COMMONWEALTH OF MASSACHUSETTS
Division of Administrative Law Appeals

DEPARTMENT OF EARLY EDUCATION AND CARE, *Petitioner*	:	
v.	:	
LUIS SANCHEZ & IRISABEL CORREA *Respondents*	:	Docket No. OC-22-0453 & OC-22-0601[1]

Appearances:

For Petitioner: Leah Potash, *Esq.*
For Respondents: Christopher Long, *Esq*., David Zuares, *Esq.*

Administrative Magistrate:

Eric Tennen

SUMMARY OF RECOMMENDED DECISION

An infant died from complications arising out of head trauma. She began experiencing symptoms while at the Respondents' daycare. After an investigation, DEEC concluded that the Respondents were responsible for the trauma that ultimately caused the infant's death. It recommended revoking their licenses. However, the evidence adduced at this hearing shows the acute trauma detected in a CT scan could have been inflicted days before, and not just hours before, her symptoms began. Additional evidence showed the infant had other head trauma that pre-dated her enrollment at the Respondents' daycare. Finally, the Respondents credibly explained all the circumstances surrounding this incident, none of which point to them as having caused the infant any harm. I therefore recommend DEEC reinstate the Respondents' licenses.

[1] The matters were consolidated on December 13, 2022.

INTRODUCTION

There are few events more tragic than the death of an infant. Infant A was 13-months old when she suffered a seizure while at the Respondents' daycare. Though rushed to the hospital, she died two days later. The issue in this appeal may seem trivial in comparison: whether the Department of Early Education and Care ("DEEC") properly refused to renew Mr. Sanchez's family daycare license and revoke Ms. Correa's childcare assistant certification. But that question is incredibly important to Mr. Sanchez and Ms. Correa because, among other things, it requires examining whether they bear any responsibility for Infant A's death.

The Petitioners timely appealed DEEC's notice of revocation and suspension. I held a hearing over three days, two of which were in-person and one of which was remote. DEEC presented the testimony of Maria Martinez, DEEC Northeast Regional Director; Fernando Lazu, DEEC investigator; and Dr. Daniel Rauch, the Chief of Pediatric Hospital Care at Tufts Medical Center at the time of Infant A's admission. The Respondents both testified[2] and presented the testimony of Jacqueline Harrington, the manager of Community Teamwork Incorporated ("CTI") and Dr. Philip Storm, Chief of Neurosurgery at the Children's Hospital in Philadelphia. I entered Petitioner's Exhibits 1-14, and Respondents' Exhibits A-M, into evidence.

DEEC provided a closing argument at the end of conclusion of the hearing. The Respondents submitted a closing brief on May 10, 2024, at which point I closed the administrative record.

[2] Both Respondents testified through a Spanish interpreter. I find both were credible witnesses and adopt their testimony in its entirety, as elaborated in my findings of fact.

FINDINGS OF FACT

Background

1. The Respondents, a married couple, operated a family daycare since 2018 called 1A Learning Childcare ("1A Childcare"). It was operated out of their home's basement. They had two older children who lived in the home but never came down to the daycare space. (Sanchez testimony.)

2. The daycare license was in Mr. Sanchez's name. Ms. Correa was a certified childcare assistant. (Sanchez testimony; Correa testimony.)

3. Since they opened, they cared for a total of six children. In September 2021, they had four children enrolled in their daycare. Three were there during the day and one came after school. One of the day students was a 13-month-old boy and had been at the daycare since he was two months old. (Sanchez testimony; Correa testimony.)

4. There had never been any previous concerns with 1A Childcare raised by DEEC, DCF, parents, or CTI. [3] (Lazu testimony; Harrington testimony.)

Infant A

5. Infant A was a 13-month-old girl when she began attending 1A Childcare. Her first day was September 13, 2021. (Ex. 1.)

