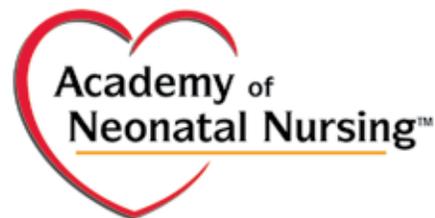




For health care professionals:

Guidelines on prevention of and response to infant abductions

10th edition
2014



THE TYPICAL ABDUCTOR

Profile developed from an analysis of 292 cases occurring from 1983 through June 2014.

1. Usually a female of childbearing age, range now 12 to 55, who appears overweight to suggest pregnancy.
2. Most likely compulsive; most often relies on manipulation, lying and deception.
3. Frequently indicates she has lost a baby or is incapable of having one.
4. Often married or cohabitating; companion's desire for a baby or the abductor's desire to provide her companion with "his" baby may be the motivation for the abduction.
5. Usually lives in the community where the abduction takes place.
6. Frequently initially visits nursery and maternity units at more than one health care facility prior to the abduction; asks detailed questions about procedures and the maternity floor layout; frequently uses a fire exit stairwell for her escape; and may also try to abduct from the home setting.
7. Usually plans the abduction, but does not necessarily target a specific infant; frequently seizes any opportunity present to abduct a baby.
8. Frequently impersonates a nurse or other allied health care personnel.
9. Often becomes familiar with health care staff members, staff member work routines and victim parents.
10. Often demonstrates a capability to provide care to the baby once the abduction occurs, within her emotional and physical abilities.

In addition an abductor who abducts from the home setting (is):

11. More likely to be single while claiming to have a partner.
12. Often targets a mother **whom she may find by visiting health care facilities** and tries to meet the target family.
13. Often plans the abduction **and** brings a weapon, although the weapon may not be used.
14. Often impersonates a health care or social services professional when visiting the home.

Note: There is no guarantee an infant abductor will fit this description.

Prevention is the best defense against infant abductions.
Know whom to look for and that person's mode of operation.

To receive free technical assistance by telephone or on-site
call the National Center for Missing & Exploited Children® at
1-800-THE-LOST® (1-800-843-5678).

Post this flier out of view of the public in locations such as at the nurses' station, nurses' lounge, medication room, emergency department, security office and risk management unit.
A PDF version of this flier is available at www.missingkids.com/InfantAbduction.

For health care professionals:

Guidelines on prevention of and response to infant abductions

**10th edition
2014**

**John B. Rabun, Jr., ACSW
Director, infant abduction response
National Center for Missing & Exploited Children®**

**Copyright © 1989, 1991, 1992, 1993, 1996, 1998, 2000, 2003, 2005, 2009 and 2014
National Center for Missing & Exploited Children.
All rights reserved.**

**This information is intended solely to provide general,
summary information and is not intended as legal or security advice
applicable to specific matters.**

**National Center for Missing & Exploited Children®, 1-800-THE-LOST® and CyberTipline®
are registered trademarks of the National Center for Missing & Exploited Children.**

**1-800-THE-LOST (1-800-843-5678)
www.missingkids.com**

Contents

Acknowledgments.....v	
A message to the reader.....vii	
1. The problem.....1	
2. The offender and modes of operation.....5	
3. Guidelines for health care professionals.....9	
3-1 General.....9	
3-2 Proactive measures.....13	
3-3 Physical security safeguards.....22	
3-4 Critical incident response plan.....26	
General guidelines.....26	
Nursing guidelines.....29	
Security guidelines.....33	
Law enforcement guidelines.....35	
Public relations guidelines.....36	
4. Liability.....43	
5. After discharge/transfer from a maternal child care unit.....47	
Special care nurseries.....49	
Pediatric units.....50	
Outpatient areas.....52	
Homes.....54	
6. What parents need to know.....57	
7. Self-assessment for health care facilities.....63	
8. Bibliography.....91	

Acknowledgments

The National Center for Missing & Exploited Children® is indebted to the individuals noted below whose knowledge, expertise, original contributions to and/or review made this 10th edition possible. For ease of use by health care professionals, contributors are listed in groupings per professional roles. **Note:** Additional individuals have been so acknowledged for their contributions to the previous editions.

Health care security and safety

Russell Colling, CHPA, CPP, consultant, Colling & Kramer Healthcare Security Consultants, Salida, Colorado
Jim Crumbley, CPP, PPS, J Crumbley Associates, Lawrenceville, Georgia
William A. Farnsworth, CHPA, director, Safety and Security, St. Vincent's Medical Center (Retired), Jacksonville, Florida
Linda M. Glasson, CHPA-L, health care security consultant, Williamsburg, Virginia
Evelyn F. Meserve, CHPA-L, HEM, executive director, International Association for Healthcare Security & Safety, Glendale Heights, Illinois
Bonnie S. Michelman, CPP, CHPA, director, police and security and outside services, Massachusetts General Hospital, Boston, Massachusetts
Tim Portale, chief safety & security officer, HCA, Nashville, Tennessee
Fredrick G. Roll, MA, CHPA-F, CPP, president, Roll Enterprises, Inc., Fredrick, Colorado
Thomas A. Smith, CHPA, CPP, president, Healthcare Security Consultants, Inc., Chapel Hill, North Carolina
David Sowter, president, National (United Kingdom) Association for Healthcare Security, and trust security risk manager, Hammersmith Hospitals NHS Trust, London (Retired), Esher, Surrey, United Kingdom

Nursing

Ann Wolbert Burgess, RN, DNSc, professor of psychiatric nursing, Boston College School of Nursing, Boston, Massachusetts
Nancy Chambers, RN, BSN, nurse manager, Maternal Newborn Unit, Intermountain Healthcare, LDS Hospital, Salt Lake City, Utah
Robert E. Emerson, RNC-NIC, MSN, IBCLC, NICU/nursery nurse, Women and Newborns Center, MedStar Southern Maryland Hospital Center, Clinton, Maryland
Connie Blackburn Furrh, RN, risk manager, Oklahoma Spine Hospital, Oklahoma City, Oklahoma

Law enforcement

William Hagmaier, unit chief, National Center for the Analysis of Violent Crime, FBI Academy (Retired), Fredericksburg, Virginia

Lee Reed, detective, Youth Division, Abilene (Texas) Police Department (Retired)

Pediatrics

Daniel D. Broughton, MD, Department of Pediatric and Adolescent Medicine, Mayo Clinic (Retired), Rochester, Minnesota

Sharon W. Cooper, MD, FAAP, University of North Carolina, Chapel Hill
Developmental and Forensic Pediatrics, PA, Fayetteville, North Carolina

Risk management

Sharon L. Groves, BSN, MSA, ARM, CPHRM, DFASHRM, AVP Risk Management, BerkleyMed, Columbus, Ohio

Faye W. Robbins, ARM, CPHRM, Risk Management, Roper Saint Francis Healthcare System, Charleston, South Carolina

Other professionals

Robert B. Bucknam, vice president, 3M, Reston, Virginia

Christine Candio, RN, FACHE, chief executive officer, Inova Alexandria Hospital, senior vice president, Inova Health System, Alexandria, Virginia

Robert Christensen, LPE, CBP, senior forensics advisor, 3M, Reston, Virginia

Stephen J. Hall, president and owner, Maryland Sales Training & Management Development, Inc., Annapolis, Maryland

John Kittle, director of national accounts, Mead Johnson Nutrition™, Atlanta, Georgia

Jim McKenna, president and chief operating officer, CertaScan Technologies™, Fairfield, Connecticut

National Center for Missing & Exploited Children

John B. Rabun, Jr., ACSW, director, infant abduction response

Cathy Nahirny, senior analyst, infant abduction cases

Paul D. Lockwood, CPP, director of corporate protection and administration

Preston Findlay, counsel, Missing Children Division

Marsha Gilmer-Tullis, executive director, Family Advocacy Division

Terri Delaney, director, publications

A message to the reader

The National Center for Missing & Exploited Children® or NCMEC is a resource for law enforcement and the health care industry about the topic of infant abductions. As the nation's clearinghouse about missing and sexually exploited children, NCMEC maintains statistics regarding the number and location of infant abductions and provides technical assistance and training to health care and security professionals in an effort to prevent infant abductions from occurring in their facilities. NCMEC also provides evidence-based guidance about how to respond when an infant abduction does occur and technical assistance to law enforcement during and after an incident. Many organizations have joined NCMEC in the effort to set guidelines and standards to better safeguard infants from abduction including those noted below.

The Joint Commission, an accrediting agency, is a private, not-for-profit organization dedicated to improving the quality and safety of medical care provided to the public. The Joint Commission sets the principal standards and evaluations for a variety of health care organizations. Infant/pediatric security is an issue of concern to The Joint Commission and is often referred to as a security sensitive area due to the high risk. Such areas require a specific access control plan, initial and periodic security related training for staff members working in those designated areas, and a critical incident response plan. It is common for Joint Commission surveyors to ask in-depth questions regarding the implementation of infant/pediatric security plans.

Infant/pediatric abductions or discharge to the wrong family are reviewable sentinel events under the sentinel event standards of The Joint Commission. A Sentinel Event Alert relative to infant abductions was issued by The Joint Commission on April 9, 1999, and is available on their website at www.jointcommission.org. In addition **The Joint Commission's official handbook for the current year should be consulted as important reference information. The primary Joint Commission security requirements relative to infant security are found in the Environment of Care Section of the Joint Commission's requirements.** Joint Commission publications may be obtained at www.jcrinc.com or by calling 1-877-223-6866.

The International Association for Healthcare Security & Safety or IAHSS publishes *Healthcare Security: Basic Industry Guidelines* and *Security Design Guidelines for Healthcare Facilities*. Both of these publications contain important reference material addressing infant and pediatric operational and design security elements. The basic industry guidelines contain sections about security sensitive areas including infant and pediatric abduction prevention and response.¹ The security design publication contains specific security design guidelines for infant and pediatric facilities. Both of these resources are available in booklet form online at www.iahss.org or by calling 1-888-353-0990.

In 2002 the National Quality Forum published 27 serious reportable events with a 28th added in 2006 and updates issued in 2011. The events are easily identifiable, easily measurable and of a nature the risk of occurrence is influenced by policies and procedures of the health care facility. One of these 28 serious reportable events is abduction of a patient of any age. Centers for Medicare and Medicaid have linked payment to some of these events. Patient Safety — Obstetrical **never events** have listed infant abduction as one of these events.

¹Currently Guideline 09.02 in *Healthcare Security: Basic Industry Guidelines* addresses infant/pediatric security. That document, however, is under revision with guideline number changes pending.

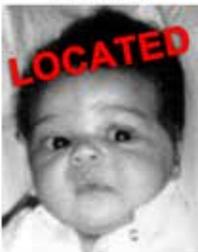
The guidelines presented in this document are intended to provide, in part, security strategies and protocols to support and enhance The Joint Commission and IAHS security guidelines. The National Center for Missing & Exploited Children encourages facilities not accredited by The Joint Commission to follow the intent of The Joint Commission requirements and IAHS guidelines.

The information and practices described in these guidelines have been provided for informational purposes only and do not constitute legal advice. This guide may contain time sensitive information and is subject to change. Obtain legal advice from qualified health care counsel before acting in any specific situation. This information is not intended to be exhaustive about the subjects addressed. There is no guarantee any benefit will accrue to entities adhering to these points. Any resources or websites are offered as reference points only and without endorsement to content, accuracy or currency.

Caution The focus of this guide is defined by the criteria of age of the victim and motivation for the abduction. The cases discussed involve the abduction of infants, birth through 6 months, for nontraditional motives. The age criterion is fairly straightforward and obvious. It is also the reason for use of the common descriptive term infant abduction used throughout this guide. It should be noted an infant is missing and presumed to be abducted until proven otherwise. The motivation criterion in these types of abductions is more complicated and more uncertain leading to the reason for use of the term nontraditional abduction. The term nontraditional refers to child abductions **not** motivated by more commonly seen reasons such as sexual gratification, profit, ransom, revenge and power. This guide focuses on cases apparently motivated by the offender's need to have a child to fill a perceived void in her life. Because motivation often is not discernible with certainty, readers must use caution when applying the findings set forth in this guide. It cannot be assumed the abduction of every infant is motivated by these nontraditional reasons and therefore fits the dynamics set forth. Individuals with other motivations and characteristics may also abduct infants. In addition offenders with the discussed motivations and characteristics may abduct toddlers and even older children. **Regardless of the setting, circumstances or perceived offender motivation, all professional and law enforcement efforts must have only one common primary goal of the safe recovery of the infant.**

Non Family Abduction

Carlina White Age Progression by NCMEC 15/2007

	<p>Birth: 7/15/2007 Missing: 04/2007 Age/Time: 23 yrs Race: Black Sex: Female Hair: Black Eyes: Brown Ht: 1'00" Wt: 8lbs</p> <p>Missing From: Harlem NY United States</p>	
---	---	--

The photo on the right is a composite image of Carlina may look like at age 19. She was last seen in a Harlem Hospital room, where she had been taken due to a high fever.

 **ANYONE HAVING INFORMATION SHOULD CONTACT**
The National Center for Missing and Exploited Children
1-800-843-5678 (1-800-THE-LOST) OR
New York City Police Department (New York) 1-212-694-7781
Or Your Local FBI



MISSING



missingkids.com

HELP BRING ME HOME

NCMEC: 1216848

Paul Fronczak

Age Progressed



Missing Since: **Apr 27, 1964**
 Missing From: **Chicago, IL**
 DOB: **Apr 26, 1964**
 Age Now: **49**
 Sex: **Male**
 Race: **White**
 Hair Color: **Brown**
 Eye Color: **Brown**
 Height: **1'8"**
 Weight: **8 lbs**



The photo on the right is a composite sketch of how Paul may appear at age 49. He was allegedly abducted by an unknown female on April 27, 1964. Paul is listed in NCIC as John Doe with a date of birth of 4/26/1964.

DON'T HESITATE!

ANYONE HAVING INFORMATION SHOULD CONTACT

Case handled by

CALL 911 or

1-800-843-5678 (1-800-THE-LOST®)



Follow us [@twitter.com/missingkids](#) [facebook.com/missingkids](#)



MISSING



missingkids.com

HELP BRING ME HOME

NCMEC: 1079986

Raymond Green

Age Progressed



Missing Since: **Nov 6, 1978**
 Missing From: **Atlanta, GA**
 DOB: **Nov 1, 1978**
 Age Now: **35**
 Sex: **Male**
 Race: **Black**
 Hair Color: **Black**
 Eye Color: **Brown**
 Height: **5'10"**
 Weight: **189 lbs**



The composite on the right shows what Raymond may look like at 31 years. His height and weight are approximations. Raymond was abducted from his home by an unknown black female on November 6, 1978. The abductor was last seen getting into a brown vehicle. She is described as being 5'08, medium build, and she may have a mole on her left cheek. The abductor may go by the name Lisa.

DON'T HESITATE!

ANYONE HAVING INFORMATION SHOULD CONTACT

Case handled by

CALL 911 or

1-800-843-5678 (1-800-THE-LOST®)



Atlanta Police Department (Georgia) 1-404-658-6666

Follow us [@twitter.com/missingkids](#) [facebook.com/missingkids](#)



missingkids.com

MISSING

HELP BRING ME HOME

NCMEC: 708557



April Williams



Missing Since: **Dec 3, 1983**
 Missing From: **Washington, DC**
 DOB: **Aug 17, 1983**
 Age Now: **30**
 Sex: **Female**
 Race: **Black**
 Hair Color: **Black**
 Eye Color: **Brown**
 Height: **2'0"**
 Weight: **11 lbs**



Sex: **Female**
 Race: **Black**
 Hair Color: **Red**
 Height: **5'3"**

The photo on the right is a composite image to show how April may look at 27 years old. She was last seen on December 3, 1983. April was allegedly abducted by an unknown female who may go by the name Laloya. She may appear similar to the composite sketch shown above. April has a birthmark on her right wrist.

DON'T HESITATE!

CALL 911 or
 1-800-843-5678 (1-800-THE-LOST™)

ANYONE HAVING INFORMATION SHOULD CONTACT

Metropolitan Police Department (Washington, D.C.)
 1-202-727-9699

Case handled by



Follow us [Twitter](#) [Facebook](#)



missingkids.com

MISSING

HELP BRING ME HOME

NCMEC: 603368



Donel Minor



Missing Since: **Dec 20, 1984**
 Missing From: **Inglewood, CA**
 DOB: **Oct 8, 1984**
 Age Now: **29**
 Sex: **Male**
 Race: **Black**
 Hair Color: **Brown**
 Eye Color: **Brown**
 Height: **1'8"**
 Weight: **10 lbs**



The photo on the right is a composite image of how Donel may look at 26 years. He was abducted from his home by an unknown person who was posing as a photographer.

DON'T HESITATE!

CALL 911 or
 1-800-843-5678 (1-800-THE-LOST™)

ANYONE HAVING INFORMATION SHOULD CONTACT

California Department of Justice 1-800-222-3463

Case handled by



Follow us [Twitter](#) [Facebook](#)

X - FOR HEALTH CARE PROFESSIONALS

1. The problem

While **not** a crime of epidemic proportions, the abduction, by **nonfamily** members, of **infants, birth through 6 months**, from health care facilities has clearly become a subject of concern for parents, maternal child care nurses, health care security and risk management administrators, law enforcement officials, and the National Center for Missing & Exploited Children® or NCMEC. With the goal of preventing crimes committed against children, NCMEC — in cooperation with the FBI, International Association for Healthcare Security & Safety and Boston College School of Nursing — has studied infant abductions from birthing/health care facilities, homes and other sites and considers them preventable in large part by hardening the target as described in this guide. **Note:** In general the crime legally attaches once the abductor crosses the threshold of the mother’s room or nursery. The abductor does **not** have to exit the unit, floor or health care facility for the crime to attach.

Because a number of infant abduction cases may not be reported to NCMEC or other organizations, the number of cases reported in this guide may be conservative. The good news is, no matter what the actual number has been, it appears to be a small percentage of infants are victims of this crime. For instance in 132 of the cases studied the infants were abducted from the premises of health care facilities. Of all the infants abducted from health care facilities, 96 percent were located and safely returned, usually within a few days to two weeks. The bed size of a facility, urban or rural, does not seem to be a factor as to whether or not they will experience an abduction. An additional 119 infants were abducted from the home following most of the same patterns as the abductions from health care facilities but with the addition of violence committed against the mother or other present caregiver. An additional 41 infants were abducted from other places such as malls, offices and parking lots. As a point of comparison, in 2013 there were nearly 4 million births in the United States,² and there are nearly 2,800 birthing facilities.³ The concerning news is, the devastating impact this crime can have on families victimized in this way.

*In general the crime legally attaches once the abductor crosses the threshold of the mother’s room or nursery. The abductor does **not** have to exit the unit, floor or health care facility for the crime to attach.*

Anecdotal evidence strongly suggests there may be numerous abduction attempts at birthing facilities each year. Information regarding attempted abductions should be reported to NCMEC at 1-800-THE-LOST® (1-800-843-5678). A NCMEC infant abduction specialist will then work with the facility to obtain needed details about the incident. NCMEC wishes to collect this information in order to identify any possible changes in the profile or emerging trends in the abduction of infants.

