COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss. **Division of Administrative Law Appeals**

Department of Early Education and Care,
Petitioner

v. Docket No. OC-15-656

Laurie Lentini,
Respondent

Appearance for Petitioner:

Denise J. Carlin, Esq.
Assistant General Counsel
Department of Early Education and Care
51 Sleeper Street, 4th Floor
Boston, MA 02210

Appearance for Respondent:

Camille F. Sarrouf, Jr., Esq.
Sarrouf Law, LLP
115 Broad Street, 4th Floor
Boston, MA 02110

Administrative Magistrate:

James P. Rooney

Summary

The Department of Early Education and Care has failed to demonstrate a valid basis for revoking a family day care provider's license. Although a child had died three years earlier while in her care, there is no evidence that any failure on the licensee to watch the infant constantly while napping had any bearing on the infant's death from a bacterial infection.

DECISION

Laurie Lentini appeals from a November 13, 2015 "Order to Protect Children: Notice of Revocation" issued by the Department of Early Education and Care (EEC) revoking her family

day care license primarily because of the death in 2012 of an infant in her care. I held a hearing on September 21, 2016 at the Division of Administrative Law Appeals and recorded the hearing digitally. I admitted fourteen exhibits submitted by the EEC and nine submitted by Ms. Lentini, to which I added her appeal as a tenth exhibit. EEC presented three witnesses: Fernando Lazu, an EEC investigator, Timothy Smith, a special investigator with the Department of Children and Families, and Michael Avery, the interim regional director of the metro-Boston office of EEC. Ms. Lentini did not testify. Both parties filed closing briefs.

Findings of Fact

Based on the testimony and exhibits admitted at the hearing and reasonable inferences from them, I make the following findings of fact:

1. Laurie Lentini first received a family day care license in 1988. She operated under that license out of her home in Belmont, Massachusetts until 1996, when she voluntarily closed her program. (Lentini Ex. 9.)

2. On March 14, 2007, EEC received a complaint that Ms. Lentini was caring for children in her home without a family child care license. EEC licensing staff made an unannounced visit to the home on March 20, 2007. Ms. Lentini declined to allow the staff into her home and said that any children under her care were related to her. (Lentini Ex. 9.) On April 17, 2007, EEC issued Ms. Lentini an order to cease providing unlicensed child care. (EEC Ex. 13.) On May 30, 2007, EEC renewed Ms. Lentini's family day care license. (EEC Ex. 3.) The license allowed her to care for six children. (EEC Ex. 4.) If someone is operating an unlicensed day care, EEC will typically give that person an opportunity to obtain a license. Ms. Lentini's license was renewed much more quickly than is usual for someone EEC thought was operating

without a license. There is no need to obtain a child care license to look after the children of relatives. (Avery testimony.)

3. EEC renewed Ms. Lentini's license in 2010. (EEC Ex. 6.) By then, EEC had revised its regulations. The regulatory changes EEC adopted should have been covered in license renewal meetings. (Avery testimony.) One such change involved the adoption of a "safe sleep" rule requiring that "[c]hildren younger than six months of age at the time of enrollment must be under direct visual supervision at all times, including while napping, during the first six weeks they are in care." 606 C.M.R. § 7.10(5)(a). Typically, if EEC learns that a day care provider is not following the safe sleep rule, it will require that the provider take a two-hour training course. If it happens again, EEC will not allow the provider to care for infants. If it happens a third time, EEC will revoke the provider's day care license. (Avery testimony.[1])

4. In 2012, Ms. Lentini had arranged, prior to an infant's birth, to take her into day care in September when the infant was expected to be twelve weeks old. Ms. Lentini was caring for six children at the time, but two boys were to transfer to a pre-school at the end of August, and thus by September, she would have space to take the infant. However, the infant was born five weeks premature and the infant's mother had to return to work before September. Ms. Lentini agreed to take the infant, who was three months old, for two days per week, starting on July 23, 2012. (EEC Ex. 6.) This meant that she would potentially have seven children on days when the infant was in day care, one over the limit in her license. She would also have had four children under

