



STATE OF DELAWARE
Child Death, Near Death and Stillbirth Commission
900 King Street
Wilmington, DE 19801-3341

CAPTA¹ REPORT

In the Matter of
Kyle Harrison Jr.
Minor Child²

9-03-2008-00003

September 16, 2011

¹ The federal Child Abuse Prevention and Treatment Act requires the disclosure of facts and circumstances related to a child's near death or death. 42 U.S.C § 5106 a(b)(2)(A)(x). See also, 31 Del.C. § 323 (a).

² To protect the confidentiality of the family, case workers, and other child protection professionals, pseudonyms have been assigned.

Background and Acknowledgements

The Child Death, Near Death and Stillbirth Commission (“CDNDSC”) was statutorily created in 1995 after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The mission of CDNDSC is to safeguard the health and safety of all Delaware children as set forth in 31 Del.C., Ch., 3.

Multi-disciplinary Review Panels meet monthly and conduct a retrospective review of the history and circumstances surrounding each child’s death or near death and determine whether system recommendations are necessary to prevent future deaths or near deaths. The process brings professionals and experts from a variety of disciplines together to conduct in-depth case reviews, create multi-faceted recommendations to improve systems and encourage interagency collaboration to end the mortality of children in Delaware.

Summary of Incident

The case regarding Kyle Harrison is considered a child death incident due to diphenhydramine intoxication with perpetrators unknown. At the time of Kyle’s death, Kyle was two months eight days of age and residing in the home of his mother and alleged father.

Kyle was born at thirty five weeks gestation at approximately 1255 hours on the 16th of July. At birth Kyle weighed 2265 grams (4 pounds 15.89 ounces) and was a singleton birth. During pregnancy mother received no prenatal care. Upon birth, Kyle presented with no congenital anomalies. Kyle was admitted to the Neonatal Intensive Care Unit (NICU) due to hypoglycemia which was treated via intravenous fluid for approximately one day. Upon discharge, Kyle was placed into the care of his mother and alleged father.

On the day of Kyle’s death, Kyle was found unresponsive while attending daycare. The daycare, which was licensed by the Office of Child Care Licensing (OCCL) regulations, stated that the child had been sleeping since around 1430 hours. Daycare staff stated that Kyle was believed to have been placed to sleep on his back. Between 1700 and 1715 hours an aunt arrived to pick Kyle up from daycare. It was at that point in time that Kyle was found to be unresponsive and on his back.

Kyle was transported by foot to a local pediatrician’s office, attempts at resuscitation occurred until Emergency Medical Services arrived. Cardiopulmonary Resuscitation (CPR) continued and Kyle was then intubated and intraosseous access was established. Kyle was then transported to a children’s hospital where it was observed that his pupils were fixed and dilated. After numerous unsuccessful attempts at resuscitation, Kyle was pronounced dead at 1800 hours.

Past medical history revealed that three days prior to Kyle’s death, Kyle was seen by his primary care physician for complaints by mother of “constant crying.” It was reported that Kyle had been crying nonstop for the past three days and that the crying “episodes” would last approximately 30 to 40 minutes in the early evenings. Mother also reported that Kyle seemed to be gassy. Kyle was diagnosed with colic and it was also noted that he had minor nasal congestion. Less than one month prior to Kyle’s death,

Kyle was seen by his primary care physician for complaints by mother of congestion at night and concerns with breathing. At that point in time, Kyle was diagnosed with an upper respiratory infection (URI).

The Division of Family Services Child Abuse and Neglect Report Line received a referral pertaining to Kyle's death and began an institutional abuse investigation in collaboration with local law enforcement. After a thorough investigation by the Division of Family Services, the case was unsubstantiated with concern for abuse and neglect.

The Office of Medical Examiner found that Kyle had ingested a lethal dose of the substance known as diphenhydramine, the active ingredient in the over-the-counter medicine *Benadryl*. In collaboration with local law enforcement, a timeline was established which excluded the daycare as the source of ingestion. It was determined that based upon the fact that Kyle's bottle's were pre-made at home by Kyle's mother, if a dose of Benadryl was given to Kyle while he was attending daycare, it was done so without knowing that Kyle's bottles had contained the substance. Therefore it was shown that the daycare had no intent to harm Kyle and any allegations against the daycare for institutional abuse were dismissed.

Through the investigation by the Division of Family Services it was made known that the daycare had been under investigation by the OCCL on four separate occasions. In each of these previous complaints, it was determined by OCCL that there was not enough evidence to substantiate. However, with regard to Kyle's death, OCCL substantiated the daycare for incorrect child to staff ratios and other non-compliances were noted as well. The daycare was placed on compliance probation which was withdrawn shortly thereafter. Since this incident, OCCL has continued to receive numerous complaints against the daycare. Out of seven complaints, OCCL has only substantiated one complaint due to lack of supervision which was directly observed by a Division of Family Services' caseworker.

As a result of the investigation conducted by law enforcement and in collaboration with the Attorney General's Office, no criminal charges were brought forth in this case due to the fact that there was insufficient evidence and therefore a perpetrator was unable to be identified and a timeframe was unable to be established.

System Recommendations

After review of the facts and findings of this case, the panel determined that reasonable standards of practice were met by the systems involved; therefore, no recommendations were put forth. However, an ancillary issue that was noted pertained to local law enforcement's death scene investigation as it relates to the collection of evidence. CDNDSC recommends that all law enforcement who responds to such an investigation receive training in best practices for maintaining and securing a crime scene with specific regard to the preservation of evidence.

In addition, CDNDSC collaborated with the Office of Child Care Licensing to provide the child care facility with training regarding Infant Safe Sleeping Practices since unsafe sleeping practices were noted during the review.