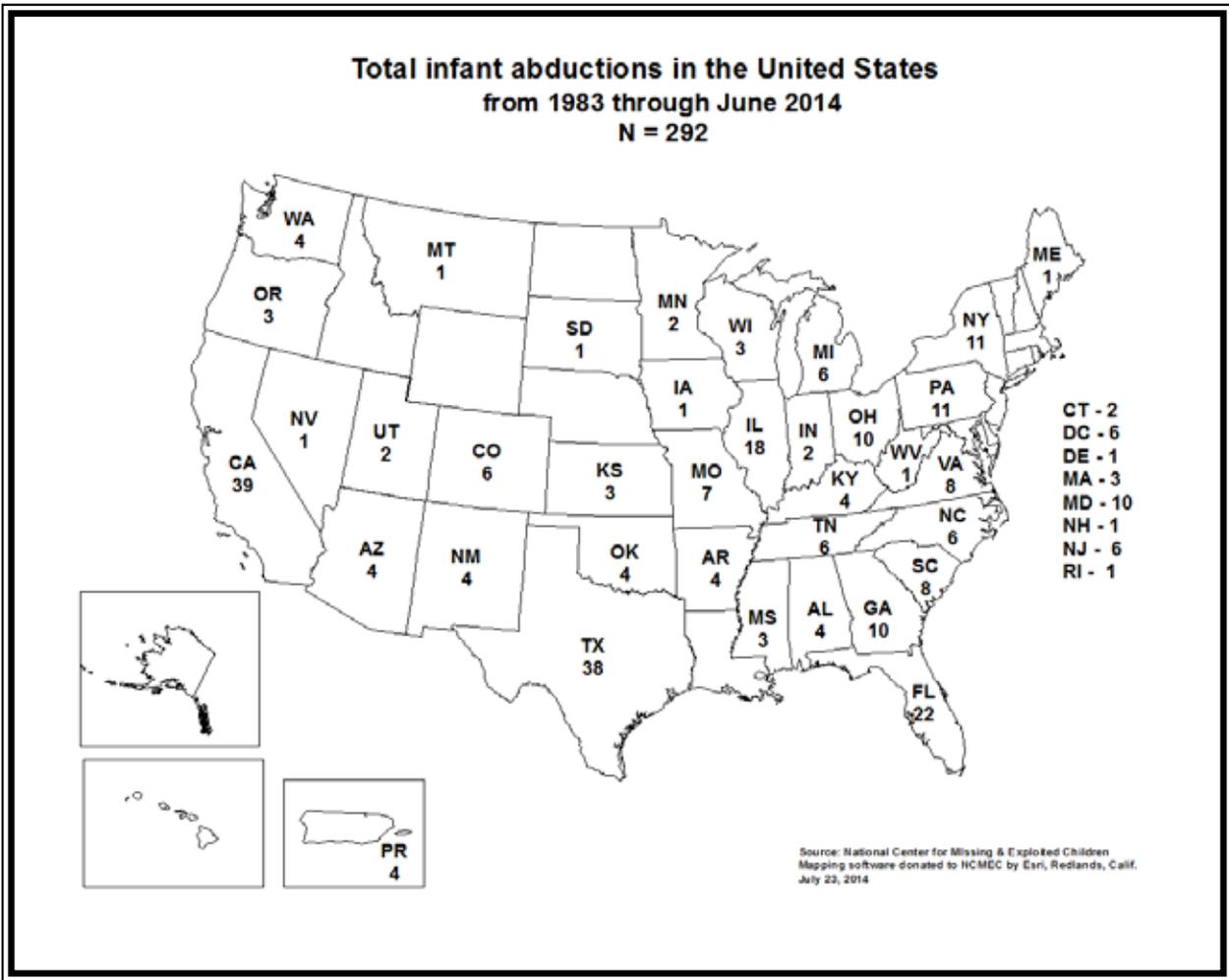
²According to “Births: Preliminary Data for 2013” by Brady E. Hamilton, Joyce A. Martin, Michelle J.K. Osterman and Sally C. Curtin in *National Vital Statistic Reports*, Vol. 63, No. 2, May 29, 2014, Page 1, there were 3,957,577 births in 2013.

³According to the American Hospital Association 2,542 hospitals in the United States reported having obstetrics inpatient care units in 2012, the most recent year of available data (*AHA Hospital Statistics: The Comprehensive Reference Source for Analysis and Comparison of Hospital Trends*, 2014 Edition, Page 160). Per *Birth Center FAQs* by the American Association of Birth Centers, accessed Oct. 28, 2013, at www.birthcenters.org/webfm_send/127, there are 255 birth centers in the United States.

TOTAL - abductions of infants from 1983 through June 2014: 292
TOTAL - still missing: 12

		Case status
Health care facilities	132	Located = 127 Still missing = 5
Mother's room	77 (58%)	
Nursery	17 (13%)	
Pediatric units	17 (13%)	
On premises: Outside building but still on grounds	21 (16%)	
With violence to mother/caregiver on premises	11 (8%)	
Homes	119	Located = 115 Still missing = 4
With violence to mother	36 (30%)	
Other places	41	Located = 38 Still missing = 3
With violence to mother	11 (27%)	
<p>*To date there has been no use of violence or attempts of violence against the mothers within health care facilities; however, there have been several cases in which assault and battery have occurred against nursing staff members during abduction attempts and abductions. In addition there is clear evidence of increasing violence by abductors when the abductions move outside of the health care setting.</p>		

The typical abduction from a health care facility involves an abductor unknown to the child's family who impersonates a nurse, health care employee, volunteer or relative in order to gain access to an infant. The areas providing care to the mother and infant after delivery are typically a comfortable atmosphere where patients' decreased length of stay, from one to three days, gives them less time to know staff members. In addition it can be filled with medical and nursing staff members, visitors, students, volunteers and participants in classes about parenting and newborn care. The number of new and changing faces on the unit is high, thus making the unit an area where someone who is considered to be a stranger is unlikely to be noticed. Because there is generally easier access to a mother's room than to the newborn nursery and a newborn infant spends increasingly more time with his or her mother rather than in the traditional nursery setting, most abductors use manipulation, conning, lying and ruses to take the infant directly from the mother's arms.





missingkids.com

MISSING

HELP BRING ME HOME

NCMEC 601889



Marlene Santana



Missing Since: **Oct 21, 1985**
 Missing From: **New York, NY**
 DOB: **Oct 18, 1985**
 Age Now: **28**
 Sex: **Female**
 Race: **Hispanic**
 Hair Color: **Brown**
 Eye Color: **Brown**
 Height: **1'8"**
 Weight: **7 lbs**

Age Progressed



Unknown



Suspect

Sex: **Female**
 Race: **Hispanic**
 Hair Color: **Blonde**
 Height: **5'2"**
 Weight: **130 lbs**

Marlene was three days old when she was taken at gunpoint by a female suspect who her mother met at Brookdale Hospital. The image on the right is a composite sketch of the female suspect as she appeared at the time of the abduction. The image on the left is an artist's rendering of what Marlene may have looked like at 2 years of age. The photo in the center is a composite image of what Marlene may look like at 25 years of age.

DON'T HESITATE!

CALL 911 or
1-800-843-5678 (1-800-THE-LOST®)

ANYONE HAVING INFORMATION SHOULD CONTACT

New York City Police Department (New York) - Missing Persons Unit - 1-212-694-7781

Case handled by



Follow us [Twitter.com/missingkids](#) [Facebook.com/missingkids](#)



MISSING

HELP BRING ME HOME

Show this poster [Twitter](#) [Facebook](#) [LinkedIn](#) [YouTube](#)

Case# 721896

Andre Bryant



Missing Since: **Mar 29, 1989**
 Missing from: **Brooklyn, NY**
 DOB: **Feb 17, 1989**
 Age Now: **24**
 Sex: **Male**
 Race: **Black**
 Hair Color: **Black**
 Eye Color: **Brown**
 Height: **1'7"**
 Weight: **10 lbs**

Age Progressed



Andre's photo is shown age-progressed to 22 years. He was last seen with his mother, who was later found deceased. Mother and child had left their residence at about 2 p.m. to go shopping with two black female acquaintances in a burgundy Pontiac Grand Am, possibly with Maryland tags.

DON'T HESITATE!

CALL 911 or
1-800-843-5678 (1-800-THE-LOST®)

ANYONE HAVING INFORMATION SHOULD CONTACT

New York City Police Department (New York) 1-212-694-7781

Case handled by



2. The offender and modes of operation

The offender:

- Is **almost** always a female.
- Appears overweight, in general, to suggest pregnancy.
- Ranges in age from 12 to 55 but, in general, is in her early 20s; usually has no prior criminal record.

If the offender has a criminal record, however, it is often for fraudulent activity such as:

- Shoplifting.
- Passing bad checks.
- Committing forgery.

Many of these women are gainfully employed. While she appears to be considered a normal person, the woman is most likely to:

- Be compulsive.
- Suffer from low self-esteem.
- Have faked one or more pregnancies.
- Rely on manipulation and lying as coping mechanisms in interpersonal relationships.

The infant may be used in an attempt to maintain/save a relationship with her husband, boyfriend or companion, hereinafter referred to as the significant other.

Sometimes she wishes either to replace an infant she has lost or experience a vicarious birthing of an infant she is for some reason unable to conceive or carry to term. On occasion an abductor may be involved in a fertility program at/near the facility from which she attempts to abduct an infant. Of the 285 cases in which the abductor's race is known, 122 are Black, 107 are Caucasian, 55 are Hispanic, and 1 is Asian. The race/skin color of the abductor almost always matches the infant's or reflects the race/skin color of the abductor's significant other.

Although the crime may be precipitated by impulse and opportunity, the abductor has usually laid careful plans for finding another person's infant to take and call her own.

Of the 132 infants who were abducted from health care facilities, 72 percent were 7 days old or younger. As a point of comparison, of the 119 infants who were abducted from homes, 21 percent were 7 days old or younger. Of the 41 infants who were abducted from other locations, 17 percent were 7 days old or younger. The abducted infant is perceived by the abductor as **her newborn baby**. A strong gender preference, in the abduction of these infants, is not revealed in the data.

Although the crime may be precipitated by impulse and opportunity, the abductor has usually laid careful plans for finding another person's infant to take and call her own. In addition, prior to the abduction, the offender will often exhibit nesting behavior by announcing her pregnancy and purchasing items for an infant in the

same way an expectant mother prepares for the birth of her baby. The positive attention she receives from family members and friends validates her actions. Unfortunately this nesting activity feeds the need for the woman to produce an infant at the expected time of arrival.

Many of these abductors have a significant other at the time of the abduction, and a high percentage of them have already given birth to at least one child. Typically, of the women married/cohabitating/involved in a relationship at the time they abduct an infant, their significant other — sometimes a considerably older or younger person — is not known to be involved in the planning or execution of the abduction, but may be an unwitting partner to the crime. The significant other is often gullible in wanting to believe his wife/girlfriend/companion indeed gave birth to or adopted the infant now in her possession and may vehemently defend against law enforcement's attempts to retrieve the infant.

The vast majority of these women take on the role of a nurse or other health care staff person, such as a lab technician, health department employee, social worker or photographer, and represent themselves as such to the victim mother and anyone else in the room with the mother. Once the abductor assumes this role she asks to take the infant for tests, to be weighed, to be photographed or for other logical purposes in the health care setting. Obviously arriving at the decision to ask the mother if she can take the infant for a test or photograph takes forethought on the part of the abductor.

The pretense of being someone else is most often seen in abductors who use interpersonal coping skills including manipulation, conning, lying and ruses. These women demonstrate a capability to provide care to the infant, once the abduction occurs, within their emotional and physical abilities. The infants who have been recovered seem to have suffered no ill effects and were found in good physical health. The offenders, in fact, consider the infants to be their own. There is no indication these are copycat crimes, and most offenders can be found in the same general community where the abduction occurred.

These crimes are not always committed by the stereotypical person who is considered to be a stranger. In most of these cases the offenders made themselves known and achieved some degree of familiarity with health care personnel, procedures and the victim parents. The abductor, a person who is compulsively driven to obtain an infant, often visits the nursery and maternity unit for several days before the abduction, repeatedly asking detailed questions about procedures in the health care facility and becoming familiar with the layout of the maternity unit. While the majority of the abductors visit the maternity unit in the days prior to the abduction, and pose as a nurse, some abductors are known to have been former employees/patients or have a friend or relative who was a patient at the facility where the crime is committed. The women who impersonate nurses or other health care personnel usually wear uniforms or other health care worker type attire. They have also impersonated home health nurses, staffers with financial assistance programs and other professionals who may normally work in a health care facility. They often

visit more than one health care facility in the community to assess security measures and explore infant populations, somewhat like window shopping.

The abductor may also follow the mother to the home setting. As of the publication of this guide in August 2014 there has been **no** use of violence against mothers **within** health care facilities; however, there have been several cases in which assault and battery have occurred against nursing staff members during abduction attempts and abductions. In addition 30 percent of the abductions from homes involved some type of violent act committed against the mother including homicide. Clearly the location of abduction in the last few years seems to be changing from the health care to home setting as evidenced by the fact there was violence committed against the parent in 58 cases from 1983 to 2013, but, of those cases, 41 occurred from 1996 through June 2014. What is also clear is the health care facility can be the initial point of contact in the abduction planning.

The abductor may not target a specific infant for abduction. When an opportunity arises, she may quickly snatch an available victim, often be visible in the hallway **for as little as four seconds** with the infant in her arms and escape via a fire exit stairwell. It is not uncommon for the abductor to focus on mothers' rooms located closest to a stairwell exit to allow for immediate flight and minimize contact with others they might encounter in an elevator or public stairwells. Since the abductor is compelled to show off her new infant to others, use of traditional and social media to publicize the abduction is critical in encouraging people to report situations they find peculiar. Most often infants are recovered as a direct result of the leads generated by media coverage of the abduction. In that process it is not a good idea to release speculative information to the media about the motive for the abduction.

At various points in time reductions in infant abductions have been observed.⁴ These reductions seem directly attributable to the proactive education programs offered since 1989 combined with hardening the target through the procedural and security measures discussed herein. The primary seminar, *Safeguard Their Tomorrows™*, has been sponsored by the Association of Women's Health, Obstetric, and Neonatal Nurses; the National Association of Neonatal Nurses; and NCMEC in association with the International Association for Healthcare Security & Safety. Education has greatly increased the awareness of nursing and security staffs in health care facilities nationwide. Through June 2014 the author and his colleagues have provided direct educational training on behalf of NCMEC to more than 72,550 health care professionals and informal on-site, assessments of maternal child care units for more than 1,170 health care facilities nationwide, in Canada and in the United Kingdom. Because infant abductions and attempted infant abductions continue to happen, it is vitally important to continue these proactive educational programs.

These crimes are not always committed by the stereotypical person who is considered to be a stranger.

⁴In 1999, for the first time since records began to be kept by NCMEC in 1983, the annual incidence of infant abductions from **health care facilities** decreased to **zero**. This zero period actually began in November 1998 and ran for 17 months. As of July 2002 another zero period began and ran for 17 months. Another zero period began in April 2004 and ran for 20 months. Another zero period began in May 2010 and ran for 20 months.



MISSING

HELP BRING ME HOME

Tavish Sutton



Missing Since: **Mar 9, 1993**
 Missing from: **Atlanta, GA**
 DOB: **Feb 10, 1993**
 Age Now: **20**
 Sex: **Male**
 Race: **Black**
 Hair Color: **Black**
 Eye Color: **Brown**
 Height: **2'0"**
 Weight: **8 lbs**

Age Progressed



The pictures shown are "PHOTO COMPOSITES" of what the child may have looked like at age 4 and what he might look like now at age 17. The child was abducted from his hospital room at Grady Memorial Hospital in Atlanta, Georgia, sometime between 6:45 and 7:00 a.m. on Tuesday, March 9, 1993.

DON'T HESITATE!
CALL 911 or
 1-800-843-5678 (1-800-THE-LOST™)

ANYONE HAVING INFORMATION SHOULD CONTACT

Atlanta Police Department (Georgia) - Missing Persons Unit -
 1-404-853-4235 Or Your Local FBI

Case handled by



MISSING

HELP BRING ME HOME

NCMEC 840605



missingkids.com

Sabrina Aisenberg



Missing Since: **Nov 24, 1997**
 Missing From: **Valrico, FL**
 DOB: **Jun 27, 1997**
 Age Now: **16**
 Sex: **Female**
 Race: **White**
 Hair Color: **Brown**
 Eye Color: **Blue**
 Height: **2'6"**
 Weight: **20 lbs**

Age Progressed



Sabrina's photo is shown age-progressed to 16 years. She became missing from her residence sometime during the early morning hours of November 24, 1997. Her yellow blanket is also missing.

DON'T HESITATE!
CALL 911 or
 1-800-843-5678 (1-800-THE-LOST™)

ANYONE HAVING INFORMATION SHOULD CONTACT

Hillsborough County Sheriff's Office (Florida) -
 1-813-247-8000 Or Your Local FBI

Case handled by



Follow us twitter.com/ncmec facebook.com/ncmec

3. Guidelines for health care professionals

The guidelines shown in red type are considered to be essential for the prevention and documentation every facility should strive to meet. All other guidelines listed are highly recommended.

3-1 General

The intent of these guidelines is to encourage health care facilities to develop security standards, to better protect infants, which are reasonable, appropriate and defensible. Safeguarding newborn infants requires:

- A comprehensive program of health care policy, procedures and processes.
- The thorough **education of and teamwork by nursing personnel, parents, physicians, security and risk management personnel.**
- The complete coordination of various elements of physical and electronic security.

Collectively all three actions serve to harden the target of potential abductors. Without question, the first two elements can and should be immediately implemented at **all** health care facilities.

A multidisciplinary approach to the development of specific health care policies and critical incident response plans, should an abduction occur, is needed to effectively combat this infrequent but highly visible crime. Nurse managers/supervisors may be well suited to take a lead role in this approach because of the holistic philosophy of nursing, the large amount of nursing time spent with parents and infants, the educational component of nursing care, and the ability of nurse managers/supervisors to incorporate teaching infant safety to parents and other staff members. Additionally, given the nature of maternal child care, obstetric, nursery and pediatric nurses have close working relationships to facilitate implementation of effective policies and process improvement measures. In the health care facility nurses are surrogate parents and the **front line of defense in preventing abductions** and documenting any incidents.

Electronic security measures are simply modern tools used to **augment** or **back up** a health care facility's policies, procedures and nursing practices. These devices are designed to further discourage or deter potential abductors and augment the overall protection process. They may also serve as a physical basis for enhancing the ability of nursing, security and risk management personnel to work as a team. There are several technologies available for this purpose including video surveillance systems with high-quality recording, access control and electronic security tag alarms. Each one, used singly or in some combination, provides several potential benefits. First these systems are reliable when properly designed, installed, tested, serviced and maintained. These systems are constantly vigilant and unaffected by distractions, rest/lunch breaks and shift changes; however, these systems are not infallible and should be tested. As such regular, scheduled testing of each system's operational

elements, in accordance with the manufacturer's specifications, is required as is a post alarm assessment in order to determine the cause of the alarm. Second, and more importantly, such systems serve to **document** and **help deter**, not simply prevent, an abduction. Digital video recording, coupled with access control, serves to document a potential abduction as it unfolds. They may also help in resolving

*Regardless of the safety controls selected and implemented, parents and staff members must always understand the security and surveillance systems described herein are **not a substitute** for continuous and personal vigilance toward infant security. These health care organization policies and measures in no way diminish the empowerment of the parents in their responsibilities to their newborn infant, but together they can better safeguard their tomorrows.*

and documenting false alarms of systems, varying according to manufacturer, for supervisory and/or investigative follow-up. Additionally video surveillance cameras and alarm panels coupled with security signage serve as a visual deterrent to the potential abductor. If properly used by facilities, these precautions clearly add to the potential of deterring an abduction; identifying and locating the abductor more quickly when an abduction does occur; prosecuting offenders; and, most importantly, aiding in the recovery of an abducted infant. Regardless of the safety controls selected and implemented, parents and staff members must always understand the security and surveillance systems described herein are **not a substitute** for continuous and personal vigilance toward infant security. These health care organization policies and measures in no way diminish the empowerment of the parents in their responsibilities to their newborn infant, but together they can better safeguard their tomorrows.