1. Mr. Avery's testimony is similar to public pronouncements by EEC regarding how it will handle "safe sleep" violations. *See* http://www.mass.gov/edu/docs/eec/licensing/policies/safe-sleep-infants.pdf (EEC policy after September 1, 2014: retraining after first violation plus notification to parents of infants involved; notification to all parents in day care after second violation; third violation may result in freeze on infant enrollment or prohibition of the care of infants.)

the age of two, although her limit was three such children. EEC does not necessarily regard overenrollment as neglect, however, according to Investigator Fernando Lazu. (Lazu testimony)

5. On August 7, 2012, the infant awoke at 4:30 a.m.; her father brought her to day care at 8:05 a.m. There is no indication in the record that the father told Ms. Lentini that the infant was unwell. At 8:55 a.m., Ms. Lentini bottle-fed the infant for about 25 minutes. There is no indication in the record that Ms. Lentini, who was holding the infant during that time, noticed the infant was ill. After the other six children arrived, Ms. Lentini took them outside. The infant slept from 10:00 a.m. to 11:30 a.m. Ms. Lentini fed the children lunch around noon. She bottle-fed the infant from 12:15 to 12:50 p.m. Again, there is no indication in the record that she noticed the infant was ill. Thereafter, in accordance with a request by the father, she put the infant on her stomach and played with her for 15-20 minutes. The infant did not like being on her stomach, and so Ms. Lentini placed her on her back and continued to play with her. (Lazu and Smith testimony; EEC Exs. 4 and 6.)

6. At 1:50 p.m., Ms. Lentini placed the infant on her back in a crib for a nap. The infant was in a room with three other napping children. The other three children were also napping in a nearby room. Ms. Lentini performed household chores while the children napped. She cleaned up the lunch dishes, continued with laundry she had begun in the morning, and cleaned a toilet. The room in which the infant was sleeping was open; Ms. Lentini could hear, but not see, the infant while she was performing her chores. At around 2:10 p.m., she heard the infant crying. She went into the room and gave the infant a pacifier that had fallen out of her mouth. (Lazu and Smith testimony; EEC Exs. 4 and 6.)

7. Ms. Lentini returned to check on the infant 5 to 15 minutes later. She saw that the infant's dress was pulled up almost to her face, although it was not restricting her breathing. She picked up the infant in order to pull the dress down and noticed that the infant's arm was limp. She screamed and ran upstairs to the first floor where she met her husband who had just returned from work. He called 911 while Ms. Lentini performed CPR on the infant. Paramedics took the infant to Mr. Auburn Hospital. She died that day at 3:43 p.m. (Lazu testimony; EEC Exs. 4, 6, and 10.)

8. EEC and the Department of Children and Families (DCF) conducted a joint investigation of the infant's death. EEC Investigator Lazu and DCF special investigator Timothy Smith interviewed Ms. Lentini on August 14, 2012. The investigators discussed the EEC safe sleep rule with Ms. Lentini. She told them she knew that she should leave open the door of the room in which day care children were sleeping, but denied knowing of the safe sleep rule. (EEC Exs. 4 and 6.) Ms. Lentini surrendered her day care license that day. (Lazu and Smith testimony; EEC Ex. 5.)

9. The EEC and DCF investigators also spoke with a representative of the Middlesex DA's office, who told them that "a cause of death has not been determined . . . and there is concern the infant may have been placed on her belly during the nap." (EEC Ex. 4.) As a consequence, Ms. Lentini was reinterviewed by the police and she consistently maintained that the child, who could not roll over, was placed on her back for her nap. (EEC Ex. 6.)

10. EEC sent Ms. Lentini an undated letter stating that:

> The investigation found that you were operating your program over the license capacity and were caring for more children under the age of two than allowed for one caregiver.

> EEC found that you failed to provide direct supervision of the infant in your care. The investigation determined that you were neglectful in the care you provided.

(EEC Ex. 4.) The letter noted that Ms. Lentini had already surrendered her license. *Id*.

11. A death certificate for the infant was issued on August 13, 2012. It listed the cause of death as having been from "natural causes," specifically Klebsiella Pneumoniae Septicemia.[2] (Lentini Ex. 3.)

12. On August 29, 2012, DCF sent Ms. Lentini a letter stating that its investigation had found that she had neglected the infant who died. DCF gave Ms. Lentini an opportunity to appeal this finding. (EEC Ex. 7.)

