

# South Carolina Drug Endangered Children Protocol (SCDEC Protocol)

The SCDEC Protocol addresses a narrow but dangerous category of cases: The investigation of a home or other structure where children are exposed to the manufacture of methamphetamine.<sup>1</sup> In all such cases, procedures must be in place to protect children exposed to harmful substances and to ensure that evidence is collected in a forensically sound manner. This protocol addresses both of these goals.

## Part One: Pre-Response

### Law Enforcement

1. **Contact the Drug Enforcement Administration.** Prior to any operational briefing, contact the Drug Enforcement Administration (DEA).<sup>2</sup>
2. **Contact a CPS worker.** Prior to the operational briefing, contact a CPS worker who is certified in the SCDEC Protocol. The CPS worker should attend the operational briefing.
3. **Obtain search warrants.** When drafting warrants, keep in mind the need to search for evidence of danger to children (chemicals in cupboards and other containers within the reach of children; sexually explicit material that is commonly found among methamphetamine addicts).

### Child Protective Services (CPS)

1. **Gather clothing for children.** Create a clothes bank from local merchants or other organizations that are able to provide clothing for children (consider also asking for donations of blankets, stuffed animals, books, and games). Implement a system for taking the clothes and comfort items to the scene to replace contaminated items.
2. **Begin identifying potential foster care placements.** Maintain information for foster parents on caring for children who have been exposed to a methamphetamine lab.

1. Although inspired by the methamphetamine problem in our community, this protocol could be applied to any situation involving children's exposure to hazardous chemicals.
2. DEA must be informed of an interdiction in order to use federal resources to clean up meth sites. DEA also must be informed of any meth lab interdiction/cleanup to identify contaminated areas to collect that data.

### Fire Department/Emergency Medical Services

**Plan decontamination procedure.** Work with local law enforcement to prepare a method of decontaminating any person located at the site of a lab.

## Part Two: Responding at the Scene

### Law Enforcement

1. **Take the lead in securing the scene.** In addition to securing the scene for evidence collection purposes, LE must secure the scene to protect all people present. CPS and Fire Department/EMS (FD/EMS) responders should not approach or enter buildings until the premises are declared safe by law enforcement.
2. **Notify CPS immediately if children are at the scene.** If CPS has not been involved in the pre-operational briefing, notify CPS immediately if children are found at a lab site. CPS also should be notified if children are not at the scene, but there is reason to believe: (a) children have been exposed to chemicals or drugs from the lab; and (b) a parent or guardian allowed the children to be at the lab site.
3. **Protect any children at the scene.** One officer should have primary responsibility for ensuring the safety of children at the scene. This officer should:
  - (a) Take Emergency Protective Custody (EPC) of the child. A case-by-case determination of EPC is necessary, but virtually every child exposed to the manufacture of methamphetamine will be in substantial and imminent danger.  
*Note: Even if CPS expects to place the child with a relative, it is important to take EPC of every child who is in imminent and substantial danger.*
  - (b) Remain with the children until the CPS worker arrives. When a CPS worker has been involved in the pre-operational briefing, the transfer to CPS care can be immediate.
  - (c) If a CPS worker is unable to respond to the scene, the officer should transport the child to a medical facility.
4. **Notify EMS immediately to evaluate and transport children to medical care when urgent health concerns or evidence of contamination of children are present.**

5. **Decontaminate children exposed to toxins.** All children should be decontaminated under the supervision of DEA-certified or hazmat-trained personnel.

(a) Special consideration should be given to children's privacy and dignity and children should immediately be provided age-appropriate clothing.

(b) Following decontamination, contaminated clothing should be placed in a plastic bag pursuant to evidence collection procedures.

6. **Identify chemicals for purposes of children's health care.** Use Form Two to identify chemicals at the scene. A duplicate of this form (Form Three) should accompany children to the medical examination and should become part of the children's health care records.

7. **Collect evidence.**

(a) Photograph or videotape the location. When making a visual record of the location, pay special attention to chemicals and weapons accessible to children (e.g., in or near the kitchen, bedrooms, playrooms).

(b) Photograph or videotape the children. Record the general condition of children that would show evidence of abuse, neglect, contamination, or other injury.

(c) Measure and record location of chemicals and other items that are dangerous to children.

(d) Seize physical evidence pursuant to evidence handling procedures. Likely items include: computers, weapons, chemicals, blister packs, and sexually explicit materials.

*Note: Follow appropriate agency protocols and policies concerning the collection, storage, and disposal of hazardous materials.*

8. **Interview children.** As soon as possible (usually within 48 hours), conduct a forensic interview of children pursuant to local interviewing protocols. The purpose of this interview is to gather information from children about harms they may have experienced.

#### Child Protective Services

1. **Attend to children at the scene.** After law enforcement has taken emergency protective custody of any children, the CPS caseworker should assume the primary role with respect to any children at the scene and remain with the children through the medical assessment and until the children are in appropriate placement.

2. **Collect information on children's health history.** Using Form Four, collect health history information about children from parents, children, or other adults available at the scene. This form should become part of the medical record at the facility evaluating the child.