Each facility's appropriate executive officer, with the appropriate management staff members, should regularly review specific protocols and critical incident response plans to see if all issues concerning security measures are addressed as related to their specific needs. Such a review should both help prevent abductions and document any that do occur. It should also allow a facility to review the prescribed measures to be taken in case an infant abduction occurs at their facility and help them document the fact reasonable and appropriate measures are in place and/or identify areas needing to be improved. The guidelines enumerated in this chapter will aid facilities in this process. *See Chapter "7. Self-assessment for health care facilities"* beginning on Page 63 containing a summary of these guidelines. To create a justifiable and defensible posture, each

facility should use a multidisciplinary team to conduct a self-assessment with this tool and note how they meet these guidelines or document what is not applicable to their facility and why. Once this assessment step is completed facilities should use the outline created to review and modify their policies and procedures as needed based on the format of these national guidelines. It is recommended this process be done annually to validate there have been no substantial changes in the physical layout of the departments and no changes in the services rendered.

Be alert to unusual behavior. Health care security, nursing and risk management administrators should remind all personnel the protection of infants is a **proactive responsibility** for everyone in the facility, not just for security. The current U.S. Department of Homeland Security protocol of, “If you see something, say something™” should apply. One of the most effective means of thwarting, and later identifying, a potential abductor is to use phrases such as:

- “May I help you?”
- “**Whom** are you here to visit?”

This would emphasize the need to obtain the name of the mother the person wishes to visit. When asking these questions:

- Make eye contact.
- Observe the person’s behavior.
- Note a physical description.
- Escort individuals to their destination.
- Notify security resources, if necessary.
- Follow-up as is appropriate for the situation.

All health care facility personnel should be alert to any unusual behavior they encounter from individuals such as:

- Visiting repeatedly or requesting just to see or hold the infants.
- Questioning those on the floor about health care facility procedures, security devices and layout of the floor such as, “When is feeding time?” “When are the babies taken to the mothers?” “Where are the emergency exits?” “Where do the stairwells lead?” “How late are visitors allowed on the floor?” “Do babies stay with their mothers at **all** times?”
- Taking uniforms or other means of identification within that facility.
- Carrying an infant in the facility’s corridor instead of using the bassinet to transport the infant, or leaving the facility with an infant while on foot rather than in a wheelchair.
- Carrying large packages off the maternity unit, such as gym bags, suitcases and backpacks, particularly if the person carrying the bag is cradling or talking to it.

In this process facilities **should consider** having in place protocols to:

- Teach staff how to effectively approach a suspected abductor.
- Limit visitors to those who are able to provide the mother’s full name.
- Photograph all maternity unit visitors.
- Teach staff how to ask each mother, not the visitor, about her visitors to avoid staff incorrectly assuming a visitor is someone well-known to that mother.

Be aware disturbances, such as a fire in a closet near the nursery or loud, threatening argument in the waiting area, may be used to create a diversion to facilitate an infant abduction. Health care facilities should be mindful of the fact infants can stay

in or need to be taken to many areas within the facility. Thus vigilance for infant safety must be maintained in all areas of the facility when infants are present.

General guidelines

- 3-1-1 People exhibiting the behaviors described above should be immediately asked why they are in that area of the facility. Immediately report the person's behavior and response to the nurse manager/supervisor, security and administration. The person should be positively identified, kept under close observation and interviewed by the nursing manager/supervisor and security. Remember caution should be exercised when interacting with people who exhibit these behaviors. Ideally such vigilance should be exercised at all stages of the family's stay in the facility from admission to the accompanied discharge of both the mother and infant all the way to their vehicle.
- 3-1-2 Report and interview records about the incident should be preserved in accordance with the organization's internal procedures. Many suggest records should be kept from a minimum of seven years up to the child reaching adulthood.
- 3-1-3 Each facility should designate a staff person in their critical incident response plan having the responsibility to alert other birthing facilities in the area when there is an attempted abduction or someone is identified demonstrating the behaviors described above, but who has not yet made an attempt to abduct an infant.

Each facility should develop/use a concise, uniform reporting form to facilitate the timely recording and dissemination of this information to help ensure due diligence is used in sharing knowledge about a potential abduction or abductor. Care should be taken this alert does not provide material for libel or slander claims against the facility by the identified person. *See the "Sample notification form" on Page 38 adapted from a form designed by Jeff Karpovich when affiliated with the HCA Raleigh Community Hospital and reprinted with his permission.*

- 3-1-4 Notify authorities at the local law enforcement agency, then notify NCMEC at 1-800-THE-LOST® (1-800-843-5678) of all attempted/thwarted abductions. Information reported to NCMEC may be submitted anonymously to protect the confidentiality of the facility and is most helpful in assisting NCMEC in learning more about what strategies are most effective in thwarting abduction attempts.

3-2 Proactive measures

The guidelines shown in red type are considered to be essential for the prevention and documentation every facility should strive to meet. All other guidelines listed are highly recommended.

Proactive prevention guidelines

- 3-2-1 As part of contingency planning, the backbone of prevention, every health care facility must develop, test and critique a written proactive prevention plan for infant abductions including all of the elements listed in this section. In addition measures must be taken to inform new or rotating/temporary employees of these procedures as they join the staff. This plan should be tested, documented and critiqued at least annually.
- 3-2-2 Immediately after the birth of the infant and before the mother and infant are separated, attach identically numbered ID bands to both the infant (2 bands) and mother (1 band) and 1 band to the father or mother's significant other when appropriate. Inform parents of the reason or need for the bands. Remember, when deliveries occur outside of the facility or in the emergency department and the mother and infant are transferred to labor and delivery/the maternity unit, these identically numbered ID bands should be attached as soon as possible. **Note:** Potential abductors have falsely presented themselves in the emergency department as being pregnant and in active labor in an effort to gain access to newborns in the labor and delivery area. Joint review by the emergency department, maternity and security should regularly occur to assure a system wide response to these attempts.

If the fourth band is not used by the father/mother's significant other, that fact must be documented. This band may be stapled to the medical chart/record or cut and placed in the sharps container. For information about the importance of bands in regard to transporting infants see 3-2-6(a) on Page 18.

An infant's band should be examined and verified with the mother's band when taking the infant for care as well as upon delivery of the infant to the mother after care has been rendered. The caregiver must examine and verify both the infant and the mother's, or father/significant other's, identification bands and have the mother, or father/significant other, do the same. This should be documented in the medical records.

If an infant band is removed for medical treatment or comes off for any reason, immediately reband the infant after identifying the infant, using objective means such as footprint comparisons or blood samples for a subset of DNA such as human leucocyte antigen, and change all bands, mother's, father/significant other's, and infant's, so once again the bands all have the same number. If the band is cut or entirely removed, parents should be present at the removal and replacement.

If electronic tagging is used, and no matter what form of attachment bands or clamps are used with the electronic tagging of infants, health care facilities should be careful to assure there is **never a delay** in activation of the alarm function upon separation and should perform frequent, ongoing testing in support of that guideline. Staff members should be trained to **immediately** respond so there is no delay between detection of the alarm condition and generation of the alarm notification. **Note:** Trouble alarms, to include skin sensor alarms, full alarms, time-delayed exit alarms and/or exit alarms, should be responded to in the same consistent manner. Staff members should never consider an alarm to be a false alarm.

Case
example

After the birth of her daughter, and while still a patient, a new mother was approached by a woman claiming to be a social worker from another hospital who was there to conduct a survey and provide assistance to families in need.

The woman claiming to be a social worker spent the day at the hospital, entering and exiting this patient's room several times. At one point she brought in and left a suitcase. During the day the victim mother's family was also in the room with her as the woman came and went. They too believed this woman was a social worker and observed what appeared to be an empty ID holder partially hidden by her suit jacket. **While the victim mother and her family believed the woman claiming to be a social worker was a staff member of a nearby health care facility, staff members of that health care facility were under the impression the woman was a member of this infant's family.**

At approximately 9 p.m., after the mother's family had left, the woman claiming to be a social worker insisted the victim mother take a shower and get ready for bed. Around 9:20 p.m. the mother entered the restroom and exited about five minutes later to discover her infant, the woman and the suitcase were gone. The mother immediately contacted the nurses' station, and security and law enforcement were called. The local law enforcement agency issued a be on the lookout or BOLO bulletin for the suspect.

A few hours later a uniformed officer observed the suspect at a fast food restaurant about four blocks from the health care facility. The officer made eye contact with the suspect, and the suspect immediately left the restaurant. Her physical description and behavior reminded the officer of the BOLO, and he followed her from the restaurant. The woman and the infant were taken into custody after the suspect was unable to satisfactorily answer the officer's questions.

Key factors helping to recover the infant

Key factors helping in the recovery of this infant included the:

- Victim mother did not delay in notifying staff members her infant was missing.
- Health care facility did not delay in contacting law enforcement, and law enforcement immediately issued a BOLO.
- Arresting officer heard the BOLO and followed through when observing the suspect and her behavior at the restaurant.

Teaching points

Facilities should conduct frequent, ongoing testing of infant tagging security systems to help ensure they are properly functioning. See 3-2-2 beginning on Page 13 for additional information regarding these points.

Facilities should also consider protecting nursery units in the same way behavioral units are protected, when possible with electronic card-in and card-out readers for authorized staff members and ask-in and ask-out for visitors to help eliminate confusion regarding who is a visitor and who is a staff member. See 3-2-11 on Page 19 and 3-3-3 on Page 23 for additional information regarding these points.

Facilities should also take every opportunity to educate parents about the procedures used by the facility to identify staff members including ID badges worn by those authorized to transport the infant within and affiliated with the facility. See 3-2-4 and 3-2-5 beginning on Page 17 for additional information regarding the use of ID badges.

3-2-3 Prior to the removal of a newborn from the birthing room or **within a maximum of two hours of the birth:**

- a. Footprint, with emphasis on the ball and heel of the foot, the infant making sure the print is clear. Repeat if necessary.
- b. Take a color photograph or color video/digital image of the infant.
- c. Perform a full, physical assessment of the infant, and record the assessment along with a description of the infant.
- d. Store a sample of the infant's cord blood and any other blood specimens until at least the day after the infant's discharge.

Note: The following item would only apply to those facilities using an electronic security tag system.

- e. Place electronic security tags, if such a system is being used.

The footprints, photograph or video/digital image, physical assessment, and documentation of the placement of the ID bands, including their number, must be noted in the infant's medical record. The recording of infant biometrics characteristics early in a child's life can prove to be of value to the child, that child's parents and health care facilities.

Take footprints of each infant at birth/admission/readmission. Take a complete impression of the infant's foot using light pressure to capture ridge detail on the ball and heel of the foot.

Footprints are excellent for confirming the identification of a child while still in the health care facility or if an abducted infant is recovered. Thus health care facilities should take good, readable footprints of each infant. Consult your local FBI office or law enforcement agency for appropriate traditional techniques, paper stock, various products and methods to capture prints. For further information about traditional footprint techniques see Michael E. Stapleton's 1994 article about footprinting listed in the "Bibliography" on Page 94. Since the use of inked prints can result in inconsistent and illegible footprints not suitable for

Facilities should also take every opportunity to educate parents about the procedures used by the facility to identify staff members including ID badges worn by those authorized to transport the infant within and affiliated with the facility.

identification purposes, technological solutions can be implemented to address these challenges. The use of electronic or live scan technology enables health care personnel to capture an infant's footprint including unique ridge detail.

No matter which footprinting method is used, care should always be taken to obtain clear, readable footprints with an emphasis on the ball and heel of the infant's foot.

Like footprints, cord blood collected at the time of delivery is an excellent form of identification. DNA testing for identification purposes, or what is called DNA fingerprinting, is considered the best current method of biological identification. There are two types of DNA tests because there are two types of DNA in human cells. They are mitochondrial DNA or mtDNA and nuclear DNA. Nuclear DNA tests are based on short tandem repeat or STR-DNA sequences and have been used extensively in criminal cases and situations such as when identifying samples from the World Trade Center attack in 2001. While mtDNA analysis is strong circumstantial evidence for identification, using STRs as a match between a known infant reference sample and a questioned sample would be taken as conclusive, positive identification. Nuclear DNA testing has become routine. In fact, in an emergency situation, a definitive identification made from DNA can now be accomplished in less than 24 hours rather than the weeks it used to take, depending on specific laboratory requirements. **If a health care facility chooses to use DNA rather than footprints, it should have a signed contract with a laboratory specifying 24 hour coverage, 365 days a year with a four to six hour turn around for infant ID tests.** Although cord blood provides the best sample, even if cord blood is not available, a simple swab from the inside of the infant's cheek will generate enough material to perform a DNA test. At a minimum the health care facility should store the sample of cord blood, dried onto a piece of sterile filter paper or the dried mouth swab, until the day after the infant is discharged from the facility or longer as a facility's policy dictates.

Even with the advances made in DNA technology, NCMEC continues to recommend footprinting of newborns because use of footprints, either as a single method of identification or in conjunction with additional methods of identification, is the number one method used to identify infants abducted from health care facilities. Of the 132 infant abductions from health care facilities, 32 infants have been identified by footprints alone or with another method whereas five infants have been identified by DNA.

Take clear, high-quality, color photographs, or digital images, of all infants at birth and up to 6 months of age upon admissions including a close-up of the face, taken straight on, and retain it at least until the infant is discharged. Inform parents an admissions photograph of their infant will be taken for

identification purposes and/or obtain permission from them to take the photograph.

When completing the physical assessment of the infant, identify and document any marks or abnormalities such as skin tags, moles and/or birthmarks. While the footprint, photograph and assessment must be placed in the infant's medical records, parents should receive a copy of this information for their own records.

- 3-2-4 Require all health care facility personnel to wear, above the waist and face side out, up to date, conspicuous, color photo ID badges. The person's name and title should be easily identifiable, and the person's photo should be large enough so he or she is recognizable. Update the photo as the person's appearance changes.

These badges should be returned to Human Resources or the issuing department immediately upon termination of employment.

All missing badges must be immediately reported and the appropriate security response enacted. Consider placing the staff member's photo and identifying information on both sides of the badge to help ensure the photo and all identifying information is fully readable no matter which side of the badge is facing the public. And, as recommended by the International Association for Healthcare Security & Safety in their *Healthcare Security: Basic Industry Guidelines* regarding access control and identification systems, health care facilities should expire and reissue previously issued badges at a minimum of five years from the date of issue.⁵

Facilities should consider implementing a policy requiring staff members to wear their facility issued ID badge at all times when in the facility and always take steps to safeguard the ID badge from loss when within and outside the facility.

- 3-2-5 Personnel who are permitted to **transport** infants from the mother's room or nursery, including physicians, should wear a form of unique identification used **only** by them and known to the parents such as a **distinctive and prominent color or marking** to designate personnel authorized to transport infants. **IDs should be worn above the waist, face side out, on attire that will not be removed or hidden in any way. Paraphernalia should not be worn on name badges, such as pins, stickers and advertisements, hiding the name, face or position.** ID systems should include provisions for all personnel, who are permitted to transport infants from the mother's room or nursery including students, transporters and temporary staff members, such as the issuance of unique temporary badges controlled and assigned each shift. This strict control should be similar to narcotics control, and the unique form of identification should be periodically changed.

⁵Currently Guideline 07.01(e) in *Healthcare Security: Basic Industry Guidelines* addresses this point. That document, however, is under revision with guideline number changes pending.

Facilities should address issues of assisting hearing, visually, physically and mentally challenged patients with their special needs in this identification process. This should also address any existing language barriers.

If not already done as a condition of employment, perform background checks, including a search of sex offender registries, on all individuals entrusted to care for and transport infants and pediatric patients.

- 3-2-6 Concerning infant transportation within the health care facility:
- a. Limit infant transportation to an authorized staff member wearing the authorized infant transportation ID badge.
 - b. Ensure the mother or father/significant other with an identical ID band for that infant are the only others allowed to transport that infant, and educate the mother and father/significant other about the importance of this precaution.
 - c. Prohibit leaving an infant without direct line of sight supervision.
 - d. Require infants be taken to mothers one at a time. Prohibit grouping infants while transporting them to the mother's room, nursery or any other location.
 - e. Prohibit carrying infants in the arms, and require all transports to be via a bassinet.

Require family members transporting the infant outside the mother's room, including the mother and father/significant other, to wear an ID wristband. All wristbands should be coded alike numerically and readily recognizable.

- 3-2-7 Distribute the guidelines for parents in preventing infant abductions, listed in "What parents need to know" beginning on Page 57, to parents during prenatal visits to their OB-GYN, in childbirth classes, on preadmission tours, upon admission, at postpartum instruction and upon discharge. Upon admission consider having the patient sign a document noting receipt of these guidelines with the patient retaining the guidelines and a copy of this signed document. Also consider permanently posting this information on patients' restroom doors and/or in a prominent location within the mother's room, in the form of a poster, during their stay. This same information should be distributed to all new/current staff members and physicians and their staff members who work with newborns, infants and child patients.
- 3-2-8 Provide staff members, at all levels, instruction, initially upon hire and at least annually, about protecting infants from abduction including, but not limited to, information about the offender profile and unusual behavior, prevention procedures, their responsibilities and critical incident response plan.

Consider use of the DVD titled *Safeguard Their Tomorrows*TM, available at no charge from NCMEC, at 1-800-THE-LOST (1-800-843-5678), as an excellent educational resource in this instructional process.

- 3-2-9 Always place infants in direct line of sight supervision either by a responsible staff member, the mother or other family member/close friend so designated by the mother, and address the procedure to be followed when the infant is with the mother and she needs to go to sleep/the restroom and/or is sedated. If the mother is asleep when the infant is returned to the room, staff members should be careful to fully awaken her before leaving the room. In rooming-in situations, place the bassinet so the mother's bed is between the exit door(s) to the room and the bassinet.
- 3-2-10 Do not post the mother's or infant's full name where it will be visible to visitors. If necessary, use surnames only. Do not publish the mother's or infant's full name on bassinet cards, rooms, status or white boards. **Do not leave medical charts, patient index cards or any other medical information visible to anyone other than medical personnel.** Be aware identifying information in the bassinet such as ID cards with the infant's photograph and the family's name, address and/or telephone number may put the infant and family at risk after discharge. **Keep this information confidential and out of sight. Do not provide patient information via the telephone or electronically.**
- 3-2-11 Establish an access control policy and procedure for the nursing unit, nursery, maternity, neonatal intensive care and pediatrics to maximize safety. At the front lobby or entrance to the maternity unit, instruct health care facility personnel to **ask visitors which mother they are visiting**. If no name is known or given, decline admission and alert security, the nurse manager/supervisor, facility administration or law enforcement. Especially after regular visiting hours, consider setting up a system to positively identify visitors, preferably with a photo ID. At a minimum require all people entering the above listed departments to check in either at a reception area or with nursing personnel on the unit, again with identification and badging recommended.