13. Ms. Lentini appealed DCF's finding of neglect. DCF conducted a hearing at which DCF Investigator Smith testified. A copy of the death certificate was introduced at the hearing. (Smith testimony.) A DCF hearing officer reversed the initial finding of neglect. In a letter to Ms. Lentini's lawyer dated September 17, 2014, DCF stated:

> Please be advised that after review of the evidence and testimony presented at the Fair Hearing, the conclusion is to overturn the support decision regarding the above referenced matter. Please accept this letter as notification that the Department has now unsupported the allegations and that such has been entered into the Department's Central Registry.

(EEC Ex. 8.)

14. On May 12, 2015, Ms. Lentini reapplied for a day care license. She noted that she had been a family day care provider for over twenty years. She acknowledged that she had

---

2. Klebsiella [kleb-see-ell-uh] is a "type of Gram-negative bacteria that can cause different types of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections, and meningitis." https://www.cdc.gov/hai/organisms/klebsiella/klebsiella.html. (Lentini brief Ex. 11.)

previously voluntarily surrendered her license because "I had a child that died in my care (SIDS)." In response to a question "have you or a member of your household, or any person regularly on the premises ever had dealings with any child protection or child welfare agency in any sate" including "whether there were any findings that you abused or neglected a child," she answered "no." She also answered "no" to a question asking whether she "had previous involvement with EEC due to unlicensed child care." (EEC Ex. 14.)

15. EEC issued Ms. Lentini a new day care license four months later on September 28, 2015. (EEC Ex. 1.) Michael Avery, the current interim director of the regional office that approved Ms. Lentini's license, testified that the agency took into account DCF's ultimate holding that Ms. Lentini had not neglected the infant who died at her day care, but that the license should not have been approved without a review by the EEC Deputy Commissioner. He said that had he been involved at the time, he would have recommended against approval because of Ms. Lentini's issues with unlicensed care and failure to adequately supervise the infant who died. (Avery testimony.)

16. Two months later, EEC revoked the license it had just granted Ms. Lentini. It gave three reasons for this change. It declared that Ms. Lentini had provided false information in her application when she stated that she had no previous involvement with EEC due to unlicensed care and no involvement with a child welfare agency (such as DCF). It also maintained that Ms. Lentini "neglected a four-month-old infant by failing to provide direct visual supervision of the infant for fifteen minutes on the infant's fourth day in the Educator's care during which time the child was found dead." It noted that Ms. Lentini's day care was overenrolled on that day, which "impacted her ability to provide appropriate supervision of children," and concluded that "[b]y

failing to provide constant supervision of an infant new to her Program and caring for more Children that permitted by her capacity, the Educator neglected an infant who died in her care." Finally, it asserted that Ms. Lentini had "engaged in conduct determined by EEC to impair her ability to care for Children." It explained that "due to the Educator's neglect of a child enrolled in her program that led to the child's death, the Educator does not have a background free of conduct [that] bears adversely on her ability to care for children" and "[d]ue to the Educator's neglect of a child enrolled in her Program and caring for more children that permitted by her capacity, the Educator neglected an infant who died in her care." (Lentini Ex. 9.)

17. Ms. Lentini timely appealed. In her answer, she maintained that she had not provided false or misleading information in her application. She noted that she had never been found to have operated an unlicensed day care and, because she was watching family members, she was not in fact operating an unlicensed day care. As for her involvement with DCF, she honestly believed that once DCF ultimately determined that she had not neglected the infant who died, the "no" was the appropriate answer to the question of whether she had involvement with a child protection agency. She also noted that she had informed EEC in the application that a child had died in her care. That death was from natural causes according to the death certificate and there was no evidence that had Ms. Lentini been continually watching the infant while she napped the death could have been averted. (Lentini Ex. 10.)

Discussion

This appeal ultimately involves the most serious possible event that can occur in the family day care setting: a child's death while in care. Although the Department of Early

Education and Care disclaims that it believes Ms. Lentini caused the infant's death,[3] the evidence suggests that the death was the key reason for the license revocation. I conclude that the other grounds asserted by the agency are insufficient to warrant revocation of Ms. Lentini's license, and the grounds related to that death have not been substantiated. There is no evidence showing that any action or inaction on Ms. Lentini's part contributed to the infant's death.