6. Before she began attending 1A Childcare, Infant A's medical records documented some gross motor skill delays. Her records also reflected a growth in her head circumference which indicates something was causing swelling—the problem could have been medical

[3] CTI is a private organization providing support to family daycares. The Respondents' daycare had subcontracted with them for about two years. CTI placed families there, but also helped with training and referrals to other organizations when warranted. (Harrington testimony.)

or could have indicated repeated trauma. (Ex. 10; Dr. Storm testimony.)

7. Infant A was referred to 1A Childcare by CTI. Her mother did not speak English, but her aunt did. Her mother went to the daycare twice: once to tour it and on the first day Infant A attended. Otherwise, Infant A's aunt would drop off and pick up Infant A when she attended. (Sanchez testimony; Correa testimony.)

8. Infant A and the other 13-month-old were usually together. The other two children were a little older and were usually cared for separately because they had different, more advanced needs. (Correa testimony.)

9. From the moment Infant A began attending, the Respondents noticed something was off. She had not hit the milestones expected of an infant her age. She could not roll over or feed herself. She could not walk or crawl. She whined a lot. She did not engage with the other children. She did not play with toys. She did not eat solid food. (Sanchez testimony; Correa testimony.)

10. The Respondents acknowledged that all children go through an adjustment period when they first start daycare, but the problems they observed went beyond this. Their assessment was based on their training[4] and their observations of the other six children for whom they had cared over the years. (Sanchez testimony; Correa testimony.)

11. They voiced these concerns to Infant A's aunt several times. She seemed dismissive of these concerns and chalked them up to Infant A's slow adjustment to her new environment. (Sanchez testimony; Correa testimony.)

12. On September 15, 2021, two days after Infant A began attending, Respondents had their

[4] Respondents attended numerous trainings (approximately 46) between April 2018 and June 2021, presumably offered and/or required by DEEC. (Ex. L.)

monthly check-in with Jackie Harrington from CTI over Zoom. (Harrington testimony.)

13. Respondents expressed their concerns about Infant A's development with Ms. Harrington. Ms. Harrington observed Infant A for about a minute. She could see that Infant A did not stand, crawl, or roll over. The Respondents also told her Infant A did not move much, liked to be held a lot, and did not eat solid food. (Ex. B; Harrington testimony.)

14. Ms. Harrington suggested the Respondents keep observing her and if their concerns persisted, she could make a referral to an outside agency. She also instructed them to discuss these problems with Infant A's mother. Ms. Harrington documented her observations. (Ex. B; Harrington testimony.)

15. The Respondents had worksheets that they filled out for each day Infant A was with them. They documented her mood, how she ate, slept, drank, and went to the bathroom. The worksheets also have space for additional comments. They noted she was "sensitive" every day and, on September 13, 2021, the Respondents additionally noted Infant A was "very still" and "cried a little." (Ex. C.)[5]

16. Infant A did not attend daycare on September 21, 2021 because her mother said, in a text message, that she was "unwell" and had an upset stomach. She did attend the next day, but her mother asked, again in a text message, that the Respondents give her water only, "no milk or juice for now." On that day, Respondents noted they were "offering solid food to [Infant A] but she throws it up." (Exs. C & E.)

[5] The worksheets are meticulously kept, documenting what time Infant A slept and how long, what time she drank and how much, whether she ate, her mood, and how often she went to the bathroom. The worksheets demonstrate the Respondents' attention to detail and care they took with the children in their daycare.

September 23, 2021

17. When Infant A arrived on September 23, 2021, the Respondents instantly noticed something was not right with her, more so than usual. She arrived during morning snack. But the minute they sat her at the table, she began to fall asleep. Later, she did not eat a lot at lunch. She slept much longer than usual at nap time, so much so that the Respondents had to wake her up. Her stool was black and abnormal. And she whined all day. (Sanchez testimony; Correa testimony.)

18. Later in the afternoon, while Mr. Sanchez was holding her, Infant A suddenly fainted. He called her name and she woke up a little. He was immediately concerned and was going to call 911. Before he could, she had a "convulsion." He saw she was not breathing and gave her CPR. He yelled upstairs for his son to call 911. As he did that, Infant A convulsed again and was purple. He immediately decided it would be quicker if they took her to the emergency room themselves, so he and his son put her in the car and raced to the hospital. (Sanchez testimony; Correa testimony.)