Case

example

An 8-day-old infant with an eye infection was admitted to the pediatric unit of the health care facility in which she was born. A woman entered the health care facility the afternoon of the abduction and proceeded to the pediatric unit. Upon arriving at the pediatric unit she informed staff members she was the relative of an infant who was being discharged and was there to help the mother. The woman claiming to be a relative had a large diaper bag and infant carrier. Staff members buzzed her into the locked unit. The woman claiming to be a relative then had a brief interaction with a nurse and proceeded to the infant's room. The infant's mother was not at the hospital at that time.

The woman claiming to be a relative was observed by the same nurse a few minutes later at the elevator with the same diaper bag and infant carrier. The nurse became suspicious of the woman's demeanor and asked a co-worker to verify if the infant was still in her room. When it was determined the infant was gone, a code was called and security was notified.

The woman claiming to be a relative was apprehended by security and personnel in the parking lot after she exited the hospital and held until law enforcement arrived.

Key factors helping to recover the infant

Key factors helping in the recovery of this infant included the:

- Nursing staff members were alert and sensitive to the behaviors exhibited by the suspect. After observing the suspect, as she exited the unit, they followed their instincts and checked the status of the infant. Upon confirming the infant was missing they did not delay in calling a code and alerting security.
- Security staff members immediately responded to the code and were able to quickly locate and apprehend the suspect and recover the infant.

Teaching points

Facilities should consider setting up a system to positively identify visitors, preferably with a photo ID, and using it in conjunction with unit access control. See 3-2-11 on Page 19 for additional information regarding this point.

Facilities should also take every opportunity to provide staff members, at all levels, instruction about protecting infants from abduction including, but not limited to, information about the offender profile and unusual behavior, prevention procedures, their responsibilities and critical incident response plan. See 3-2-8 on Page 18 for additional information regarding this point.

3-2-12 **Require a show of the ID wristband for the person taking the infant home from the health care facility and be sure to match the numbers on the infant's bands, as worn on the wrist and ankle, with the bands worn by the mother and father/significant other.**

3-2-13 For those health care facilities still providing birth announcements to the media, NCMEC strongly encourages these facilities to reconsider their role in that process. Many facilities no longer provide this service and simply share information with the parents about how they may personally do so, if they wish, after advising them of the potential risks of such public announcements. Such advice also urges parents to **not** use full names in the announcements they submit to the news media. **Be aware, if the health care facility's public relations department still releases birth announcements to the news media or social media, no home address or other unique information should be divulged to put the infant and family at risk after discharge.** **Note: The same holds true for a patient in your facility who gives birth under circumstances such as the first baby of the New Year and Mother's Day.** Also facilities should obtain parental consent before publishing an announcement in the newspaper or online. In addition be aware while

giving yard signs away may be considered good marketing, the use of these signs at parents' homes may put them at risk.

Be sure to limit **specific** information provided to the public, such as in video tours posted by health care facilities and birthing centers on their websites as part of a marketing campaign, about security measures used to help ensure potential abductors do not have easy access to information that would assist in an abduction.

In the mid 1990s some health care facilities began posting birth announcements on their Web pages. These online announcements included photographs of the infant and in some cases of both the infant and parent(s). These birth announcements should never include the family's home address and be limited to the parents' initials, such as S. and D. Smith or Sam and Darlene S. Additionally **the facility should not post this information on its Web page until after both mother and infant have been discharged from the facility and after the parents have signed a consent form for participating in this vendor service.** All postings should be activated by a predetermined ID and/or password, with no default option to circumvent this precaution enabling anyone other than individuals who are authorized by the parents, such as family members and friends, to access the announcement. Also take every opportunity to encourage families to use caution when communicating with those on social media and carefully consider what they post on social media pages remembering information already posted in their profiles. And remind parents they should never use the mother's first name nor the home location when posting announcements online.

3-2-14 When providing home visitation services, personnel entering patients' homes should wear an authorized and unique form of photo identification used only by them, strictly controlled by the issuing organization and recognizable by family members. Parents should be told about this unique form of ID at the time of discharge. Consider providing this information to the parents on the discharge instruction sheet the patient signs with the patient taking a copy of the discharge sheet when leaving the facility.

Consider using a system in which the mother is called before the visit to inform her of the date and time of the visit; name of the staff person visiting; and requirement for that staff person to wear the current, unique photo ID badge. See 3-2-4 on Page 17 for a discussion of ID badges. For additional information about this topic see "Outpatient Areas" beginning on Page 52.

3-3 Physical security safeguards

The guidelines shown in red type are considered to be essential for the prevention and documentation every facility should strive to meet. All other guidelines listed are highly recommended.

Guidelines for physical security

- 3-3-1 Every health care facility must complete a written assessment of the risk potential for an infant abduction.

In determining the physical security requirements for the prevention of infant abduction, each health care facility must conduct and document a physical security needs assessment. This assessment should be performed by a qualified health care security related professional, such as a certified protection professional, certified health care protection administrator or certified professional health care risk manager, who identifies and classifies vulnerabilities within the health care facility. The needs assessment should include an evaluation of the facility and the existing policies and procedures, together with the possible appropriate application of any combination of physical controls or electronic systems such as video surveillance cameras, locked and alarmed emergency exit door controls, intercoms, remote door releases, and electronic security tagging systems. The application of safeguards, such as guidelines, systems and hardware, developed by the facility to harden the target from infant abduction should be dependent upon the risk potential determined and reflect current professional literature about infant abduction. **This process must be considered ongoing as targets, risks and methods change, particularly in the event of new construction, with the written risk assessment being conducted at least on a yearly basis and when significant changes are identified.** For assistance in this process, see the “Self-assessment for health care facilities” beginning on Page 63.

Assessments of an organization’s infant safety program often identify opportunities for improvements. Therefore it is important to perform such assessments under the auspices of the organization’s performance improvement program or their Patient Safety Organization in order to lend possible protection from legal discovery to such information, if and when such statutory protections exist. Reports and/or corrective action plans relating to findings of such assessments should also be treated as performance improvement materials, with access limited to authorized people.

- 3-3-2 Install alarms, preferably with time-delayed egress, on all stairwell and exit doors leading to/from or in close proximity to the maternity, nursery, neonatal intensive care and pediatrics units. Establish a policy of responding to all alarms and instruct responsible staff members to silence and reset an activated alarm only after direct observation of the stairwell or exit and person using it. The alarm system should never be disabled

without a defined countermeasure in place. A record of the alarms should be maintained and periodically analyzed for cause and potential opportunities for improvement to minimize false or nuisance alarm activations.

Optimally, video/digital recording should be integrated into the alarm activity. When an alarm is activated, the camera should automatically come to full screen at the alarm enunciator location. This situation should be properly documented, a report about the incident should be submitted to the proper authority within that facility, and the recorded data should be retained and reviewed by security. A monthly report should be generated and reviewed with security and nursing. *See 3-4-3 on Page 29 for a discussion regarding a head count of all infants.* Document each false or nuisance alarm, ascertain what went wrong and take any necessary corrective actions. If a video security monitor is located at a nurses' station, policy should specify the purpose of that placement in such a way as to limit liability.

3-3-3 All doors to all nurseries must have self-closing hardware, remain locked at all times and have a staff member present at all times when an infant is in the nursery. Consider protecting nursery units in the same way behavioral units are protected, when possible with electronic card-in and card-out readers for authorized staff members and ask-in and ask-out for visitors.

3-3-4 If there is a lounge, locker room or storage area where staff members change, leave clothing or store scrub suits, all doors to that room must be under strict access control/locked at all times.

3-3-5 **Conduct and document** a needs assessment for an electronic article surveillance or EAS detection system. Such a system would use an **always** activated electronic security tag tied to video/digital recording of the incident and alarm activation integrated with electronic locking devices to prevent exiting when a tagged infant is in close proximity to the exit. If a health care facility installs an infant EAS system, the system must always be operational. Staff members should never adopt a philosophy of only turning the system on if/when they suspect a problem. Because such actions present major liability risks, documented records should be maintained on testing procedures and preventative maintenance schedules. In the event the system becomes inoperable, defined countermeasures should be established and provided until the system is restored.

If an electronic tagging system is employed by a facility, all activations should be documented and a record kept. Weekly tests should be conducted on the electronic tagging system by way of using a randomly selected tag, not a test tag, and the results reported to the nurse manager, security manager and other proper authority within the facility. If more than one area or door is covered by the system, the testing must include each individually protected area to help ensure proper operation. **The documentation of the test results is essential.** Realistically zero is the number of acceptable false

alarms. Tests should include all aspects of the system used including skin sensor alarms, door locking and elevator controls, and camera activations.

- 3-3-6 **Install a security camera with recording capability.** Cameras should be placed in strategic locations to cover all exit points where infants and pediatric patients are located. Consideration should be given to the entrances of units, the nursery, hallways, stairwells and elevators. Cameras should be adjusted to capture a potential abductor's full face, and care should be taken to avoid strong lighting behind the individuals on camera. **Recording must be functional at all times. Videotape or digital recordings should provide a minimum of seven days of prior activity.**

Case example	<p>As a new mother watched her 2-day-old daughter from her hospital bed, a woman portraying herself to be a nurse dressed in scrubs entered her room and asked if she needed any assistance. The mother stated she would like to take a shower. The woman claiming to be a nurse offered to take the infant back to the nursery and send another nurse to assist with the shower. The victim mother observed the woman claiming to be a nurse take the infant from the bassinet and walk out of the room. According to the mother, the woman claiming to be a nurse returned two to three minutes later with the infant and nervously claimed the other nurses were busy and she would return within 10 to 15 minutes. The woman claiming to be a nurse exited the room and did not return.</p>
	<p>Key factors helping to thwart the infant abduction Key factors helping in thwarting this infant abduction included:</p> <ul style="list-style-type: none">■ The suspect did not know the infant had a security tag on her ankle, which prevented her from leaving the unit with the infant through an exit stairwell door.■ A nurse observed the suspect much earlier in the morning in the hospital solarium and then again observed the same individual lingering by a patient room on maternity a few hours later. This same nurse verbally challenged the suspect who told her she was looking for a patient and provided a specific name and room number.■ Another nurse observed the suspect carrying the infant in her arms when walking down the hallway in proximity to an exit stairwell door and made a comment to the suspect, who then returned the infant to the patient's room.■ The detective assigned to the case advised staff members to alert other hospitals in the area about the incident. This action resulted in the receipt of information from two other hospitals days after the first incident reporting similar incidents at their facilities with a similar looking suspect.
	<p>Teaching points Facilities should take every opportunity to educate parents about the procedures used to transport infants while in their care, especially in regard to the prohibition against anyone carrying infants in their arms, and the need to notify the nurses' station when that procedure is violated. See 3-2-6 on Page 18 for additional information regarding this point.</p> <p>Facilities should also take every opportunity to remind staff members to immediately call facility security and/or other designated authority per their facility's critical incident response plan when observing the behaviors exhibited by this suspect. See 3-4-4 on Page 29 for additional information regarding this point.</p>

Facilities should also install and properly maintain a security camera system. When images of a suspect or abductor are available, they greatly aid in the apprehension of suspects and prevention of abductions or abduction attempts at other facilities. See 3-3-6 on Page 24 for additional information regarding this point.

- 3-3-7 The camera(s) should be set at real time recording, versus time lapse, and remain functioning at all times. **Mount (these) camera(s) in plain sight, at a location to capture a full face view and materials being carried at all points of exit and post a sign with each (all) camera(s) prominently stating the reason for use of video surveillance.** For example the sign could state, "Area under video surveillance/recording for the protection of infants and pediatric patients/security purposes." Some health care facilities have found placing a live video surveillance monitor at/near the camera showing the picture being recorded successfully replaces the signs. There are now integrated flat panel monitors with built in cameras called public view monitors, which are excellent for this purpose. These monitors are now seen frequently in retail stores.
- 3-3-8 **Install signage in the maternal child care unit; lobbies; obstetric, emergency department and day surgery waiting room areas instructing visitors not to allow their children to be out of their direct line of sight.**
- 3-3-9 Additional items to consider regarding electronic surveillance and access control equipment include:
- Color images aid in the identification of perpetrators. There is virtually no cost difference between color and black and white cameras today so there is no reason to use black and white cameras.
 - Purchase and repair records should be maintained to include date of purchase, date of installation, date of any repairs performed and description of work.
 - Routine preventive maintenance should be performed as recommended by the manufacturer and documented.
 - All alarms on stairwell and exit doors should be adjusted to allow for the maximum delay in unlocking allowed by local fire regulations.
 - Audit trails of recorded media should be maintained as an aid to investigators. Tapes, if used, or digital recording should be retained as part of the facility's retention policy as long as possible but for a minimum of seven days. Information should be contained on the recorded media providing the identification of the image being recorded to include location, date and time it was recorded.
 - Electronic systems should be fully integrated wherever possible. Alarms, door controls, motion detectors, elevator controls and video surveillance pictures can automatically be combined and presented on a single monitoring device to greatly facilitate response and be supported by integrated, delayed egress access alarms, monitored video surveillance, intercoms and remote release devices.

- All cameras covering emergency exits, such as stairwells, should be working in conjunction with time-delayed and other alarms as well as electronic tagging system alarms to identify individuals at the point of exit and before actually leaving the unit. This will allow individuals at the camera monitoring location(s), such as security dispatch and/or a defined nursing unit, to receive the alarm and concurrently the image of the individual prior to actually leaving the unit. Notification of a breach of security, such as a Code Pink, can then be called, which can include the exit point and description of the perpetrator. With staff members on the unit responding to the alarm from the interior and security and other responders covering perimeter exit points from the building, knowing the location of the alarm and the description of the perpetrator, the likelihood of capture prior to leaving the building and/or campus is increased. Any additional cameras placed inside the stairwell should face the emergency exit door to view an adult head height. **Note:** Once individuals are off of the unit, they are generally moving very quickly and cameras at the exit points only reduce the ability to effectively record a usable image. Also it is unlikely these individuals will go up in stairwells. To save recording space on cameras in seldom-traveled areas, it is recommended they be equipped with motion detection, activation devices.

3-3-10 Be sure infants are discharged/tags removed, if used, only after **all functions are completed** such as blood work, the taking of photographs and finalization of discharge paper work. An infant should not be left unattended by health care personnel after a tag is removed.

3-4 Critical incident response plan

*The guidelines shown in red type are considered to be **essential** for the prevention and documentation every facility should strive to meet. All other guidelines listed are highly recommended.*

General guidelines

3-4-1 As part of contingency planning, every facility must develop a written, critical incident response plan regarding prevention of and response to infant abductions.

All protocols and critical incident response plans with reference to abductions of infants from the health care facility must be in writing. In addition they must be communicated to all staff members within the maternal child care areas and pediatrics. When these plans are part of staff training, records must be maintained verifying attendance. Training should be performance and competency based and documented. Other departments, including but not limited to security, communications/switchboard, environmental services, accounting and public relations, should also have written action plans to

follow in the event of an abduction. This training should begin at general orientation and be part of their departmental orientation competencies and annual refresher training similar to training offered about hazardous materials and fires.

When formulating the critical incident response plan, facilities should consider several items. For instance the layout or schematics and traffic patterns differ among facilities. Review factors such as:

- Accessibility.
- Location of entrance/exit doors, both vertical and horizontal.
- Systems for enhancing physical security including alarms.
- Number of visible staff members on the unit and staffing patterns.
- Departments adjacent to the unit.
- Proximity of unit and exits from the unit to parking areas, city streets and other locations where vehicles can be positioned for escape.
- Coordination with local law enforcement.

The plan must include a provision regarding the handling of the incident in relation to the time of day in which it occurs. For example if the incident occurs at shift change, the plan must include a provision for holding the shift scheduled to leave until excused by law enforcement or a designated authority within the facility.

It is the responsibility of staff members to secure the facility and begin a systematic search for the infant as quickly and completely as possible. Facility staff members must be assigned to immediately report to **all** exits of the facility including areas such as doors, stairwells and loading docks. They must be trained in both what to look for and what to do if they suspect an individual entering their assigned area may present the ability to conceal an infant in an attempt to depart the health care facility.

The plan must include a provision to designate a staff person, usually the security director, to act as the liaison with law enforcement. It is important to consider the health care facility's protocol for Joint Commission sentinel event reporting. In addition details about code words and drills needing to be considered when formulating or updating a plan are below.

Using a code word, and Code Pink is strongly recommended, to alert facility personnel there is a missing infant, is essential as part of the facility's critical incident response plan in the event of an infant abduction whether the infant is a patient or nonpatient. Code Pink is becoming an industry standard practice among health care organizations to use for this incident. Periodically quiz staff members about their knowledge of this code word and their responsibilities when the code is used. Health care facilities in each community should standardize the code word used within their community. Code words currently used by law enforcement and retailers such as AMBER Alert, AMBER and Code Adam should be strictly avoided to represent infant abductions or missing children in the health care setting.

In addition to use of a code word, consider emailing and/or using mass emergency messaging to alert all employees with essential information about an abduction.

Conduct at least one unannounced, facility wide infant abduction drill each year involving all facility personnel taking into account more than one drill may need to be held in order to include personnel who work day, evening, weekend and/or nontraditional shifts. In addition to the facility wide drill, facilities should conduct quarterly unit specific drills, tabletop exercises or audit type exercises. Critique each exercise to identify opportunities for improvement to enhance policy, procedure or performance standards. Tabletop exercises take place around the table with the key players acting out a specific scenario generally without simulated or actual patients involved. An audit type exercise may be a formal review of a procedure by actually walking through the procedure or testing a procedure. During drills, when using a person posing as an abductor, the scenario should be patterned after the typical offender profile and include realistic scenarios foreseeable to health care personnel.

In addition staff should use teachable moments throughout each patient's stay to help reinforce procedures to be followed by patients and their families when in the facility. This could include a scenario such as making sure family members check for proper identification being worn by staff members when entering the room and stating they need to transport the infant out of the room for a given purpose. The staff member should congratulate all family members who ask to see the ID for staff members authorized to transport infants within the facility. In cases when a family member may fail to ask to see that special ID, the staff member should show the ID to the family member and reinforce the policy about only those with that special ID being able to transport the infant.

Law enforcement should be advised, and/or invited to participate, in advance of all facility wide drills to avert any unnecessary response should an employee, patient or visitor take the initiative to call law enforcement during the drill. Encourage the agency to send at least one law enforcement representative, from a supervisory level, to observe the drill.

Also invite the local law enforcement agency to visit the facility to do a walk-through of the newborn areas to review protocols, learn the facility's layout and learn how the labor and delivery and postpartum units operate.

For additional information about drills and the evaluation of them, *see* "Drill components" on Page 39 and "Drill critique form" beginning on Page 40. These items were adapted from information designed by Connie Blackburn Furrh of the Oklahoma Spine Hospital and reprinted with her permission.