(a) If a search can be safely conducted, check the facility for children's medication, medical equipment (e.g., nebulizer, glucometer), glasses, contacts, and other equipment. Thoroughly describe all medical equipment on Form Four. In most cases, medications and medical equipment that have been exposed to toxins in a methamphetamine lab will need to be destroyed.

(b) To the extent possible, obtain a signed release from parents or legal guardians for access to all prior medical records of children.

3. **Accompany children to the medical facility.**

(a) Children who are not in critical condition should be decontaminated at the scene before any transportation to a medical facility.

(b) CPS should inform the health care provider of the children's health records, medications, and any health equipment used by the child.

4. **Attend to children not at the scene.** Children who have been exposed to a lab may be at another location at the time of the interdiction. CPS must attend to these children who are not at the scene. In cooperation with law enforcement, CPS should promptly evaluate the safety and well-being of these children. The medical components of this protocol should be followed for any children with significant exposure to a site.

#### *Emergency Medical Services (EMS)*

1. For all children who are not obviously critical, perform a field medical assessment consisting of: *vital signs* (temperature, pulse, respirations, blood pressure); and the *pediatric triangle of assessment* (airway, breathing, circulation).

2. Transport any children to the hospital immediately if:

(a) The lab is actively manufacturing methamphetamine at the time of the interdiction;

(b) There is an explosion at the lab where children are present;

(c) The children appear ill; or

(d) There are signs of chemical exposure, including:

(i) Breathing difficulty or distress, prolonged coughing, wheezing, gagging, dry or sore throat, pain or tightness in chest;

(ii) Red, watering, burning eyes;

(iii) Burns or a burning sensation on the skin;

(iv) Strong smell of ammonia, cat urine, chlorine, or other chemical odors on the children or clothing;

- (v) Unusual behavior (e.g., very sleepy or difficult to arouse in the daytime, overly stimulated, fidgeting, trembling, agitated).

*If there are signs of acute chemical irritation, give first aid immediately, including flushing eyes and skin with water.*

### Part Three: Medical Assessments

#### Immediate Care Assessment

All children should be taken to an appropriate medical facility for an immediate care assessment within 4 hours, and not later than 6 hours, of a child's removal from a methamphetamine lab. The facility to be used will depend upon the severity of the medical condition, the urgency of the problem, and the time of day.

An appropriate medical facility includes: (a) a provider affiliated with a regional child advocacy medical assessment center; (b) a local physician trained in the SCDEC Protocol; or (c) an emergency department trained in the SCDEC Protocol.

1. **Review child's medical history.** The physician should receive information from CPS and law enforcement on the chemicals to which children may have been exposed and the children's medical history (to the extent this is available).
2. **Review of systems (standard medical review).** This review should pay attention to neurological and respiratory status.
3. **Urine toxicology screen.** Collect a urine specimen for toxicology screening *within 6 hours, and not later than 12 hours*, of the discovery of a child at a lab site.
  - (a) Instruct to report urine toxicology screen at any detectable level.
  - (b) Follow up on all positive urine tox screen with gas chromatography/mass spectroscopy.
  - (c) Be sure to document the chain of custody.
  - (d) Instruct to save a portion of the sample for later confirmation of positive test results.
4. **Perform O<sub>2</sub> saturation level.** Consider chest X-ray AP/lateral, if indicated.
5. If appropriate to the medical facility, follow the steps in the baseline medical assessment.

#### Baseline Medical Assessment (within 24 to 72 hours)

Within 24 to 72 hours after a child is identified at a lab site, the child should receive a baseline assessment from an appropriate medical provider. An appropriate medical provider is: (a) a provider affiliated with a regional child advocacy medical assessment center; or (b) a local physician trained in the SCDEC Protocol. Prompt medical assessment is warranted due to the

risk of toxicologic, neurologic, respiratory, dermatologic, or other adverse effects of methamphetamine lab exposure, and the high risk of abuse and neglect.

1. **Review child's medical history.**
2. **Perform a complete pediatric physical exam.** Include as much of the Early Periodic Screening, Detection, and Treatment (EPSDT) exam as possible. Pay particular attention to vital signs (temperature, heart/respiratory rate, blood pressure), the *neurologic screen* and *respiratory status*.
3. **Conduct the following evaluations:**
  - (a) Liver function tests: AST, ALT, Total Bilirubin and Alkaline Phosphatase.
  - (b) Kidney function tests: BUN and Creatinine.
  - (c) Electrolytes: Sodium, Potassium, Chloride, and Bicarbonate.
  - (d) Complete Blood Count (CBC).
  - (e) Consider lead level (on whole blood).
  - (f) Obtain urinalysis and urine dipstick for blood.
  - (g) Obtain results of urine toxicology screen/confirmatory tests done at immediate care assessment.
4. **Conduct a developmental screen.** This is an initial age-appropriate screen, not a full-scale assessment; may need referral to a pediatric specialist.
5. **Provide a mental health screen**, as clinically indicated. These services require a qualified pediatrician or mental health professional and may require a visit to a separate facility.
6. **Follow-up.** For any positive findings, follow-up with appropriate care as necessary. All children must be provided long-term follow-up care.