EEC may revoke a day care license if a licensee "failed to comply with any applicable regulation" or "submitted any misleading or false statement or report required under 102 CMR 1.00 through 8.00." 102. C.M.R. § 1.07(4)(a)1 and 3. When considering what sanction to impose, EEC must consider at least the following factors:

> a) any non-compliance at the facility or program;
> (b) the risk the non-compliances present to the health, safety, and welfare of children;
> (c) the nature, scope, severity, degree, number, and frequency of the non-compliances;
> (d) the licensee's failure to correct the non-compliances;
> (e) any previous non-compliances; and
> (f) any previous enforcement action(s).

102 C.M.R. § 1.07(2).

The first ground for revocation asserted by EEC is that Ms. Lentini provided false information when reapplying for a license in 2015. Her application contained two falsehoods, in EEC's view. First, she responded "no" to a question asking whether she "had previous involvement with EEC due to unlicensed child care." There is no dispute that EEC suspected that Ms. Lentini was providing unlicensed care, and that it attempted to inspect Ms. Lentini's

---

3. In EEC counsel's closing brief, she stated: "for EEC's purpose[s], the cause of the child's death is not relevant. EEC must determine if the Respondent was providing care . . . that ensured the safety of children in her care by following EEC's regulations and policies." EEC closing brief at 2.

home in March 2007, but was denied admittance by Ms. Lentini. Nor is that any dispute that on April 17, 2017, EEC sent Ms. Lentini a letter ordering her to cease providing unlicensed care. But there is also no dispute that Ms. Lentini denied providing unlicensed care, telling EEC staff that she was providing care for children related to her. The license application question asked not whether she had involvement with EEC because the agency thought she was providing unlicensed care, but rather whether she had involvement with EEC because she was in fact providing unlicensed care. Since Ms. Lentini had a valid basis for believing she had not been providing unlicensed care, her "no" answer was not false.

The second alleged falsehood concerns her "no" response to a question about whether "you or a member of your household, or any person regularly on the premises ever had dealings with any child protection or child welfare agency in any state" including "whether there were any findings that you abused or neglected a child." There is no dispute that Ms. Lentini was investigated by a child welfare agency, the Department of Children and Families, following the death of the infant while in her care, and that DCF initially determined that she had been neglectful. Ms. Lentini maintains that she answered "no" because DCF ultimately cleared her of neglecting the infant. But the question did not ask whether she was found neglectful or cleared of the charge, just whether had any dealings with a child welfare agency over alleged neglect of a child. Thus, her answer was inaccurate. Standing alone, the answer is false and misleading. But, taken as a whole, the application is not false and misleading because Ms. Lentini had also stated in her application that she had previously voluntarily surrendered her license because "I had a child that died in my care (SIDS)." This was sufficient information to alert the agency that an investigation of the death of the child by a child welfare agency had occurred. EEC's witness

Michael Avery thought EEC was aware of DCF's investigation during the review of Ms. Lentini's application, and that DCF's ultimate finding that Ms. Lentini had not neglected the infant who died played a role in the decision to grant her a license. Because EEC is required to take into account a licensee's actions to correct a non-compliance, *see* 102 C.M.R. 1.07(2)(d), the portion of Ms. Lentini's application in which she acknowledged that a child died in her care must be considered. It is sufficient to make her application as a whole accurate and not misleading.

That was apparently EEC's view when it first reviewed her application. EEC had records of Ms. Lentini's licensing history when it was deciding whether to grant her a license in 2015. Thus, it should have known that the agency had previously thought she had provided unlicensed care and that she had been investigated by DCF after a child died in her care in 2012. If EEC thought her application answers were so misleading as to warrant a sanction, one would have expected the agency to deny her license application then. That it did not do so suggests it did not think her applicaton was misleading enough to warrant rejection.[4]

The second and third bases for revocation focus mainly on the circumstances surrounding the death of the infant, but the third basis also mentions the "allegations of previous unlicensed care." This is an insubstantial reason for revocation. That EEC suspected Ms. Lentini of providing unlicensed care has never been more than that – a suspicion. Licensing staff did not confirm that Ms. Lentini was providing unlicensed care in 2007. The April 17, 2007 letter EEC sent Ms. Lentini telling her to cease providing unlicensed care does not transform its suspicion

4. There was some testimony at the hearing about how much EEC licensing staff would have known about prior investigations of Ms. Lentini. EEC's internal practice as to what information is available to particular staff has no bearing on whether Ms. Lentini's application was false or misleading.

into proof. What proof there is involves the unusual speed with which the agency approved Ms Lentini's application for relicensing. It is hard to believe that EEC approved the application by May 30, 2007 without a satisfactory explanation by Ms. Lentini regarding her care-giving activities.