- 3-4-2 Call NCMEC at 1-800-THE-LOST (1-800-843-5678). NCMEC is in an excellent position to provide technical assistance, network with other agencies and organizations, assist in obtaining media coverage of the abduction and activation of emergency alert systems, coordinate dissemination of the infant's photograph as authorized by federal law per 42 U.S.C. § 5773, and provide support for victim families.

With the approval of law enforcement, a media or crisis communication plan should be developed to brief the media about the incident, enlist their aid in publicizing the abduction, promote the dissemination of accurate descriptive information about the infant and abductor, coordinate photo dissemination, and provide appropriate access to victim parents while protecting their privacy. It is imperative all media releases be coordinated with the attending law enforcement agency. The key to achieving the safe return of the infant is often through the cooperation of the public and, many times, specifically through the cooperation of the abductor's family members or associates. A concerted and well thought out media plan is critical in this process.

Nursing guidelines

- 3-4-3 **Immediately and simultaneously** search the entire unit while doing a head count of all infants. Time is critical. Question the mother of the infant suspected to be missing as to other possible locations of the infant within the facility. If the count is reconciled, the accountable person calls an all-clear. Records should be maintained reflecting how each infant alarm activation was resolved or reconciled, by whom, at what time and on what day.

- 3-4-4 **Immediately and simultaneously** call facility security and/or other designated authority per your facility's critical incident response plan.

This includes the announcement of the incident to all staff members using the predesignated code word, see the Section of 3-4-1 addressing code words on Page 27, and immediate notification of the local law enforcement agency. Make sure the law enforcement agencies frequenting your facility, for such things as assaults and car accidents, know this code word.

Where a facility has no security staff, immediately call the local law enforcement agency and make a report. Then call the local FBI office requesting assistance from the unit handling crimes committed against children.

Where a facility has no security staff, immediately call the local law enforcement agency and make a report.

Then call the local FBI office requesting assistance from the unit handling crimes committed against children.

Case
example

A woman presented herself to the victim mother at the health care facility as a volunteer from a church who could assist in obtaining supplies for her infant. During the conversation the woman posing as a volunteer asked the victim mother to complete forms including requests for information such as name, address and telephone number. The woman posing as a volunteer left, and the mother and infant were later discharged.

Two weeks later the same woman arrived unannounced at the victim mother's home and offered to drive her to the church to get some of the free supplies. The victim mother declined the offer on that day; however, she agreed to accompany the suspect the next day. On the next day they met and walked to a park approximately five blocks from the home bringing along the infant. A rose colored minivan was in the parking lot at the park. Once there the suspect informed the mother they were waiting for someone else to arrive and suggested the mother cross the street, go to a store and purchase soft drinks. The mother agreed to leave her son with the suspect and went to make the purchase. Upon her return the victim mother discovered the woman, the minivan and her son were gone. The victim mother flagged down a passing law enforcement officer, and shortly thereafter a statewide AMBER Alert was issued providing a description of the van and a composite sketch of the suspect.

The next day law enforcement released video surveillance images of the suspect as captured when the suspect visited the health care facility, but no pictures of the infant were available. The suspect was positively identified from those images. Tips eventually lead officers to the suspect's home where the infant was safely recovered.

Key factors helping to recover the infant

Key factors helping in the recovery of this infant included the:

- Law enforcement agency was able to retrieve videotaped images of the suspect from the health care facility **two weeks** after the birth of the infant.
- Law enforcement agency quickly issued an AMBER Alert with a composite of the suspect and description of the vehicle.
- Public response to the AMBER Alert was swift and positive.

Teaching points

Facilities should take color photographs or color video/digital images of infants and footprints of infants prior to the removal of a newborn from the birthing room or within a maximum of two hours of the birth. Such photographs and footprints can be invaluable in recovering and identifying an abducted infant. See 3-2-3 beginning on Page 15 for additional information regarding these points.

Facilities should take every opportunity to educate parents about ways to prevent infant abductions. Such should include consideration of providing information about the services offered by the health care facilities and any affiliated organizations. See 3-2-7 on Page 18 for additional information regarding this point.

Facilities should also take every opportunity to provide staff members, at all levels, instruction about protecting infants from abduction including, but not limited to,

being alert for unusual behavior. See the discussion about this concept on Page 11 of Section 3-1 for additional information regarding this point.

Facilities should also take every opportunity to remind staff members at all levels to immediately call facility security and/or other designated authority per their facility's critical incident response plan when observing such behaviors. See 3-4-4 on Page 29 for additional information regarding this point.

- 3-4-5 Secure and protect the crime scene, which is the area where the abduction occurred, and allow no one entrance until law enforcement releases it, in order to preserve the subsequent collection of any forensic evidence by law enforcement officials. Since interviews with all people on the unit during the incident are of great importance to the investigation, staff members should remain on the unit until permitted to leave.

This duty should be relinquished to security upon their arrival and subsequently to law enforcement upon their arrival.

- 3-4-6 Move the parents of the abducted infant, **but not their belongings**, to a private room off the maternity floor. The room; furnishings; and all items within the room, including patient possessions, should be untouched pending possible forensic processing by law enforcement.

Have the nurse assigned to the mother and infant continue to accompany the parents at all times, protecting them from stressful contact with the media and other interference. Secure all medical records/charts of the mother and infant, and check for adequate documentation. Notify lab and place stat hold on infant's cord blood and any other blood specimens for follow-up testing. Consider designating a room for other family members to wait in. Such will give them easy access to any updates in the case while offering the parents some privacy. Also consider designating a room for media and another one for law enforcement.

Following relocation of the parents of the abducted infant from the unit, the facility should:

- Coordinate services to meet other emotional, social and/or spiritual needs of the family.
- Provide regular, ongoing, informational updates, in collaboration with other entities such as law enforcement personnel.

Note: Such communications with the family following this type of unanticipated outcome should be consistent with the organization's disclosure protocol.

- 3-4-7 **The nurse manager/supervisor should brief all staff members of the unit. In turn nurses should then explain the situation to each obstetric patient/mother while the mother and her infant are together.** Mothers should

never hear this news from the media or law enforcement. The nurse manager/supervisor should also be available to liaise with law enforcement. The nurse manager/supervisor should remind staff members not to discuss the incident with the media. The two other areas in the facility greatly affected are medical records and Human Resources because both departments are asked to produce a great deal of documentation.

3-4-8 A staff person, preferably the nurse assigned to the mother and infant, should be assigned to be the primary liaison between the parents and facility after the discharge of the mother from the facility.

3-4-9 Nurse managers/supervisors must be sensitive to the fact nursing staff members may suffer post-traumatic stress disorder or PTSD as a result of the abduction. Make arrangements to hold a group discussion session, led by a qualified professional, as soon as possible in which all personnel impacted by the abduction are **required** to attend. Employee assistance programs, critical incidence stress debriefings and/or spiritual/pastoral care should be available. Efforts should be made to provide ongoing counseling for individuals who need it.

Such a session will allow health care facility personnel a forum for expressing their emotions and help them address the stress resulting from the abduction. During this group session reinforce the directive staff members are **not** to communicate with the media about the abduction incident reminding them all media communication should be from the designated law enforcement spokesperson/health care public relations representative. Organizations with employee assistance programs may refer staff members to such services.

Discussion of case details should be limited to individual information sharing with appropriate law enforcement authorities, security and/or designated risk management/quality improvement staff members/committees and/or assigned claim/legal defense counsel. Staff member participation in critical incident debriefing activities and/or counseling sessions should focus on obtaining emotional support rather than disclosing case details.

Care should be taken **not** to discuss case details before any criminal/civil trials are concluded. Individual information sharing disclosure of case details should be limited to law enforcement authorities and security, performance improvement and office of risk management authorities. Certain staff members may require additional assistance to psychologically integrate this incident and return to their duties on the unit. Facilities should make every effort to assist these staff members with this process.

Consider inviting those from the law enforcement agencies investigating the case while emphasizing feelings, not details about the abduction, are the only things to be explored in these sessions.

Note The National Center for Missing & Exploited Children® is an important resource for assessing and consulting about PTSD among staff members. Individual health care facilities are often so overcome with the enormity of the abduction event itself it is hard to see past the moment to recognize the signs and symptoms of PTSD in their staff members. It seems unimaginable to realize staff members suffering from PTSD have to continue working, encourage laboring mothers in bringing forth new life and soothe away their patients' fears of this crime. This is their job, but whose job is it to soothe away the nurses' fears and ease their crushed spirits so they may do their jobs? This time of healing should be strongly encouraged. The result of doing nothing can be a destruction of wonderful professionals. Help from NCMEC is a telephone call away. Nurse managers should not misjudge the intensity of the emotional storm that can rage within nurse victims after an abduction event and call 1-800-THE-LOST® (1-800-843-5678) for assistance with this healing process after an infant abduction in their facility.

Connie Blackburn Furrh, RN, risk manager, Oklahoma Spine Hospital.

As an aid in this entire process, if not already employed in your facility, consider use of a nursing checklist such as the one compiled by Connie Blackburn Furrh available at www.missingkids.com/InfantAbduction. It contains an example of the type of content to be included in orientation and annual competency training.

Security guidelines

3-4-10 Upon notification an infant is missing, security should:

- Respond to perimeter points of the grounds or campus of the facility to **immediately** and **simultaneously** observe people leaving and record vehicle license plate numbers. After securing the perimeter, proceed to the location of the incident and activate a search of the entire health care facility, both interior and exterior. Time is critical.
- Call the local law enforcement agency, and make a report. Then call the local FBI office to report the incident to the unit assigned to investigate crimes committed against children.
- Assume control of the crime scene, which is the area where the abduction occurred, until law enforcement arrives.
- Assist the nursing staff in establishing and maintaining security within the unit, such as access control to the unit, and notify public relations.
- Secure videotapes/digital recordings for seven days prior to the incident, and request the same from other health care facilities in the area and adjacent businesses.
- Provide access to equipment, technical assistance and a private location where law enforcement officials may review the recorded electronic images and obtain image copies for their response to an investigation of the incident. Formal release procedures may be required. Given the speed with which electronic technology changes, it is possible the electronic recording equipment in the health care facility will not be compatible with equipment currently used by law enforcement.

Ask law enforcement to dispatch an officer to the scene using only the standard crime code number over their radio without describing the incident. This will help deter media and others who are listening to law enforcement channels on scanners from being alerted about the incident before appropriate law enforcement procedures are initiated. Also make sure the law enforcement agency knows the specific unit to respond to within the facility.

- 3-4-11 In order to safeguard against panicking the abductor into abandoning or harming the infant, follow the facility's media plan, which should mandate all information about the abduction be cleared by facility **and** law enforcement authorities involved before being released to staff members and the media.

Most often infants are recovered as a direct result of the leads generated by media coverage. In that process it is not a good idea to release speculative information to the media about the motive for the abduction.

Consider limiting official spokespersons to **one** health care facility staff person, preferably from public relations, and **one** law enforcement representative. These people should be on the premises or on call throughout the crisis.

- 3-4-12 Brief the health care facility spokesperson, and then that spokesperson can inform and involve local media by requesting their assistance in accurately reporting the facts of the case and soliciting the support of the public. Be as forthright as possible without invading the privacy of the family.

The family should be apprised of the media plan and their cooperation sought in working **through** the official spokespeople.

- 3-4-13 Call NCMEC at 1-800-THE-LOST (1-800-843-5678) for technical assistance in handling ongoing crisis management.

- 3-4-14 Newborn nurseries, pediatrics units, emergency departments, outpatient clinics for postpartum/pediatric care at other local health care facilities and the health department's bureau of vital statistics should be notified about the incident and provided a full description of the infant and suspected or alleged abductor.

As part of her plan, the abductor may take the infant to another facility, such as a private physician or public agency, in an attempt to have the infant checked out, obtain a birth certificate for an infant she claims giving birth to at home or secure public assistance.

- 3-4-15 As part of the facility's overall annual security program review, as required under Joint Commission standards, document a specific review of the infant

security and safety program through use of the self-assessment tool beginning on Page 63, or through the use of the certified individual as described in 3-3-1 on Page 22.

Law enforcement guidelines

Law enforcement should treat a case of infant abduction from a health care facility as a serious crime requiring **immediate** response.

3-4-16 Enter the infant's name and description in the FBI's National Crime Information Center's Missing Person File or NCIC-MPF. If the abductor is known and has been charged with a felony, cross-reference the infant's description with the suspected abductor in the NCIC Wanted Person File. If a suspect has not been charged with a felony, consider use of a Person with Information supplemental record in NCIC. This record creates searchable fields within the missing person record for information pertaining to a person who may have information regarding a missing or abducted child case for which there is no warrant.

3-4-17 Call NCMEC at 1-800-THE-LOST (1-800-843-5678). NCMEC is in an excellent position to provide technical assistance, network with other agencies and organizations, assist in obtaining media coverage of the abduction, and coordinate dissemination of the infant's photograph as authorized by federal law per 42 U.S.C. § 5773.

Parents or law enforcement authorities may request an age progressed image of the infant as time elapses if the infant is still missing after two years. An age progression of an infant's image can only be done based on heredity and if the biological family is able to provide reference photos of the mother, father and siblings at or around the age the missing child would currently be today. See examples on Pages ix, x, 4, 8, 42, 46 and 56.

3-4-18 Call the local FBI office requesting the assistance of their crimes against children coordinator. This coordinator can request assistance from the FBI's National Center for the Analysis of Violent Crime. They can provide technical and forensic resource coordination; computerized case management support; investigative, interview and interrogation strategies; and information about behavioral characteristics of unknown offenders.

3-4-19 Immediately secure and review any available videotapes/digital recordings from the abduction scene and contact all other birthing facilities in the community and adjacent businesses to request the retrieval and secure storage of the previous seven days of videotapes/digital recordings for review. These videotapes/digital recordings should be treated as photographic evidence. Given the speed with which electronic technology changes, it is possible the electronic recording/viewing equipment within

a law enforcement agency may not be compatible with the equipment used by the health care facility. Law enforcement officials should ask for access to the facility's equipment and review the recorded images in a private location within the facility. **Note:** The release of any and all video recordings should be done with the concurrence of risk management and legal counsel to avoid any future privacy or HIPAA violations.

- 3-4-20 Consider setting up one dedicated local telephone hotline for receipt of sightings/leads or coordinate this function with a local organization.
- 3-4-21 Polygraphs may be useful with a female offender and her male companion to determine any foreknowledge on his part about the abduction. While polygraphing the infant's father may be useful for eliminating him as a suspect, it should be done early in the investigation. Be aware polygraphing the infant's mother within 24 hours of the delivery, or while medicated, is ill-advised.
- 3-4-22 To deter future crimes and document criminal behavior, the abductor should be appropriately charged and every effort made to sustain a conviction.
- 3-4-23 Any release of information concerning an infant abduction should be well planned and agreed upon by the health care facility and law enforcement authorities involved. Care should be taken to keep the family fully informed. Consider designating **one** law enforcement official to handle media inquiries for all investigative data. All media releases should focus on the safe return of the infant, **not** the arrest/conviction of the abductor.

Public relations guidelines

- 3-4-24 As soon as possible after the abduction, contact the local media and request they go to a designated media room at the health care facility to receive information about the abduction. **The media should be provided with the facts as accurately as possible, asked to request the assistance of the public in recovering the infant and asked to respect the privacy of the family.** Public relations professionals should be forthright with the media, but make certain to release only information approved by the law enforcement authority in charge of the investigation, **limit sharing too much information about security procedures and technology in place within the facility, and refrain from blaming the victim parent in cases in which a parent may have unwittingly handed the abducted child to an alleged abductor.** Press releases should be prepared and presented jointly by law enforcement's public information officer and the health care facility's media liaison. **Most often infants are recovered as a direct result of the leads generated by media coverage of the abduction.**

Place a news release on the facility's website regarding the abduction as a quick place for the media and public to find information about the case. Doing this may reduce the number of calls the facility receives.

Designate a separate area where friends and family members of the parents can gather to receive regular updates about the abduction in order to keep them informed about the case and shielded from the press. Designate a separate area for the media to gather. Provide the media escorted opportunities to film an OB/nursery area or personnel. Advise staff members to be alert for possible rogue reporters who may attempt to obtain confidential information from staff members not authorized to offer such and/or gain access to areas of the facility not accessible to them.

3-4-25 Provide switchboard/communications staff members with a written response or forwarding information they may use for outside callers including anxious parents who are planning to have their infants delivered at that facility and people calling with tips or information about the abduction.

3-4-26 Activate the crisis communication plan and/or the facility incident command center. Those should list steps to be taken, people to be notified and resources available such as photo duplication and dissemination. This should include dissemination of information to staff members before they go off duty.

...limit sharing too much information about security procedures and technology in place within the facility....

For additional information about planning for, creating and responding to a critical incident plan, see James T. Turner's 1990 article listed in the "Bibliography" on Page 92.

Drill components

- Conduct an infant abduction drill at least once a year including the entire facility not just obstetrics.
- Ensure drill is patterned after the offender profile and includes realistic scenarios foreseeable to health care personnel.
- Hold a training class, prior to the drill, for those who will observe and assess the drill. Training classes should include:
 - A review of physical security features in place.
 - A review of facility's critical incident response plan.
 - The selection of a planned abduction scenario.
- Commence drills with an alarm sounding or by handing someone a note within the birthing center explaining an infant has been abducted.
- Choose observers from all job levels.
- Use standardized drill reports.
- Inform, shortly before drill begins, administration, FBI/law enforcement and NCMEC it is a drill only.
- Provide real time instruction by observers during the drill if needed.
- Forward drill evaluation forms to the security director and/or other appropriate designee.
- Evaluate the drill via a meeting including mid- and senior level management.
- Review the drill, step by step, with observers and staff members involved to identify areas needing improvement.
- Include information, in the final drill report, about what did and did not work and a plan of action for improvements.
- Send final report to administration and the obstetric unit within two weeks of drill completion.

Congratulations!

My Name _____ Rm _____

Sex _____ My Birthdate _____ Time _____

Birth Weight _____ lbs. _____ oz. Length _____ in. Head _____ Chest _____

My Doctor _____

Mother's Doctor _____

Sample crib card as provided by Mead Johnson Nutrition™.

Drill critique form

	Date	Time	Yes	No	N/A	Descriptors	Name
What time was the discovery made?							
What time was the nurse manager notified?							
What time was security called?							
What time was law enforcement notified?							
What time was administration notified?							
Who notified administration?							
What time was the facility operator notified to call a Code Pink drill?							
Does PA system reach all areas of the health care facility?							
Are some areas too noisy to hear PA announcements?							
Who was assigned to stay with the nurse who discovered the missing infant?							
Who was assigned to stay with the mother of the missing infant?							
Were patients alerted a drill was in progress?							
What parts of the infant abduction prevention plan were affected?							
■ Did someone manage to breach the security entrance?							
■ Was someone carrying an infant in his or her arms?							
■ Were OB staff members wearing visible ID badges?							
Did abductor have a visitor badge?							
Were all egresses, as identified in prevention plan, monitored?							
Was search of entire OB unit accomplished?							
Were the rest of the infants accounted for?							
Were trash cans searched?							
Were suspicious people approached/followed?							
Suspect description:							
■ Age.							
■ Race.							
■ Eye color.							
■ Weight.							
■ Height.							