19. As soon as they got to the hospital, Mr. Sanchez called Infant A's aunt and told her what happened. He then handed the phone over to the nurse. (Sanchez testimony.)

20. Infant A was unresponsive and intubated. Although Mr. Sanchez brought her to Lowell General Hospital, she was soon airlifted to Tufts Medical Center. Doctors there were able to obtain a head computerized tomogram ("CT") scan that showed "a chronic subdural hematoma on the left, mixed density blood on the right, right to left shift, a skull fracture, soft tissue swelling over the fracture, and loss of the grey-white matter differentiation." (Ex. A.)

21. Ultimately nothing could be done to save her. Infant A "suffered a catastrophic injury

from the seizure and progressed to brain death." She passed away on September 25, 2021. (Exs. A & 1.)

Respondents' cooperation with the investigation

22. From the minute the incident happened, the Respondents cooperated totally with every investigating entity: the State Police, the Department of Children and Family ("DCF") and DEEC. DCF and DEEC conducted a joint investigation separate from the Police investigation. (Lazu testimony.)

23. Soon after Mr. Sanchez brought Infant A to the hospital, he was met by a police officer. Mr. Sanchez told the officer what happened. He agreed to let the officer take pictures of his car. The officer asked Mr. Sanchez to accompany him to the station that night to make a formal statement, which Mr. Sanchez did. (Sanchez testimony.)

24. At some point, Mr. Sanchez also voluntarily turned over his cellphone. (Sanchez testimony.)

25. Sometime after Mr. Sanchez left to take Infant A to the hospital, the police arrived at the daycare. Ms. Correa was there with the remaining children. They told her to go upstairs with the kids, which she did. There were many law enforcement officers there and they took pictures all over the house. After the kids were dismissed from her daycare, Ms. Correa spoke to an officer to tell them what had happened. She was then asked to go to the station and give a formal statement, which she also did. (Correa testimony.)

26. The Respondents were at the police station until about 9:00 p.m. and then went home. After they got home, around 10:30pm, investigators from DCF arrived and interviewed them again. The Respondents told them what happened and showed them around the daycare. The investigator noted that they appeared to be very concerned for Infant A's

well-being "and were forthcoming with information." (Ex. 6, pg. 6.)

27. On September 24, 2021, Mr. Sanchez submitted a written report of the incident to the DEEC. (Ex. 6, pg. 19.)

28. On that same day, he voluntarily agreed to place his license in "inactive status" pending the results of the investigation. (Lazu testimony; Ex. 8.)

29. On September 28, 2021, the Respondents were again interviewed by investigators from DCF and DEEC. (Ex. 6, pg. 23.)

30. Their many statements have remained consistent throughout and were consistent with the testimony they gave at this hearing.

The investigation

31. DCF and DEEC also interviewed Infant A's family, the parents of other children who attended 1A Daycare, Ms. Harrington, and the Respondents' son. They had various conversations with the District Attorney's office, the Medical Examiner's office, and Dr. Daniel Rauch. (Exs. 1 & 2.)

32. Dr. Rauch is an experienced pediatrician, having worked in that capacity at various institutions for over 30 years. At the time of the incident, he was the Chief of Pediatric Hospital Care at Tufts hospital. That role involved many duties. He was not Infant A's treating physician. Rather, he was the liaison between the hospital and the authorities. He was the hospital's only representative at two multi-agency team meetings on September 24, 2021. (Rauch testimony.)

33. Although he could not remember much about this case by the time he testified, he was able to review his notes and explain his normal practices at the time. For example, although he had some familiarity with reading a CT scan, it was not his specialty. Instead,

he would defer to a radiologist. In this case, he could not remember whether he spoke directly to a radiologist or reviewed their notes, but his practice was to do one or the other, or both. He believes he did one of those things prior to the second multi-agency meeting. (Rauch testimony; Ex. 11, pgs. 30-31.)

