Hodges communicated with the case manager and Dr. Meidev to have changes made in Craig's medications to control his outbursts. The July 15, 2019 Individual Program Plan discussed that Hodges Residential worked to reduce outbursts by working with Craig's clinical team and the RCEB psychiatrist.

I do not believe, as applicant does, that the failure to evict Craig in January and June of 2019 was Mr. Hodges prioritizing financial gain over worker safety. (6/15/2026 Petition, p. 9, lines 8-12.) Instead, I find that the failure to evict Craig in January and June of 2019 was due to RCEB suggestions of alternatives to eviction that would mitigate the threat posed by Craig's outbursts. For example, after the January incident there appears to have been discussion of the use of CABA, with Mr. Hodges agreeing to their use by February 25, 20219. There were also discussions of modifications to Craig's medication. These indicate that some changes were being implemented to alleviate the outbursts by Craig, and that these steps may have been part of the reason an eviction did not occur after the January 2019 eviction notice.

Similarly, after the June 2019 eviction notice there was a meeting with two psychologists and psychiatrist Tamar Meidev, M.D. with Mr. Hodges, Craig's mother, and Craig's case manager Corinne Mahoney, and Jesslyn Farros, PhD of CABA also in attendance. Besides CABA being in the midst of an assessment, it was also indicated by Craig's mother that she would be willing to call and speak with Craig on a set schedule as a preventative measure. (Def. Ex. C.) This multi-party meeting indicates that there were new steps being taken to address Craig's behavior. It is the implementation of these additional steps that could have been the reason the evictions were not carried out, as opposed to a desire for financial gain.

Although there may well have been other steps which could have been undertaken, Mr. Stewart's testimony includes that the staff knew de-escalation techniques to address Craig's outbursts, including having his listen to classical music. The staff also took steps to avoid interaction between Craig and the other patient that triggered the outbursts. So, although Craig's outbursts may have created temporary unsafe conditions for Hodges Residential staff, his residence in the home was not itself an inherently unsafe condition. Additionally, I find that Hodges Residential was taking reasonable steps to alleviate the danger posed by Craig to

staff. Therefore, I do not find that the failure to remove Craig from Hodges Residential constitutes serious and willful misconduct by Hodges Residential.

VI RECOMMENDATION

For the foregoing reasons, I recommend that applicant's Petition for Reconsideration, filed herein on June 15, 2026, be **DENIED**.

This matter is being transmitted to the Appeals Board on the service date indicated below my signature.

DATE: June 30, 2026

LAWRENCE A. KELLER
WORKERS' COMPENSATION JUDGE