	Date	Time	Yes	No	N/A	Descriptors	Name
Anything unusual about the person such as a limp?							
Description of suspicious vehicle:							
■ Make.							
■ Model.							
■ Color.							
■ Year.							
■ Tag number.							
■ Anything unusual about vehicle?							
Direction of travel for any suspicious vehicle?							
Did all staff members stay on duty until end of the drill?							
Was a staff member assigned to the designated crime scene so it was not disturbed?							
Was infant's picture, medical records and blood specimen secured?							
Was a temporary command center set up in the department of concern?							
When was the National Center for Missing & Exploited Children® notified?							
Who notified the National Center for Missing & Exploited Children?							
When was the FBI notified?							
Who notified the FBI?							
When was the security tape retrieved for evidence?							
Who retrieved the tape?							
Was drill realistic?							
Did staff members perform according to protocol?							
What time were other birthing facilities in area notified?							
What was the length of the drill?							
What time was the all-clear sounded?							
What time were periphery guards notified?							
When were drill evaluations submitted?							

MISSING

HELP BRING ME HOME

Case# 849827

Kamiyah Mobley



Missing Since: **Jul 10, 1998**
Missing from: **Jacksonville, FL**
DOB: **Jul 10, 1998**
Age Now: **15**
Sex: **Female**
Race: **Black**
Hair Color: **Black**
Eye Color: **Brown**
Height: **1'9"**
Weight: **8 lbs**

Additional Photo



The images shown are all composites. The infant was abducted from her mother's room at University Medical Center in Jacksonville, FL at 3:00 p.m. on July 10, 1998. The suspect was dressed in a nurse's blue floral smock and green scrub pants. She is a black female, approx. 25-35 years old, 130-160 lbs. She possibly wears wigs and glasses. The child has Mongolian spots on her buttocks which tend to fade in 6-8 months. No infant metabolic screening has been performed on the baby. Birth mother has tested positive for sickle cell anemia and strep type B. Kamiyah also has an umbilical hernia.

1 associated adults



Suspect Composite
Age Now: **45**

DON'T HESITATE!

ANYONE HAVING INFORMATION SHOULD CONTACT

Case handled by

CALL 911 or
1-800-843-5678 (1-800-THE-LOST®)

Jacksonville Sheriff's Office (Florida) 1-904-630-0500, FBI-Jacksonville 1-904-721-1211 Or Your Local FBI

4. Liability

Note: The information cited in this section is based on anecdotal information learned by NCMEC staff members and does not necessarily represent an analysis of all claims associated with infant abductions from health care settings. The comments herein are provided for informational purposes only and do not constitute legal advice. Obtain legal advice from qualified health care counsel before acting in any specific situation.

A comprehensive program of health care policy, including education of and teamwork by nursing, parents, security and risk management as well as various elements of physical and electronic security enhancements, helps the position of a health care facility should an abduction occur. In the cases litigated, damages awarded against a facility generally have been mitigated when a health care facility has had the foresight to proactively reduce abduction risks.

In the cases studied so far, of health care facilities sued as a result of infant abductions, a higher percentage of suits occurred in those cases when the infant was not recovered within one week of the abduction. The likelihood of litigation did not vary based on the location of the abduction. Families sued those facilities in equal proportions whether the infant was abducted from the nursery, the mother's room or a pediatric room. The facility was more likely to be sued in cases when the abductor impersonated facility staff members than in those cases when the abductor did not impersonate staff members.

In cases of infant abduction, a health care facility is potentially liable on two grounds. The first is based on its general duty to take reasonable care to prevent the occurrence of foreseeable harm to its patients. The health care facility could be liable for any physical, psychological or other harm suffered by the abducted infant or family.

The second area of liability is based on the health care facility's contractual duty to use reasonable care to prevent the occurrence of foreseeable injury to third parties. Thus the health care facility could be liable to the parents for the costs of any searches and psychological harm. And this liability could extend to abductions from settings other than the health care facility after the infant's discharge if the abductor obtained information about the victim family from the health care facility that aided in the abduction.

Another area of liability concerns the need for obstetric/pediatric physicians, especially those in group practice, to have photo IDs to identify themselves to mothers, such as on-call physicians who may not be known to the family and/or staff members, or to be introduced to the mother by the nurse responsible for their care.

Another area of liability concerns the need for obstetric/pediatric physicians, especially those in group practice, to have photo IDs to identify themselves to mothers, such as on-call physicians who may not be known to the family and/or staff members....

Today's administrators, risk managers and security directors have the duty and responsibility for guiding not only the public trust in their facility but also the patient's safety and staff awareness for potential events. In addition, as noted on Page 10 in Section 3-1, to create a justifiable and defensible posture, each facility should use a multidisciplinary team to conduct a self-assessment, using the form beginning on Page 63, and note how they meet these guidelines or document what is not applicable to their facility and why. Once this assessment step is completed facilities should use the outline created to review and modify their policies and procedures as needed based on the format of these national guidelines.

The liability to a facility regarding an infant encompasses many aspects going beyond potential out of pocket expenses during an event and settlements awarded to family members from any resulting lawsuits. Facilities should consider expenses such as potential loss of faith of patients within the area to continue using their facility for OB-GYN or other services and the negative impact on staff members on duty during an incident up to and including loss of staff members and training of replacement staff members. One tool to assist in this process of assessing security improvements and facility readiness is a Hazard Vulnerability Analysis or HVA. Per The Joint Commission's Environment of Care Standard EC.4.11.2, hospitals conduct an HVA, regarding emergency management and security management, to identify events that could affect demand for its services or its ability to provide those services, the likelihood of those events occurring and the consequence of those events. **When considering changes if an abduction has occurred, NCMEC is available, at 1-800-THE-LOST® (1-800-843-5678), to provide technical assistance.**

Though infant abductions do not occur with high frequency in any given area, they do occur. Given the statistics and known information from this guide and the other professional sources summarized in the "Bibliography" beginning on Page 91, ignoring the potential for infant abduction — especially with the special protections due to infants in adoption proceedings, legal hold and guardian ad litem situations — negates the prudent due diligence of risk managers, nurse managers and health care security necessary for them to perform their jobs. The foreseeability of a particular infant abduction incident may vary given the totality of circumstances. Considering the volume of material published in professional and popular literature, however, there is wide agreement foreseeability affixed to the health care industry nationwide at least as early as January 1992. The "Bibliography" outlines, in chronological order, the benchmark articles in journals and publications for health care professionals.

Case
example

The parents of a 3-day-old boy were waiting for a nurse to come into the mother's room to discharge the mother and infant. When the discharge nurse entered the room and began providing discharge instructions, another woman who appeared to be a nurse quietly entered the room and stood a short distance behind the discharge nurse observing the exchange of information.

The second woman was wearing scrubs with a hospital emblem. After the discharge nurse finished providing the instructions, she removed and disabled the security tag worn by the infant. The discharge nurse then exited the room believing the parents would immediately exit behind her.

Instead the woman posing as a nurse then stepped forward and told the parents she needed to take the infant for one last physical check and stated she would return shortly.

After waiting 45 minutes, the infant's father told staff they were ready to leave. At that time it was discovered the infant was missing.

Key factors helping to recover the infant

Key factors helping in the recovery of this infant included the:

- Staff at the health care facility immediately searched the unit and contacted law enforcement when they could not find the infant.
- Shop where the suspect purchased the scrubs she wore during the abduction had video surveillance footage of the suspect.
- Family of the suspect saw media reports about the abduction and contacted law enforcement with their suspicions about her involvement in the abduction. Those suspicions were heightened because they did not believe her claims of being pregnant and thus did not believe she gave birth to the child now in her possession.

Teaching points

Facilities should encourage staff members to approach and question any person wearing facility attire without a facility issued ID badge. For more information about this topic see 3-1-1 on Page 12.

Facilities should consider implementing a policy requiring staff members to remove and safeguard their ID badges before leaving the facility. For more information about the use of ID badges see 3-2-4 on Page 17.

Facilities should require, upon discharge, an authorized staff member accompany the parent(s) and infant all the way to their vehicle and wait there until both the infant and parent(s) are inside the vehicle. For more information about the importance of the facility's vigilance needed from admission through discharge see 3-1-1 on Page 12. This would also be an opportunity for facility staff to confirm the infant car seat in the vehicle is properly installed if such is the facility's policy.



missingkids.com

MISSING

HELP BRING ME HOME

NCMEC: 911229



Jacqueline Vasquez



Missing Since: **May 6, 2001**
 Missing From: **Avondale, AZ**
 DOB: **Jan 14, 2001**
 Age Now: **13**
 Sex: **Female**
 Race: **Hispanic**
 Hair Color: **Black**
 Eye Color: **Brown**
 Height: **3'0"**
 Weight: **13 lbs**

Age Progressed



The photo on the right is a composite image to show how Jacqueline may look at 12 years. She was last seen at a swap meet in Avondale, Arizona. At the time of her disappearance, Jacqueline was wearing a white outfit. She has a heart shaped birthmark on her upper right arm.

DON'T HESITATE!

ANYONE HAVING INFORMATION SHOULD CONTACT

CALL 911 or
1-800-843-5678 (1-800-THE-LOST®)

Avondale Police Department (Arizona) 1-623-333-7001

Case handled by



Follow us twitter.com/missingkids facebook.com/missingkids

5. After discharge/transfer from a maternal child care unit

After discharge from a maternal child care unit, most newborns go home with their families; however, all infants need follow-up care whether in a special care nursery situation immediately after birth or for regular check-ups. This chapter offers advice to health care professionals about helping to safeguard infants and children during such times of follow-up care whether at home, at a regular check-up or when in a health care facility for either a short or prolonged stay.

Infant security policies and procedures should be consistent throughout a health care facility from the maternal child care unit to special care nurseries to the pediatric unit to outpatient areas. All items contained in Chapter “3. Guidelines for health care professionals,” beginning on Page 9, should be carefully considered for implementation in any area of the health care facility where infants will be located. Consistency of policies and procedures, training of staff members, and use of security protocols will help ensure compliance, better safeguard infants and children when in any area of the facility, and be closely scrutinized if an incident is litigated.

When admitting and discharging infants and children to these areas of the health care facility:

- **Footprint, photograph and take a blood or saliva sample for DNA purposes of all infants aged birth to 3 months.**
- **Perform and record a full, physical assessment noting any unique features.** The footprints, photograph and physical assessment must be placed in the infant’s or child’s medical chart/record. Over time refootprinting is advised, but certainly before discharge. For instance if children stay longer than one month, they should be photographed and refootprinted monthly. **The blood sample must be saved until at least one day after the infant’s or child’s discharge.**
- Prepare for meeting the infant’s or child’s special needs at home. As discharge nears parents may use a rooming-in service. When doing so it is imperative security procedures be followed stressing the importance of direct line of sight supervision by parents in these rooming-in situations.
- Require a show of the ID wristband, upon discharge, for the person taking the infant home from the health care facility, matching the bands on the wrist and ankle of the infant with the bands worn by the mother and father or significant other. If parents do not have identification bands, require verification of identification with an official photo ID such as a driver’s license.

To better safeguard the infant or child while being transported within the health care facility, personnel must ensure:

- **All health care facility personnel authorized to transport infants and children wear conspicuous, color photo IDs as described in Guideline 3-2-4 on Page 17.**
- **Only personnel authorized to transport infants and children or a person with an authorized ID band for that infant or child is allowed to transport**

children as described in Guideline 3-2-5 beginning on Page 17. In cases when the infant or child needs to be taken for tests in other units of the facility, such as X-ray and MRI, staff members should tell parents the transporter is an employee of the facility and parents should be encouraged to accompany their infant or child if and when possible. The facility should consider giving infants and children priority for testing to decrease their waiting time in the other unit. Transporters, who accompany infants and children, should receive education in abduction prevention and infant security policies and procedures. Facilities with an electronic tagging system in maternity units should consider tagging all infants and toddlers, who are younger than 2, and any child on police or child protective services hold. For details about use of electronic tagging systems, *see* 3-3-5 beginning on Page 23.

- **All infants and children are transported one at a time and never left out of direct line of sight supervision.**
- **All infants and children are always pushed in/on a bassinet, crib, stretcher or wheelchair and never carried.**
- **All people visiting with or transporting the infant or child, who are not an authorized staff member, including the mother, father or any other person designated by the parents, is required to wear an ID wristband or produce an official photo ID.** All matching wristbands should be coded alike numerically and readily recognizable. This process should be clearly documented, especially to facilitate discharge of the infant or child. Identification policies should clearly outline steps to be implemented for reapplying matching identification bands when the mother has been discharged from the facility but the infant is still in the facility.
- All infants and children who cannot be in direct line of sight by staff members or parents, when possible, are placed in rooms physically located away from stairwells and elevators. Children involved with custody or abuse issues should receive greatest priority for this room placement, and security should be notified of their high risk status. The person admitting an infant or child should be discreetly questioned regarding any custody issues and any positive history documented in the medical record.
- **An access control policy is established for these areas of the health care facility to maximize safety.** All exterior doors to the unit where infants and children are staying must have self-closing hardware and be under strict access control/locked. Health care facilities should consider the use of alarms and security cameras on these doors. At the front lobby or entrance to the unit, instruct health care facility personnel to ask visitors which infant or child they are visiting and their relationship to the patient. If no name is known or given, decline access and alert security, the nurse manager/supervisor, the facility administration and/or law enforcement. Set up a sign-in log for visitors to the unit including a need for each visitor to specify the infant or child to be visited and show an official photo ID.
- Always activate the critical incident response plan if an infant or child is missing from one of these units. That activation should include the use of a different or modified code word from the one used for infants taken from the maternal child care unit. *See* the text regarding code words on Page 27.

Special care nurseries

Neonatal and Pediatric Intensive Care Units or N/PICUs typically consist of large rooms with multiple bassinets where parents may **not** be constantly in the unit until the infant's discharge. In addition these units generally do **not** often utilize the same level of security as employed in well-newborn nurseries due to continuous monitoring and increased nurse to patient staffing ratios. There is, however, a current trend toward pod designs where four or five infants are cared for in smaller rooms and parents spend more time at the bedside. Staff members must be vigilant in these situations especially when family members other than parents are allowed to visit without the parents also being present.

Because parents often spend quality, one on one time with their child while in these units, each family member should be positively identified and documented by nursing staff members. Consideration should be given to using multipart patient ID bands for parents or some other form of identification and unit pass system to be used by family members and visitors approved by the parents. Visitors approved by parents must be carefully observed and not allowed near any other infants.

While there has been only one reported case of a **nonfamily** member infant abduction from NICUs, a number of infant abductions from these units have occurred involving **family** members of infants who were on court hold for such reasons as positive drug screens and custody issues; infants awaiting adoption; and guardian ad litem situations. While these abductions may be reported to local authorities, no national figures have been systematically tabulated about the incidence of this crime as committed by family members. Implement a policy and procedure meeting the security needs of an infant who is on court hold. For example if the mother and/or father/significant other is in the well-newborn nursery or NICU to visit the infant, the parent(s) should be under close and direct supervision and observation at all times. Special attention should be exercised if an emergency, such as a fire alarm or bomb threat, occurs in another part of the facility. Associates of perpetrators may stage a ruse to distract or otherwise engage security and supervisory staff members while another family member attempts an abduction.

It is imperative this assessment be used to identify any variations in security protocols for inpatient infant and pediatric unit(s) to demonstrate a reasonable and appropriate protection process.

Infant security risk issues in such special care units are multifaceted and may include but are not limited to:

- Infant care procedures resulting in numerous infant identification band changes due to reinsertion of intravenous needles, edematous extremities or infant weight gain. The removed ID bands should be stapled to the medical record or cut and placed in the sharps container noting this and the ID band number in the medical record. NICU infants should be rebanded with another identification band.

- Environmental designs dividing the NICU into small, low census pods. These areas may be difficult for direct line of sight observation of infants at all times, especially in rooming-in situations, and may result in lower staffing patterns.
- Security policies and procedures possibly inconsistent with the maternity department such as discharge of infant directly from unit where parents carry the infant out of the facility in their arms.
- Large, busy units with multiple caregivers who may not be familiar with the parents.
- Temporary agency or registry personnel/traveling nurse service personnel used who are not required to wear photo or unique identifying badges monitored each shift.
- Smaller units experiencing, at times, lower census and lower staffing patterns increasing the vulnerability for direct line of sight observation.
- Discharge process **not** requiring parents to present an identification band matching the infant's or requiring verification of identification with an official photo ID.
- False sense of security, on the part of staff members, an infant abduction would not occur in such special care units to feeder and grower infants, infants ready for discharge, boarder babies or adoption babies who have yet to be placed with a family or picked up by the adoptive family. Facilities with electronic tagging systems should consider tagging infants as soon as they are moved into an open crib. For details about electronic tagging systems *see* 3-3-5 beginning on Page 23.

Consider installing alarms, preferably with time-delayed egress, on all stairwell and exit doors to these units. Optimally, video/digital recording should be integrated into the alarm activity.

Pediatric units

Pediatric units also offer special challenges when trying to safeguard children from nonfamily abduction. While 13 percent of the infants abducted from health care facilities are from nurseries, another 13 percent of the infants abducted are from pediatric units including children's hospitals. **It is recommended similar and consistent security protocols be implemented in pediatric areas since they can also include infants.** It is imperative the facility's assessment be used to identify any variations in security protocols for inpatient infant unit(s) to demonstrate reasonable and appropriate protection processes for pediatric patients.

As in special care nursery situations, parents may not be constantly present until the child's discharge. The constant presence of family should be encouraged for those patients younger than 12 months. In addition nurses may not be ever present in the infant's room when family is absent, and infants are not usually placed in a centralized nursery when family members are absent. Pediatric units in a community based hospital may be mixed with adults or on a multiservice unit with a pediatric population. Thus pediatric units often are less secure or hardened than maternal child care units and special care nurseries, and special considerations are needed when employing items as noted in 3-4-1 beginning on Page 26. Conduct a

search of public sex offender registries for any adult patient located on the same unit as pediatric patients. Alternative arrangements should be made for individuals on these registries for the protection of pediatric patients.

Consider installing alarms, preferably with time-delayed egress, on all stairwell and exit doors to the unit. Optimally, video/digital recording should be integrated into the alarm activity.

When considering installation of an electronic security system in pediatric units, at a minimum, all patients birth through 6 months of age should be tagged. A rationale should be established and documented as to any age designations for tagging such as at 12 years of age or younger than 18. And, if an electronic tagging system is to be used with patients in the pediatric unit, allowances should be made for those patients who are permitted to leave the unit such as alarm activation once the child has been gone a specified period of time. When Code Pink is used in a facility to alert staff members there is a missing infant, consider using a different code word, or the same code word with an age descriptor, for missing pediatric patients and older children visiting the facility. It is important for staff members to clearly understand the type of missing patient/child they are looking for from an infant being transported when a Code Pink is called to an older more ambulatory pediatric patient/visitor.

While nonfamily infant abductions grab the headlines, more common are family abductions involving custody disputes, child abuse and Department of Family and Children Services or DFCS intervention. While this problem is widespread and statistical information is available about the subject of family abduction, there is little systematic data available about such abductions from health care facilities. It is likely, however, family abductions and DFCS intervention are grossly underreported. And, because these cases often involve abuse and/or neglect issues, the child may be at greater risk than newborn infants taken from maternal child care units. When such abductions occur the National Center for Missing & Exploited Children® is available to provide technical assistance and may be reached at 1-800-THE-LOST® (1-800-843-5678).