34. At the first multi-agency team meeting, Dr. Rauch shared his initial impression that Infant A had multiple injuries to her head including one that was "acute" and "occurred yesterday" (the day of the incident). Dr. Rauch explained that "it fits the mechanism better that it all happened at once" rather than over time, but he added that this hypothesis would have to be confirmed by a radiologist. (Ex. 1.)

35. He explained that "if it was an acute injury, symptoms would set in quickly while if it was a slow bleed, symptoms could be headache, irritability, vomiting." (Ex. 6, pg. 8.)

36. A second medical update was provided later that same afternoon. Dr. Rauch reported that Infant A had a linear skull fracture on the right side of her head that likely occurred days or weeks earlier. He did not think this fracture caused her current condition. The medical staff was still trying to figure out what happened, but it was difficult given Infant A's condition, and would nevertheless require additional testing. (Ex. 1.)

37. Mr. Lazu, the DEEC investigator, relied exclusively on Dr. Rauch's assessments in drawing his medical conclusions about the case. By October 5, 2021 there was not much more medical evidence available. The investigators had been informed that any results from an autopsy could take months, and they were weighing whether to wait for those results before concluding their respective investigations. (Lazu testimony; Exs. 1 & H.)

38. On October 5, 2021, Mr. Lazu began an e-mail chain with various people at DEEC, including his supervisors. Ms. Martinez, DEEC Northeast Regional Director, asked if Mr.

Lazu thought he would be issuing any citations against the Respondents and whether he believed the incident occurred at the program. (Ex. H.)

39. Mr. Lazu provided a lengthy response:

> I would say that, based on the medical information and the fact that the child arrived at the daycare shortly before 9 AM and brough to the hospital shortly before 3 PM, that the most significant injuries to the child's brain occurred at the daycare. I believe that if the child had been injured prior to arriving at the daycare she would have shown signs not like the educators described as being more off than usual. The way the injuries are described on the morning meeting of 9/24 leads me to believe that [Infant A] would have shown signs of distress earlier if she had arrived at the daycare with those injuries. The 1:30 PM meeting on the same day did raise some questions as to what could have caused the damage especially when they referenced a cut of off blood flow to the brain which would speak to some type of strangulation however, there are no marks to the child's neck. So there is still some questions as to what could have caused that which hopefully the autopsy can clear up. So there is still a possibility of some type of medical event. I think we are in a tough spot as far as [citations] at this time without having a cause of death.

(Ex. H.)

40. Mr. Lazu's supervisor asked if he had spoken with the doctors to see "if the child would have shown concern prior to 3 if injured in the home." He added, "while I appreciate [Mr. Lazu's] statements they are his assumptions and I would like to know what the doctor has to say about this directly." (Ex. H.)

41. Mr. Lazu then called Dr. Rauch and spoke with him for about 1-2 minutes. According to Mr. Lazu, Dr. Rauch said that "whatever happened to [Infant A], and he does not know what occurred, happened at the daycare before 3 PM. The child did not arrive at the daycare in that condition and not be noticeable till 3 PM." (Ex. H.)[6]

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[6] Pointing to this series of e-mails, Respondents' counsel suggest Mr. Lazu perjured himself when he testified that he did not make up his mind about what happened until after speaking with Dr. Rauch. This mischaracterizes the testimony. Mr. Lazu simply had a hard time remembering the exact chronology of events from two years ago. When shown the e-mails, he did not dispute that, prior to his final conversation with Dr. Rauch, he had formed an opinion

42. Mr. Lazu did not consult with a neurologist, even though Dr. Rauch said that one should confirm his opinion. He did not speak with any doctors other than Dr. Rauch. He also did not investigate any possible prior abuse, because his mandate was just to investigate what caused the injury that led to Infant A's death, which he assumed occurred the day she was taken to the hospital. (Lazu testimony.)

43. Mr. Lazu completed his investigative report on December 2, 2021. He found that while no one could determine the way the injuries occurred, the injuries occurred while Infant A was at 1A Daycare, which then resulted in her death. (Ex. 1.)