The second and third bases for revocation – neglect of the infant who died and conduct that impaired Ms. Lentini's ability to care for children – focus on two matters purportedly related to insufficient care of the deceased infant: failure to watch the infant constantly as she slept and overenrollment. The program was overenrolled by one child, but that is irrelevant. On August 7, 2012, Ms. Lentini was caring for seven children, four of whom were under the age of two, although she was licensed to care only for six children, three of them under the age of two. While overenrollment might be a stand-alone basis for imposing a sanction on Ms. Lentini,[5] EEC tied its concern about overenrollment to the death of the infant, declaring that overenrollment "impacted her ability to provide appropriate supervision of children." There is no medical or other evidence that this is true. The evidence is that Ms. Lentini paid close attention to the infant throughout the day and observed nothing amiss until she put the infant down for a nap in the early afternoon. By then, all the other children were napping, and hence none of them were distracting Ms. Lentini from providing care for the infant. Thus, EEC's decision to revoke Ms. Lentini's license comes down to whether she neglected the infant.

---

5. *See* 606 C.M.R. §7.03(2) ("At no time shall a program admit, supervise or provide care for more than the maximum number of children indicated on the license.") The approach EEC takes when a program is overenrolled is suggested in prior cases. *See, e.g., Dept. of Early Education and Care v. Monteiro*, Docket No. OC-16-22 (Mass. Div. of Admin. Law App., Dec. 21, 2016) (EEC froze enrollment after twice finding a program overenrolled; it revoked the program's license after finding that the provider's mother was caring for two previously-enrolled children in an in-law apartment.)

EEC defines neglect as "[t]he failure, either deliberately or through negligence or inability, to adequately care for, protect, or supervise children." 102 C.M.R. § 1.02. Any form of neglect is strictly prohibited. 606 C.M.R. § 7.11(4)[6]. EEC asserts that Ms. Lentini neglected the infant by failing to follow the "safe sleep" rule's requirement that "[c]hildren younger than six months of age at the time of enrollment must be under direct visual supervision at all times, including while napping, during the first six weeks they are in care." 606 C.M.R. § 7.10(5)(a). It also contends she violated regulations providing that "Educators must not engage in any other activities or tasks that could unnecessarily divert their attention from supervising the children." 606 C.M.R. § 7.10(5)(f). From this, EEC concludes that Ms. Lentini "neglected an infant who died while in her care" and her "neglect of a child enrolled in her Program . . . led to the child's death." As EEC counsel explained it in her closing brief, "the risk of allowing an individual with such a past [a history of Safe Sleep violations] was too great a risk to consider reasonable."

There is no dispute that Ms. Lentini failed to maintain constant visual supervising of the infant while she napped. Ms. Lentini was nonetheless attentive. She left the door of the room in

---

6. The death of the infant was investigated by both EEC and DCF, which made its own determination as to whether Ms. Lentini had been neglectful. The DCF definition of neglect is worded somewhat differently. DCF defines neglect as "failure by a caretaker, either deliberately or through negligence or inability, to take those actions necessary to provide a child with minimally adequate food, clothing, shelter, medical care, supervision, emotional stability and growth, or other essential care; provided, however, that such inability is not due solely to inadequate economic resources or solely to the existence of a handicapping condition." 110 C.M..R.§ 2.00. Despite this different phrasing, EEC regulations provide that a DCF finding of neglect provides "reasonable cause" to believe that an educator has been neglectful. 606 C.M.R. § 7.11(4)(c)3. EEC regulations do not state what consequences follow if DCF finds that an educator has not been neglectful. But considering the relevance of a DCF finding of neglect, a DCF finding to the contrary should also be relevant. I do not give much weight, however, to DCF's ultimate finding that Ms. Lentini was not neglectful in her care of the infant who died because that finding was unexplained. Although it is likely that DCF changed it mind as to whether Ms. Lentini neglected the infant once it learned of the cause of death, DCF did not say that in its brief description of its ultimate decision.