Upon admission of a child to a patient room and during the orientation process, nursing staff members should ask the parent/guardian if there is any personal circumstance the facility should be aware of, especially as it relates to a family situation, that might place the parent/guardian or child at risk. Special concern should be placed on single parents who may be involved in a custody dispute or if the mother has a protective order against the infant's father or vice versa. This line of questioning is best accomplished with a caring attitude because parents/guardians will often open up about past problems of abuse and even attempted abductions by the noncustodial parent in such situations.

Several factors to review when considering to establish protection for a patient include abduction risk, age of child, probability for violence, circumstances surrounding the risk, visitor screening program and coordination of security concerns

with state and local agencies responsible for taking custody of children due to abuse and/or neglect. Protection strategies include:

- Flagging the child's name in the system to indicate no information is to be released.
- Admitting the child under an assumed name.
- Placing the child in an isolation room or the intensive care unit.
- Placing the child in a room best observed from the nursing station.
- Placing an assumed name on the child's door.
- Using a wireless video surveillance camera with a monitor at the nurses' station to closely watch the child.
- Increasing frequency of observation in the patient's area.
- Posting a description of the potential abductor with security, nursing and the front desk or reception area.
- Posting a security officer or sitter at the patient's room/floor/unit.

Please use the self-assessment tool, beginning on Page 63, when assessing needs in pediatric units.

Outpatient areas

Clinics or postpartum treatment facilities for mothers, pediatric clinics, health maintenance organizations or HMOs and waiting rooms in health care facilities should **clearly post a policy stating parents or guardians are not allowed to leave children unattended in the waiting room or delegate that duty to others**. Such facilities should enforce this rule by reminding parents when they violate it. Post this policy in all the languages spoken by patients in your service area.

Facilities should establish a policy regarding the specific identification worn by staff members authorized to transport and treat the infant, and inform parents/guardians of that policy. In addition, when possible, avoid having outpatient services located in or near inpatient service areas to cut down on the number of visitors to in-service areas where infants stay while in the facility.

Visiting nurses, home health aides, home health care workers, HMO workers, nurses in physicians' offices, and all nursing and medical students should be issued the same unique photo ID to transport badge referenced in Guidelines 3-2-4 and 3-2-5 beginning on Page 17 and 3-2-14 on Page 21. **Whenever possible families should be notified of planned visits to their home, and families should be cautioned against allowing anyone to enter their home not having the approved form of identification issued by that service.**

...clearly post a policy stating parents or guardians are not allowed to leave children unattended in the waiting room or delegate that duty to others.

The proliferation of identity theft crimes demonstrates fraudulent identification is readily made and easily obtained. As such patients should be reminded to always ask to see the visiting home nurse's photo ID, as issued by the appropriate facility, association, affiliation

and/or employer, and contact that issuing entity for verification. To facilitate this process, upon discharge, the facility should provide the parents with a list of telephone numbers parents may use to verify/confirm the identity of the visiting home nurse.

The visiting nurses and nursing/medical students should be included under the issuing facility's policies and procedures and critical incident response plan. All other health care workers should be included under a critical incident response plan from their employer whether a physician, HMO, government agency or other entity. Care must be taken to encourage physicians who are in direct contact with infants to fulfill this requirement.

Case

example

The victim mother took her 3-day-old son to the pediatrician's office for a well-baby check-up. After the appointment, when returning to the parking lot with her son, the mother noticed a vehicle parked next to hers.

The victim mother placed her son in the car seat in her vehicle and started to get into her vehicle. When doing so a woman exited the vehicle next to her and took the infant.

The victim mother tried to retrieve her son, but the woman in the other vehicle shot her multiple times and then ran over the victim mother when fleeing the scene with the infant.

Multiple witnesses were able to provide law enforcement with a description of the vehicle the woman fled in along with a partial license plate number and direction of travel. Law enforcement then issued an AMBER Alert.

The victim mother succumbed to her injuries. The infant was recovered approximately eight hours later.

Key factors helping to recover the infant

Key factors helping in the recovery of this infant included:

- Law enforcement was immediately called.
- Witnesses provided sufficient information for an AMBER Alert to be issued.
- Suspect heard about the vehicle described in the AMBER Alert and contacted law enforcement telling them she owned a similar vehicle; law enforcement considered her a primary suspect when she provided conflicting information about her whereabouts at the time of the abduction.

Teaching points

Because such physicians' offices should be considered as possible locations for infant abductions, doctors and their staff members should receive education about the topic of infant abduction and learn the characteristics of a typical infant abductor as found on the inside front cover of this guide. In addition parents should be educated about potential abduction scenarios and preventive steps to be taken to reduce the risk as noted in, "What parents need to know" beginning on Page 57.

Homes

As stated previously, as of the publication of this guide in August 2014, there has been **no** use of violence against mothers **within** health care facilities, and, of the 119 infant abductions from homes, 30 percent involved some form of violent act committed against the mother including homicide. Clearly the location of abduction in the last few years is moving primarily to the home; therefore, the importance of patient education before postpartum discharge is paramount. Consider using a signed release form indicating the parent has received the information titled “What parents need to know” beginning on Page 57. In several cases an abductor has made initial contact with a mother and infant in the health care setting and then subsequently abducted the infant from the family home. A high degree of diligence should, therefore, be exercised by the health care facility when releasing information about the birth of the infant. It is inappropriate for the health care facility to supply birth announcements to the press containing a family’s complete home address or any other unique identifying data.

An important difference is evident in the abduction style and technique used in health care versus nonhealth care settings. Since the use of violence is more prevalent in home settings, families should be cautioned to allow only family members and known friends into the home, not merely acquaintances met during the mother’s pregnancy and/or recent stay in the birthing/health care facility or known only online such as in social networking sites, blogs, chat rooms and forums. *See* “What parents need to know” beginning on Page 57.

Additionally, with the trend toward reduced stays in facilities for mothers once they have given birth, *see* the “Bibliography” on Page 96 for the 2002 entry by Madden, et al., of their article in *The New England Journal of Medicine*, about how a reduced stay for a mother increases her recovery at home during a critical time when she should be vigilant about her infant’s physical safety. Thus there could be an even greater increase in the infant’s risk of being abducted from the home setting because typically fewer people are in the home to help the mother with direct line of sight supervision. As a result every effort should be made to have trusted family members and friends assist mom in the home with all child care duties until she is fully recovered and able to take those over herself.

The most extreme cases of infant abduction from homes and other places outside of the health care setting involve a victim mother who is pregnant and her unborn child is cut from her womb by the abductor. NCMEC has documented 15 such cases from July 1987 through October 2011. Tragically, during that time period, 15 of these mothers and five of these infants died from their injuries. Miraculously 10 of the infants victimized in this way survived their traumatic abductions.

The profile of a typical abductor holds true in these extreme cases of infant abduction. Health care providers must reinforce patient education regarding personal safety issues in relation to this rare and extreme type of infant abduction.

Case
example

While her husband was at work a young mother of two sons took some time for herself and worked out while their infant son, a 1-month old, napped and his older brother, a 4-year-old, played in another room.

Just before 10 a.m. the 4-year-old noticed two adults peering in the front windows of the home. He did not answer the door and returned to playing as he thought they had left. Instead the pair apparently entered the home through an unlocked garage door.

The 4-year-old observed the pair taking his younger brother and tried to alert his mother. By the time his mother reached the room where the infant had been napping, the pair had left the home with the infant and were observed driving away.

Law enforcement was called, and by 10:30 a.m. a statewide AMBER Alert had been issued based on the detailed description provided by the 4-year-old including the fact the woman was wearing a form of photo ID. Within five hours, in response to a lead generated by the AMBER Alert, the infant was located about 100 miles away, and the female suspect was taken into custody.

While interviewing the victim family, investigators learned one month earlier, prior to discharge from the hospital, the victim parents were approached by a woman claiming to be the visiting home nurse assigned to them. The parents indicated the woman appeared to be legitimate and was wearing a form of photo ID when she met with them. This woman did go to their home a few weeks later to check on the infant. The description of the visiting nurse was similar to that of the woman who took the infant from the home.

Key factors helping to recover the infant

Key factors helping in the recovery of this infant included the:

- Immediate response by law enforcement and speed with which they issued the AMBER Alert.
- Key descriptive information about the suspects as provided by the 4-year-old.
- Positive response of the public to the AMBER Alert.

Teaching points

Facilities should take every opportunity to educate parents about any follow-up care in the home offered by the facility after discharge and the procedures surrounding that care. Such should include consideration of providing this information to the patient on the discharge instruction sheet he or she signs with the patient keeping a copy of the discharge sheet when leaving the facility. See 3-2-14 on Page 21 for additional information regarding this point.



missingkids.com

MISSING

HELP BRING ME HOME

NCMEC 1058972



Bryan Dossantos-Gomes



Missing Since: **Dec 1, 2006**
 Missing From: **Fort Myers, FL**
 DOB: **Nov 3, 2006**
 Age Now: **7**
 Sex: **Male**
 Race: **Hispanic**
 Hair Color: **Black**
 Eye Color: **Brown**
 Height: **2'0"**
 Weight: **12 lbs**



Age Progressed

Composite Sketch



Abductor
 Sex: **Female**
 Race: **Hispanic**
 Hair Color: **Black**
 Height: **5'4"**

Bryan's photo is shown age-progressed to 6 years. He was last seen in the area of Estero, Florida. He may be in the company of a heavy set White/Hispanic female, approximately 28-30 years old, with long straight black hair, and last seen wearing blue jeans and a black blouse. They may be traveling in a two-door black Ford Explorer similar to the one pictured above. The companion is armed and should be considered dangerous. CAUTION ADVISED.

DON'T HESITATE!

ANYONE HAVING INFORMATION SHOULD CONTACT

CALL 911 or
1-800-843-5678 (1-800-THE-LOST®)

Fort Myers Police Department (Florida) 1-239-321-7700 or
Your Local FBI

Case handled by



Follow us twitter.com/missingkids facebook.com/missingkids

6. What parents need to know

Personnel in health care facilities should inform **parents**, in a warm and comforting way, of the measures they can take to protect their newborn baby from the risk of abduction. The guidelines listed below provide good, sound parenting techniques to help prevent abduction of babies both while in the health care facility and once taken home. Health care providers should share this information with expectant parents during prenatal visits and at the time of birth.

Health care facilities should provide multilingual educational information. The risk levels of abduction for babies may be elevated when parents are not properly educated in their native language about the safety issues involved. A Spanish-language version of these tips is found beginning on Page 60, and health care facilities should consider translating these tips into any other languages used by patients in their service area.

While in the health care facility

1. Inquire about security procedures used by the facility at some point **before** the birth of your baby. Request a copy of the facility's written guidelines about special care and security procedures in the maternity unit. Know all of the facility's procedures in place to safeguard your baby while staying in that facility.
2. Ask again, after admission, about the facility's protocols concerning the routine nursery procedures, feeding and visitation hours, and security measures.
3. Be deliberately watchful over your newborn baby. While it is normal for new parents to be anxious, it is important to channel that energy into positive vigilance and keep your baby within direct line of sight.
4. Do not leave your baby out of your direct line of sight even when you go to the restroom or take a nap. If you leave the room or plan to go to sleep, alert the nurses to take your baby back to the nursery or have a trusted family member watch your baby. When possible keep your baby's bassinet on the side of your bed away from the door(s) leading out of the room.
5. Do not give your baby to **anyone** without properly verified identification as issued by that facility. Find out what additional or special identification is being worn to further identify facility personnel who have authority to transport your baby. Speak to a person in authority, such as a unit director or charge nurse, if you have any questions or concerns.
6. Become familiar with the staff who work in the maternity unit. During short stays in the facility, ask to be introduced to the nurse assigned to your baby and you.

7. Question unfamiliar people entering your room or inquiring about your baby — even if they are in the facility's attire or seem to have a reason for being there. Immediately alert the nurses' station.
8. Determine where your baby will be when taken for tests and how long the tests will take. Find out who has authorized the tests. It is appropriate to go with your baby to observe the procedure if you are uncomfortable with anyone who requests to take your baby, are unable to clarify what testing is being done or do not know why your baby is being taken from your room. If you are unable to accompany your baby, have a trusted family member go along.
9. Have at least one color photograph of your baby, with a full, front-face view, for your records to take home. Also, since it is recommended health care facilities footprint newborn babies, ask for a set to take home. And compile a complete written description of your baby including hair and eye color, length, weight, date of birth and specific physical characteristics.
10. Request a set of written guidelines, at some point **after** the birth of your baby, but **before** discharge from the facility, about the procedures for any follow-up care extended by the facility scheduled to take place in your home.

Once at home

1. Do not allow anyone into your home who says he or she is affiliated with the facility without properly verified identification as issued by that facility. Find out what additional or special identification is being worn to further identify those staff members who have authority to enter your home.
2. Consider the risk you may be taking when permitting your baby's birth announcement to be published in the newspaper or online. Birth announcements should never include the family's home address and be limited to the parents' surname(s). In general, birth announcements in newspapers are not endorsed by most experts. **Also use caution when communicating with those on social media and carefully consider what you post on your social media pages about your baby and you. Specifically do not include the mother's first name or home location when posting the announcement, and remember what information is already posted in online profiles that could provide these details.**
3. Know the use of outdoor announcements such as signs, balloons, large floral wreaths and other lawn ornaments are not recommended to announce a birth because they call attention to the presence of a new baby in the home.

4. Allow only people into your home who are well-known by the mother. It is ill advised to allow anyone into your home who is just a mere or recent acquaintance, especially if met briefly since you became pregnant or gave birth to your baby. There have been several cases in which an abductor has made initial contact with a mother and baby in the health care facility setting and then subsequently abducted the baby from the family home. If anyone should arrive at the home claiming to be affiliated with the health care facility where the baby was born or other health care provider, remember to follow the procedures outlined above. A high degree of diligence should be exercised by family members when home with the baby. The baby's family is the domestic security team for their family. All family members should be sensitive to any suspicious visitors.

In addition there have been cases in which initial contact with a mother and baby was made in other settings such as clinics, doctors' offices, shopping malls and bus stations. When taking your baby out, whenever possible, take a trusted friend or family member with you as an extra set of hands and eyes to protect and constantly observe your baby. **Never** leave a child alone in a motor vehicle even if just for a few moments to run a short errand, such as paying for gas, as it is too easy for someone to steal the car. Always take the child with you. And never let someone you don't know pick up or hold your child.

Note: The National Center for Missing & Exploited Children® encourages the distribution of the English- and Spanish-language version of "What parents need to know" by health care facilities to patients who will be giving birth to infants in their facility. These tips and NCMEC's reprint policy are found at www.missingkids.com/InfantAbduction.

Lo que los padres necesitan saber

Los consejos enumerados a continuación brindan a las madres técnicas buenas y sólidas para ayudar a prevenir la sustracción de bebés, tanto mientras se encuentran en hospitales o centros de salud como una vez que los llevan al hogar.

Mientras están en el hospital o centro de salud

1. Averigüe sobre los procedimientos de seguridad usados por el centro hospitalario en algún momento **antes** de dar a luz a su bebé. Solicite una copia de las pautas escritas sobre cuidados especiales y procedimientos de seguridad en la sala de maternidad. Conozca todos los procedimientos que se han adoptado para proteger a su bebé mientras esté en ese establecimiento.
2. Después de la admisión, pregunte nuevamente sobre los protocolos del centro hospitalario respecto a los procedimientos de rutina de la sala de recién nacidos, las horas de comidas y de visitas y las medidas de seguridad.
3. Vigile con atención a su bebé recién nacido. Aunque es normal que los padres nuevos se sientan ansiosos, es importante canalizar esa energía en una vigilancia positiva y mantener a su bebé directamente a la vista.
4. No deje a su bebé fuera de su vista incluso cuando vaya al baño o tome una siesta. Si sale de la habitación o tiene intenciones de dormir, avise a las enfermeras para que lleven a su bebé a la sala de recién nacidos o pida a un miembro de confianza de su familia que lo vigile. Siempre que sea posible mantenga la cuna del bebé en el lado de su cama que esté más alejado de la puerta de la habitación.
5. No entregue su bebé a **nadie** que no tenga identificación de ese centro hospitalario debidamente verificada. Averigüe cual es la identificación adicional o especial del personal del hospital que ha sido autorizado para transportar a su bebé. Si tiene preguntas o alguna preocupación hable con una persona de autoridad, como el director de la unidad o la enfermera encargada.
6. Conozca al personal que trabaja en la sala de maternidad. Durante estancias breves en el centro hospitalario pida que le presenten a la enfermera encargada de su bebé y de usted.
7. Interrogue a las personas desconocidas que entren a su habitación o que pregunten sobre su bebé, aunque estén vestidas con uniformes médicos del hospital o parezcan tener alguna razón para estar allí. Alerte de inmediato a la estación de enfermeros.
8. Averigüe donde estará su bebé cuando lo lleven a hacerle exámenes, y cuánto tiempo durarán dichos exámenes. Averigüe quién ha autorizado los exámenes. Es apropiado que acompañe a su bebé para observar el procedimiento si no se siente cómoda con alguna persona que quiera llevarse a su bebé, que no pueda aclarar qué exámenes quieren hacerle

- o por qué quieren sacarlo de su habitación. Si usted no puede acompañar al bebé, haga que lo acompañe un miembro de confianza de su familia.
9. Para los archivos que llevará a su casa, tome por lo menos una fotografía en colores de todo el rostro de su bebé, de frente. Además, dado que se recomienda que los centros hospitalarios tomen impresiones de la planta del pie de los recién nacidos, pida que le den una copia para llevar con usted. Y escriba una descripción completa de su bebé que incluya el color del cabello y de los ojos, tamaño, peso, fecha de nacimiento y características físicas específicas.
 10. En algún momento **después** del nacimiento de su bebé pero **antes** de ser dada de alta del centro hospitalario, pida una copia escrita de los procedimientos para cualquier tratamiento de seguimiento programado por el hospital que vaya a recibir en su casa.

Cuando están en el hogar

1. No permita entrar a su casa a ninguna persona que diga trabajar para el centro hospitalario sin verificar debidamente su documento de identificación emitido por ese hospital. Averigüe cuál es la identificación adicional o especial requerida del personal del hospital que ha sido autorizado para entrar a su casa.
2. Considere el riesgo que corre al permitir la publicación del anuncio del nacimiento de su bebé en el periódico o en línea. Los anuncios de nacimientos nunca deben incluir el domicilio de la familia y deberían limitarse a los apellidos de los padres. En general, los expertos no recomiendan anuncios de nacimiento en los periódicos. **También use cautela al comunicarse con otros en las redes sociales y considere qué es lo que publicará en sus páginas de esas redes sobre su bebé y usted. Específicamente, no incluya el primer nombre de la madre o la dirección del hogar al publicar el anuncio y recuerde cual es la información que ya ha publicado en perfiles en línea que pudiera dar estos detalles.**
3. Sepa que no se recomienda el uso de decoraciones en la parte de afuera de su casa para anunciar el nacimiento de su bebé, como carteles, globos, coronas de flores y otros adornos de jardín debido a que llaman la atención sobre la presencia de un nuevo bebé en la casa.
4. Deje entrar a su casa sólo a personas que sean bien conocidas por la madre. No se aconseja dejar entrar en su casa a nadie a quien acaba de conocer o no conoce bien, especialmente si conoció a esa persona brevemente desde que estuvo embarazada o desde que dio a luz. Hubo varios casos en los que el secuestrador hizo contacto inicial con la madre y con el bebé en el hospital y luego lo secuestró de su hogar. Si alguien se presenta al hogar diciendo estar afiliado al hospital donde nació el bebé u otro centro de salud, recuerde seguir los procedimientos descritos previamente. Los miembros de la familia deben ser muy cuidadosos cuando se encuentran en el hogar con el bebé. La familia del bebé es el equipo de seguridad en el hogar para su familia. Todos los miembros de la familia deberían estar atentos a cualquier visitante sospechoso.