44. Meanwhile DCF continued its investigation. On January 12, 2022 an investigator spoke with someone from the District Attorney's Office and the Medical Examiner's office. They were told that the cause of death was "blunt force trauma with undetermined manner and DA informed that there are no suspects/perpetrator unknown." (Ex. 6, pg. 35.)

45. The next day, DCF issued a 51B report[7] substantiating allegations of abuse but did not name a perpetrator. (Ex. 6, pg. 35.)

Results of DEEC's investigation

46. Mr. Sanchez's license had remained voluntarily suspended while the investigation was open. It expired on July 31, 2022. On September 28, 2022, DEEC issued a Notice of "refusal to renew license" to Mr. Sanchez and an Order revoking Ms. Correa's

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based on the evidence he had at that time (which included briefings by Dr. Rauch in the multi-disciplinary team meetings).

[7] DCF investigations of alleged abuse or neglect are initiated by reports authorized under G.L. c. 119, § 51A. The results of those investigations, and whether they are supported or unsupported, are recorded in reports governed by G.L. c. 119, § 51B. These are colloquially referred to as "51A" and "51B" reports.

certification. (Exs. 13 & 14.)

47. DEEC found that there was "reasonable cause to believe that the [Respondents] or another person caused Child A's injury while the child was at the Program on September 23, 2021 and therefore failed to provide an environment free of abuse and/or neglect." (Exs. 13 & 14.)

Dr. Storm's expert testimony

48. At the hearing, the Respondents presented the expert evidence of Dr. Philip Storm. Dr. Storm was a knowledgeable and experienced witness, and I credit his testimony. His opinion was not available to DEEC when it conducted its investigation.

49. Dr. Storm was retained by Respondents' counsel to provide an assessment of Infant A's injuries. He reviewed her medical records, police reports, DEEC records, Ms. Harrington's observations, and the Medical Examiner's report. Perhaps most importantly, he reviewed the CT images taken of Infant A at the hospital. (Ex. 1; Storm testimony.)

50. The imaging was particularly relevant because it can help understand the timing of Infant A's injuries. The CT images were of Infant A's skull and revealed different areas where blood was detected. A trained neurologist like Dr. Storm could estimate the age of the blood, and thus the age of the injury, based on its darkness. (Ex. 1; Storm testimony.)

51. He noted several injuries, one of which he classified as "acute," the rest of which he classified as either "subacute" or "chronic." He opined that the chronic injuries were over 3 weeks old. The subacute injuries were 3-14 days old. And the acute injury had to have occurred anywhere from a few hours to a few days before the scan. (Ex. 1; Storm testimony.)

52. Dr. Storm explained it was impossible to say that the acute injury absolutely occurred

while Infant A was at 1A Daycare. That injury very well could have occurred before she arrived. Beyond the acute injury, some of the other injuries definitely occurred *before* Infant A began attending 1A daycare because they were weeks old and she had been at 1A Daycare less than two weeks. (Ex. 1; Storm testimony.)

53. The subdural hematomas of various ages were consistent with constant abuse, or trauma, predating Infant A's fatal injury. (Ex. 1; Storm testimony.)

54. Furthermore, her significant developmental delays, as observed by the Respondents and documented by Ms. Harrington, as well as her expanding head circumference, were consistent with a child suffering ongoing abuse. Again, all these symptoms predated Infant A's enrollment at 1A Daycare. (Ex. 1; Storm testimony.)

55. The amount of force needed to cause this kind of trauma was significant. It is unlikely such injuries would occur when an infant simply fell or bumped her head with a toy. (Ex. 1; Storm testimony.)

56. Dr. Storm also explained that while an acute injury alone could have caused the seizure that ultimately led to Infant A's death, the combination of all the trauma could also have caused the seizure. Thus, he could not say for sure whether it was only the acute injury, or the combination of multiple injuries, that led to Infant A's death. (Storm testimony.)