#### Follow-up care

1. **30 day visit.** A visit for initial follow-up care should occur within 30 days of the baseline medical assessment to reevaluate comprehensive health status of the child, identify any latent symptoms, and ensure appropriate and timely follow-up of services. If possible, the visit should be scheduled late in the 30-day time frame for more valid developmental and mental health results. Follow-up on any abnormal test results.
2. **Long-term follow-up.** Long-term follow-up care is designed to monitor physical, emotional, and developmental health; identify possible late developing problems related to the methamphetamine environment; and provide appropriate intervention. At minimum, a pediatric visit is required 12 months after the baseline medical assessment.

Children considered to be drug endangered should receive follow-up services a minimum of 18 months after identification.

- (a) Follow-up of previously identified problems.
  - (b) Perform (EPST) comprehensive physical exam and laboratory examination with particular attention to: (1) liver function (repeat panel at 30-day visit only unless abnormal); (2) respiratory function (history of respiratory problems, asthma, recurrent pneumonia, check for clear breath sounds; (3) neurologic evaluation.
  - (c) Perform developmental screen.
3. **Developmental and mental health evaluations.** The following services require a child psychologist, qualified mental health professional, or licensed therapist.
- (a) Perform a full developmental examination using an age-appropriate instrument within 30 days and 12 months after the baseline medical assessment.
  - (b) Perform a mental health evaluation within 30 days and 12 months after the baseline medical assessment.
  - (c) If abnormal findings, schedule referral and intervention with appropriate provider.

## Part Four: Implementing the Protocol

### *Training and dissemination*

1. **Train first responders.** First responders, medical professionals, and CPS should receive in-depth protocol training resulting in SCDEC Protocol certification. Only personnel certified in the SCDEC Protocol may participate on a DEC team.
2. **Train the child protection community.** Pediatricians, judges, foster parents, school personnel, and guardians alike should receive general DEC training.
3. **Mail to relevant professionals.** Mail the protocol to all South Carolina hospitals with the request that it be discussed at a staff meeting within the Emergency, Pediatrics, Nursing, and Administration departments.

### *Protocol review*

1. The county DEC team should review all cases of children removed from methamphetamine lab sites. The DEC team should work closely with the local child abuse multi-disciplinary team in conducting these case reviews.
2. A statewide working group will be established to receive feedback on the protocol from counties and make appropriate revisions to the protocol.
3. DEC team certification will be renewed annually.

## Explanation of Forms

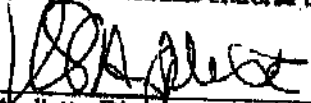
1. The forms appended to this protocol and are intended to be incorporated as part of the SCDEC Protocol. The forms are:  
Form One: Hazards to Children  
Form Two: Location of Chemicals (Law Enforcement Copy)  
Form Three: Location of Chemicals (Medical Provider Copy)  
Form Four: Form Four: Medical Information  
Form Five: Medication  
Form Six: Medical Exam Information
2. Forms One and Two are intended to assist law enforcement officers in documenting dangers at the scene posed to children. These forms should become a part of the law enforcement officer's case file.
3. Forms Three through Six are intended to assist medical providers in diagnosing and treating children. These forms should become part of the child's medical record and remain with medical providers.

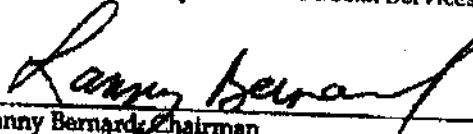
## Acknowledgements


Much of the language in this protocol is taken from the Nebraska CHEM-L Protocol developed under the direction of Dr. Gregg Wright at the University of Nebraska's Center on Children, Families, and the Law. The medical portions of this document were taken from the Kempe Child Protection Team in Denver, Colorado, under the direction of Dr. Kathryn Wells. Additional language was adapted from a model protocol developed by the National Alliance for Drug Endangered Children. We are grateful to these individuals and organizations for granting us permission to borrow liberally from their documents.


# Endorsements


The following individuals endorse the SCDEC Protocol on behalf of their agencies or associations.

  
Kim S. Aydtotts, Director  
South Carolina Department of Social Services


  
Lanny Bernard, Chairman  
Emergency Medical Services Advisory Committee

  
W. Lee Catoe, Director  
South Carolina Department of Alcohol and Other Drug Abuse Services


  
Sheriff A. Lane Cribb, President  
South Carolina Sheriffs' Association

  
Harry W. Davis, Jr., Director  
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Hon. W. Barney Giese, President  
South Carolina Solicitors' Association

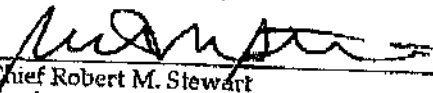
  
Joe H. Palmer, President  
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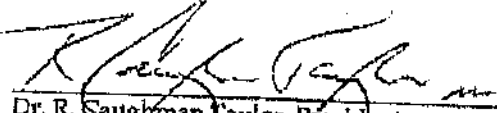
  
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