which the infant slept open. She responded once to the infant's cry and came in to check on her later, but she was not watching her at all times. This was a violation the "safe sleep" rule. But as Mr Avery described it, this one-time failure to adhere to the safe sleep rule would normally have warranted a retraining, not a license revocation. The only plausible basis for revocation here would be if there was evidence that Ms. Lentini's failure to watch the infant constantly led to her death. EEC presented no evidence to show this.

The "safe sleep" rule was adopted by EEC "to reduce the risk of infant death in child care settings from Sudden Unexplained Infant Death (SUID) and Sudden Infant Death Syndrome (SIDS). https://www.mass.gov/files/documents/2016/08/qe/safe-sleep-infants.pdf. SIDS is "the unexplained death, usually during sleep, of a seemingly healthy baby less than a year old." Babies sleeping on their stomach or their side are at greater risk of SIDS. *See* https://www.mayoclinic.org/diseases-conditions/sudden-infant-death-syndrome/symptoms-causes/syc-20352800. SUID is a broader term that encompasses SIDS and accidental strangulation. https://www.cdc.gov/sids/aboutsuidandsids.htm. To reduce SIDS and SUID, EEC requires that infants be placed for sleep on their backs, and that day care licensees maintain a constant watch on sleeping infants younger than six months old. https://www.mass.gov/files/documents/2016/08/qe/safe-sleep-infants.pdf.

The seemingly healthy infant in Ms. Lentini's care died suddenly on August 12, 2012 while napping. At the time, EEC would have had every reason to suspect that the child had died of SIDS and to suspend Ms. Lentini's license until it determined what responsibility she bore for the infant's death, if any. *See* 102 C.M.R. 1.07(5)(a).[7] Had the infant died of SIDS, there might

7. 102 C.M.R. 1.07(5)(a) allows EEC to:

well have been a plausible basis to believe there existed a connection between the death and Ms. Lentini's failure to watch her every second while she napped.

The infant died, however, not of SIDS, but of a previously-undetected bacterial infection. It is not clear at all from the evidence what Ms. Lentini's actions had to do with the death. There is no evidence that she knew or should have known that the infant was ill, let alone that the infant was ill with a potentially fatal Klebsiella infection. The infant's father did not tell Ms. Lentini when he dropped her off on August 12, 2102 that his daughter was ill. Ms. Lentini did not notice anything wrong with the infant when she bottle-fed her twice at length, nor when she observed her throughout the morning. There is also no evidence regarding the epidemiology of the bacterial infection that killed the infant, Klebsiella Pneumoniae Septicemia,[8] particularly how it killed the infant with no apparent warning. There is no evidence that any action on Ms. Lentini's part could have saved the child's life. Thus, there is no evidence that, had Ms. Lentini maintained a constant watch on the sleeping infant and noticed as soon as she stopped breathing, the result would have been any different.

In sum, the evidence shows that Ms. Lentini did not adhere to the "safe sleep" rule, but no connection has been established between this failure and the infant's death. This violation, without proof of a connection to the infant's death, would have warranted EEC to sanction Ms. Lentini in its usual fashion by requiring her to be trained on "safe sleep." Absent proof of a connection between her failure to watch the infant constantly while she napped and the infant's

---

> suspend any license or approval without a prior hearing if failure of the licensee to comply with any applicable regulation results in an emergency situation which endangers the life, health, or safety of children or staff present in the program or facility.

8. See https://emedicine.medscape.com/article/219907-overview#a4.

death, it would be unreasoned and arbitrary to deviate from this standard practice and revoke her license.

EEC had the burden of proof to justify its revocation of Ms. Lentini's license. Because it failed to demonstrate an adequate, reasoned basis for revoking her license, I recommend that the revocation be lifted and Laurie Lentini's family day care license be returned to her.

DIVISION OF ADMINISTRATIVE LAW APPEALS

James P. Rooney
First Administrative Magistrate

Dated: December 7, 2017