CONCLUSIONS OF LAW

DEEC bears the burden of proof by a preponderance of the evidence that it had grounds to refuse to renew Mr. Sanchez's license and revoke Ms. Correa's certification. *DEEC v. Boodakian*, OC-17-151 (DALA Dec. 28, 2017); *DEEC v. Lentini*, OC-15-656 (DALA Dec. 7, 2017). DEEC's actions were based on its finding that the Respondents did not provide an environment free from abuse or neglect. 606 Code of Mass Regs. § 7.11(4)(a)-(c). Whether

DEEC can meet its burden boils down to one factual question: did Infant A suffer trauma at the Respondents' daycare?

Early in the investigation, it was unclear how Infant A was injured and whether that injury occurred while in the Respondents' care. Over time, it became clear no one would be able to say how Infant A was injured. But also, after this hearing, it is now clear to me that regardless of how she was injured, the injury did not occur under the Respondents' watch.

DEEC, supported by Mr. Lazu's report, concluded otherwise. To be fair to DEEC, Mr. Lazu had to end his investigation at some point and some evidence was not available to him when he finalized his report; indeed, some of this evidence came out at this hearing only through the Respondents' expert. Thus, when Mr. Lazu finalized his report, the only real assessment of when the injury occurred was from Dr. Rauch. But Dr. Rauch was not a trained neurologist and normally relied on a neurologist's assessment, which is why he indicated his assessment should be reviewed by a neurologist.

More importantly, Dr. Rauch, like Mr. Lazu, was not privy to some of the evidence adduced at this hearing which may have changed his assessment. For example, Dr. Rauch believed it was unlikely Infant A arrived at the daycare without exhibiting symptoms and then suddenly had a seizure. But it is clear from the Respondents' credible evidence that Infant A was experiencing symptoms the moment she arrived at the daycare the day of the incident. The Respondents were concerned even more than usual about her presentation all day.

Also, neither Dr. Rauch nor Mr. Lazu, had the benefit of Dr. Storm's expert testimony, which I credit. Perhaps the most important thing he explained is that the acute injury detected by the head CT could have been inflicted anywhere from a few hours to a few days before. Dr. Rauch incorrectly thought (or assumed) it could have been inflicted only that day. Dr. Storm also

explained that the different injuries, and documented evidence of a swelling head, showed a pattern of abuse over time. These two facts taken together show Infant A was suffering repeated trauma that predated her enrollment at 1A Childcare and likely continued occurring outside of 1A Childcare. There is no evidence that the Respondents were anything but dedicated caretakers. They were concerned for Infant A, and nothing indicates they would have inflicted a significant trauma on the day in question.

Indeed, the Respondents' conduct throughout this crisis belies any consciousness of guilt. They expressed concerns about Infant A's development to her family and Ms. Harrington before September 23, 2021 (which is corroborated by Ms. Harrington's notes). On the day of the incident, the Respondents did all they could to save Infant A, including giving her CPR and rushing her to the hospital without even waiting for an ambulance. Then, they did not hide any information. Mr. Sanchez immediately called Infant A's aunt and spoke with hospital staff. The Respondents voluntarily gave multiple statements to the authorities, separately from each other, which were consistent. They wrote a detailed statement the next day. They allowed the police to take photos of their car and home without hesitation. They continued to cooperate with investigators, including giving another interview and voluntarily turning over their licenses. And at the hearing, they provided consistent and logical testimony demonstrating both empathy for Infant A but denying any wrongdoing.

CONCLUSION

DEEC's initial assessment is understandable given the state of the evidence at the time. But that is why a party is afforded a *de novo* hearing. Here, that resulted in significant, additional evidence—including an ability to assess the Respondents' credibility. DEEC's initial assessment should not stand. The evidence affirmatively supports the Respondent's position that they did not

harm Infant A. Given that DEEC bears the burden of proof, it has failed to carry it in this case. I recommend the agency's initial determinations be **reversed**.

SO ORDERED.

DIVISION OF ADMINISTRATIVE LAW APPEALS

Eric Tennen

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Eric Tennen
Administrative Magistrate

May 30, 2024