Además, hubo casos en los cuales el contacto inicial con la madre y con el bebé se hizo en otros lugares, como clínicas, consultorios de médicos, galerías comerciales o estaciones de autobús. Cuando salga con su bebé a algún lado, cuando quiera que sea posible hágase acompañar por un amigo de confianza o un miembro de la familia para tener un par extra de manos y de ojos para protegerlo y observarlo constantemente. **Nunca** deje a un niño solo en un vehículo automotor, aunque sea por un momento para hacer una diligencia breve, como pagar por la gasolina, porque es fácil robar vehículos. Siempre lleve al niño o a la niña con usted. Y nunca permita que una persona a quien usted no conozca alce o sostenga a su bebé.

Nota: El Centro Nacional para Menores Desaparecidos y Explotados fomenta que los hospitales y centros de salud distribuyan las versiones en inglés y en español de “Lo que los padres necesitan saber” a las pacientes que darán a luz en sus instalaciones. Estos consejos y la política de reimpresión del NCMEC se encuentran disponibles en www.missingkids.com/InfantAbduction.

7. Self-assessment for health care facilities

Self-assessment guides are helpful tools for recommendable/advisable policies and/or protocols. This assessment summarizes the key information noted in Chapter “3. Guidelines for health care professionals” beginning on Page 9. Please refer to that chapter for additional information about the guidelines summarized here. **Note:** The guidelines shown in red type within this assessment are considered to be essential for the prevention and documentation every facility should strive to meet. All other guidelines listed are highly recommended.

Consider using a multidisciplinary task force to complete this self-assessment tool on an annual basis. A fillable PDF is available at www.missingkids.com/InfantAbduction to assist with this process. Use the complete assessment to document areas of compliance, to develop new protocols and as an outline to revise/write policies and procedures based on these national guidelines. Document a response to each item on the self-assessment tool even if the recommendation is not applicable or N/A. Remember a reorganization of staff members or staff assignments or remodeling of a facility will require immediate reassessment of these policies and protocols to help ensure all measures are still adequate.

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
3-1 General				
3-1-1 Report immediately to the nurse manager/supervisor, security and administration people exhibiting behaviors of potential abductor.	Essential			
Be sure to positively identify suspect.	Essential			
Keep suspect under close observation.	Essential			
Interview suspect.	Essential			
Exercise caution when interacting with people exhibiting these behaviors.	Recommended			
Maintain this vigilance at all stages of the family's stay from admission to the accompanied discharge of both the mother and infant all the way to their vehicle.	Recommended			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
3-1-2 Preserve report and interview records about incident, many suggest from a minimum of seven years up to the child reaching adulthood.	Essential			
<p>3-1-3 Alert other birthing facilities in the area of attempted abductions/ when person identified who demonstrates behaviors of potential abductor.</p> <p>Develop/use concise, uniform reporting form to facilitate timely recording and dissemination of this information.</p>	<p>Essential</p> <p>Recommended</p>			
<p>3-1-4 Notify law enforcement of all attempted abductions.</p> <p>Notify NCMEC of all attempted abductions.</p>	<p>Essential</p> <p>Essential</p>			
3-2 Proactive measures				
3-2-1 Develop and test/ critique annually a written proactive prevention plan.	Essential			
<p>3-2-2 Attach identically numbered ID bands, immediately after birth, to infant, mother and father/significant other.</p> <p>Inform parents of reason/ need for identically numbered ID bands.</p> <p>Attach identically numbered ID bands as soon as possible, in cases when deliveries occur outside of the</p>	<p>Essential</p> <p>Recommended</p> <p>Recommended</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>facility or in the emergency department, once the mother and infant arrive in labor and delivery/ the maternity unit.</p>				
<p>Ensure system wide response to guard against potential abductors who falsely present themselves in the emergency department as being pregnant and in active labor in an attempt to gain access to newborn infants in the labor and delivery area.</p>	Recommended			
<p>Examine and verify infant's band with the mother's band when taking the infant for care as well as upon delivery of the infant to the mother after care has been rendered.</p>	Essential			
<p>Document above noted process in the medical, chart/record.</p>	Recommended			
<p>Assure no delay in activation of alarm function upon separation of the electronic tag, if used, from the infant no matter what form of attachment bands or clamps are used.</p>	Essential			
<p>Conduct frequent, ongoing testing of the system.</p>	Essential			
<p>Train staff members to immediately</p>	Essential			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>respond so there is no delay between detection of the alarm condition and generation of the alarm notification.</p> <p>Train staff members to respond to trouble and nuisance alarms in the same consistent manner.</p> <p>Train staff members to never assume an alarm is a false alarm.</p>	<p>Essential</p> <p>Essential</p>			
<p>3-2-3 Be sure, prior to removal of newborn from birthing room or within a maximum of two hours of the birth, to:</p> <p>Footprint infant.</p> <p>Take color photograph/video/digital image of infant.</p> <p>Perform and record full, physical assessment and description of infant.</p> <p>Note all these items in infant's medical record.</p> <p>Store sample of infant's cord blood and any other blood specimens until at least day after infant's discharge.</p> <p>Place electronic security tag, if used by facility.</p>	<p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Recommended</p>			
<p>3-2-4 Require all health care personnel wear, above the waist and face side out, up to date, conspicuous, color unobscured photo ID badge.</p>	<p>Essential</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>Be sure all ID badges show:</p> <p>Easily identifiable name and title of person.</p> <p>Conspicuous photo large enough for person to be recognized.</p> <p>Updated photo keeping pace with any changes in person's appearance.</p> <p>Return ID badges to Human Resources or issuing department immediately upon termination of employment.</p> <p>Report badges determined to be missing immediately to appropriate authority.</p> <p>Expire and reissue previously issued badges at a minimum of five years from date of issue.</p> <p>Implement a policy requiring staff members wear their facility issued ID badge at all times when within the facility and always take steps to safeguard from loss when within and outside facility.</p>	<p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Recommended</p> <p>Recommended</p>			
<p>3-2-5 Ensure personnel permitted to transport infants wear a unique form of identification such as a distinctive and prominent color or marking clearly different</p>	<p>Essential</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>than the general health care ID badge.</p> <p>Include provision for:</p> <p>Those temporarily permitted to transport infants such as students and temporary employees including strict access control of their IDs similar to controls used for narcotics.</p> <p>Periodic change of unique form of identification.</p> <p>Those hearing, visually, physically and mentally challenged patients, or those with language barriers, with special needs in this identification process.</p> <p>Perform background checks, including a search of sex offender registries, on all individuals entrusted to care for and transport infants and pediatric patients.</p>	<p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Essential</p>			
<p>3-2-6 Ensure only authorized staff members wearing authorized infant transportation ID badge and the mother and father/significant other with identically numbered ID band to that of the infant's are the only ones allowed to transport that infant within the health care facility.</p>	<p>Essential</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>Educate mother and father/significant other about the importance of this precaution.</p> <p>Ensure infant is always in direct line of sight supervision.</p> <p>Require infants be taken to mothers one at a time and never grouped together while being transported.</p> <p>Ensure infants are always pushed in a bassinet and never carried in anyone's arms.</p> <p>Require family members transporting the infant outside of the mother's room, including mother and father/significant other, wear an ID wristband matching that of the infant's ID wristband.</p>	<p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p>			
<p>3-2-7 Distribute guidelines for parents in preventing infant abductions during prenatal visits, in childbirth classes, on preadmission tours, upon admission, at postpartum instruction and upon discharge.</p> <p>Have the patient sign a document, upon admission, noting receipt of these guidelines with the</p>	<p>Essential</p> <p>Recommended</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>patient retaining the guidelines and a copy of the signed document.</p> <p>Post guidelines in prominent place(s) within the mother's room.</p> <p>Distribute this same information to all new/current staff members and physicians and their staff members working with newborns, infants and child patients.</p>	<p>Recommended</p> <p>Recommended</p>			
<p>3-2-8 Train staff members, at all levels, initially upon hire and at least annually, about protecting infants from abduction at a minimum including:</p> <p>Offender profile and information about unusual behavior.</p> <p>Prevention procedures.</p> <p>Individual responsibilities.</p> <p>Critical incident response plan.</p>	<p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p>			
<p>3-2-9 Place infants in direct line of sight supervision.</p>	<p>Essential</p>			
<p>3-2-10 Be sure not to post mother's or infant's full name where it will be visible to visitors especially on items such as bassinet cards or white boards.</p>	<p>Essential</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>Be sure not to leave medical charts, patient index cards or any other medical information visible to anyone other than medical personnel.</p> <p>Be aware any identifying information should be kept confidential and out of sight to safeguard the family both during their stay at the facility and after discharge.</p> <p>Be sure not to provide patient information via the telephone or electronically.</p>	<p>Essential</p> <p>Essential</p> <p>Essential</p>			
<p>3-2-11 Establish an access control policy and procedure for the nursing unit, nursery, maternity, neonatal intensive care and pediatrics.</p> <p>Instruct health care personnel at the front lobby or entrance to these units to ask visitors which mother they are visiting.</p> <p>Have a policy denying admission if no name is known or given.</p> <p>Set up a system to positively identify visitors, preferably with a photo ID.</p>	<p>Essential</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p>			
<p>3-2-12 Require a show of the ID wristband for the</p>	<p>Essential</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>person taking the infant home from the health care facility and be sure to match the number on the infant's band, as worn on the wrist and ankle, with number on the band worn by the mother and father/significant other.</p>				
<p>3-2-13 Be sure no home address or other unique information is divulged to the public in birth announcements, either standard or special ones for circumstances such as first birth of the year or on Mother's Day, that would put the infant and family at risk after discharge.</p> <p>Reconsider role if facility still provides birth announcements to the media and/or online by:</p> <p>Obtaining parental consent before publishing an announcement in the newspaper or online.</p> <p>Being sure to never include family's home address.</p> <p>Limiting use of the parents' name(s) to combinations with initials such as S. and D. Smith or Sam and Darlene S.</p>	<p>Essential</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>Holding release of announcement until after discharge of both mother and infant.</p>	Recommended			
<p>Activating all online postings with a predetermined ID and/or password without a default option to circumvent this precaution.</p>	Recommended			
<p>Reconsider any role in giving away yard signs announcing the birth for use by parents at home because such may put the infant at risk of abduction.</p>	Recommended			
<p>Be sure to limit specific information provided to the public about security measures used to help ensure potential abductors do not have easy access to information that would assist in an abduction.</p>	Recommended			
<p>Take every opportunity to encourage families to use caution when communicating with those on social media about their newborn infant especially as it relates to information that could put them at risk once home.</p>	Recommended			
<p>3-2-14 Be sure, when providing home visitation services, personnel entering patients' homes wear an authorized and unique</p>	Essential			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>form of identification strictly controlled by the issuing organization and explained to parents at the time of discharge.</p> <p>Provide this information in the discharge instruction sheet the patient signs and takes home.</p> <p>Use a system in which the mother is called before a visit and reminded of the:</p> <p>Date and time of visit.</p> <p>Name of visiting staff person.</p> <p>Requirement for that staff person to wear current, unique photo ID badge.</p>	<p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p>			
3-3 Physical security safeguards				
<p>3-3-1 Complete written assessment of risk potential for infant abduction.</p> <p>Conduct and document assessment of physical security requirements needed for the prevention of infant abductions on an annual basis or more often as targets, risks and methods change such as new construction, at a minimum to:</p>	<p>Essential</p> <p>Essential</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
Be performed by a qualified health care security related professional.	Essential			
Evaluate existing policies and procedures.	Essential			
Apply safeguards using recommended guidelines, systems and hardware to harden the target.	Essential			
Assess need for appropriate application/continued use of any combination of physical controls or electronic systems such as video surveillance cameras, locked and alarmed emergency exit door controls, intercoms, remote door releases and electronic tagging systems.	Essential			
Perform assessment under auspices of organization's performance improvement program or Patient Safety Organization.	Essential			
3-3-2 Install alarms, preferably with time-delayed egress, on all stairwell and exit doors on the perimeter of the maternity, nursery, neonatal intensive care and pediatrics units.	Essential			
Establish policy of responding to all alarms and instructing responsible staff members to silence and reset an activated alarm only after direct observation of the	Essential			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>stairwell or exit and person using it.</p> <p>Document activated alarms, submit documentation to proper facility authority and generate monthly reports to be reviewed with security and nursing.</p> <p>Integrate, when possible, video/digital recording into alarm activity.</p>	<p>Recommended</p> <p>Recommended</p>			
<p>3-3-3 Install self-closing hardware on all doors to all nurseries, ensure they remain locked at all times and have a staff member present at all times when the nursery is in use.</p>	<p>Essential</p>			
<p>3-3-4 Lock/have under strict access control, at all times, all doors to lounges, locker rooms and storage areas where staff members change/leave clothing or store scrub suits.</p>	<p>Essential</p>			
<p>3-3-5 Conduct and document a needs assessment for an electronic security detection system using an always activated tag tied to video/digital recording of the incident/alarm activation and integrated with electronic locking devices to prevent exiting when a tagged infant is in close proximity to the exit.</p>	<p>Essential</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>Establish defined countermeasures to be used in the event the system becomes inoperable.</p> <p>Document and keep a record of all activations when using an electronic tagging system.</p> <p>Test electronic tagging system weekly in each individually protected area/at each door, by way of using a randomly selected tag not a test tag.</p> <p>Document each test.</p> <p>Report test results to nurse manager, security manager and other proper authority within facility.</p> <p>Tests should include all aspects of the system used including skin sensor alarms, door locking and elevator controls, and camera activations.</p> <p>Allow for alarm activation after a specified period of time when using the system in pediatric units with patients who are permitted to leave the unit.</p>	<p>Recommended</p> <p>Essential</p> <p>Recommended</p> <p>Essential</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p>			
<p>3-3-6 Install and properly maintain a security camera system.</p> <p>Record at all times.</p>	<p>Essential</p> <p>Essential</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>3-3-9 Use electronic surveillance and access control equipment including:</p> <p>Cameras with color video/digital recording.</p> <p>Maintenance of purchase and repair records.</p> <p>Performance of routine preventive maintenance.</p> <p>Alarms on all stairwell and exit doors on the perimeter of the unit adjusted to allow for maximum delay in unlocking as allowed by local fire regulations.</p> <p>Audit trails of recorded media to be maintained for a minimum of seven days as an aid to investigators.</p> <p>Electronic systems, which are fully integrated.</p> <p>Cameras working in conjunction with time-delayed and other alarms as well as electronic tagging system alarms if used.</p>	<p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p>			
<p>3-3-10 Be sure infants discharged/ tags removed only after all functions completed.</p>	<p>Essential</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
Ensure infants are not left unattended by health care personnel after tag is removed.	Recommended			
<p>3-4 Critical incident response plan</p> <p>General</p> <p>3-4-1 Develop/maintain written, critical incident response plan regarding prevention of/response to infant abductions and share it with all staff members within maternal child care areas and pediatrics.</p> <p>Use code, such as Code Pink, to alert facility personnel when there is a missing infant.</p> <p>Consider emailing and/or using mass emergency messaging to alert all employees with essential information about the abduction.</p> <p>Conduct at least one unannounced facility wide infant abduction response drill annually involving all facility personnel.</p> <p>Advise about/invite law enforcement to participate in facility wide drill.</p> <p>Have written action plans to follow in case of an infant abduction in other departments such as</p>	<p>Essential</p> <p>Essential</p> <p>Recommended</p> <p>Essential</p> <p>Recommended</p> <p>Recommended</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
security, communications/ switchboard, environmental services, accounting and public relations.				
Conduct training about these plans beginning at general employee orientation through departmental orientation competencies and during annual refresher training.	Recommended			
Conduct quarterly unit specific drills, tabletop exercises or audit type exercises.	Recommended			
Ensure all abduction scenarios used are patterned after the typical abductor profile and include realistic scenarios foreseeable to health care professionals.	Recommended			
Use teachable moments throughout each patient's stay to help reinforce procedures to be followed by patients and their families when in the facility.	Recommended			
Invite local law enforcement to visit facility to do a walk-through of the newborn areas to review protocols, learn facility's layout, and learn how labor and delivery and postpartum units operate.	Recommended			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
3-4-2 Call NCMEC at 1-800-THE-LOST® (1-800-843-5678) to request technical assistance.	Essential			
Nursing 3-4-3 Conduct a head count of all infants while immediately and simultaneously searching the entire unit, and question the infant's mother about other possible locations of the infant.	Essential			
3-4-4 Call facility security and/or other designated authority immediately and simultaneously.	Essential			
3-4-5 Secure and protect the crime scene, and allow no entrance until law enforcement releases it. Ensure staff members in the unit at the time of the abduction remain until permitted to leave by the investigating authority.	Essential Essential			
3-4-6 Move the parents of the abducted infant, but not their belongings , to a private room off the maternity floor. Have the nurse assigned to the mother and infant continue to accompany the parents at all times. Coordinate services to meet the emotional,	Recommended Recommended Recommended			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>social and spiritual needs of the family.</p> <p>Provide regular, ongoing, information updates to the family in collaboration with other entities such as law enforcement.</p> <p>Secure all medical records/ charts of the mother and infant.</p> <p>Notify lab and place stat hold on infant's cord blood and any other blood specimens.</p> <p>Designate a room for other family members to wait in giving them easy access to any updates in the case while offering the parents some privacy.</p> <p>Designate a room for media and another one for law enforcement.</p>	<p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p>			
<p>3-4-7 Have nurse manager/ supervisor brief all staff members of the unit.</p> <p>Have nurses then explain the situation to each obstetric patient/mother while the mother and her infant are together.</p>	<p>Recommended</p> <p>Recommended</p>			
<p>3-4-8 Assign one staff person, preferably the nurse assigned to the mother</p>	<p>Recommended</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>and infant, to be the primary liaison between the parents and facility after the discharge of the mother from the facility.</p>				
<p>3-4-9 Hold a group discussion session as soon as possible in which all personnel impacted by the abduction are required to attend to:</p> <p>Allow health care personnel a forum for expressing their emotions and helping them address stress resulting from the abduction.</p> <p>Allow for reinforcement of the directive for staff members not to communicate with the media about the incident unless so designated to be the facility's spokesperson.</p> <p>Provide the opportunity to refer those needing additional help to facility's employee assistance program.</p> <p>Allow for reinforcement of the fact discussion of incident details should be shared with appropriate authorities only.</p> <p>Allow for reinforcement of the fact the session</p>	<p>Essential</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>is to focus on staff members obtaining emotional support rather than discussing case details.</p>				
<p>Security personnel 3-4-10 Respond, immediately and simultaneously, to perimeter points of the grounds to observe people leaving and record vehicle license plate numbers.</p> <p>Proceed to the location of the incident, after securing the perimeter, and activate a search of the entire health care facility, interior and exterior.</p> <p>Call local law enforcement, and make a report.</p> <p>Ask law enforcement to dispatch an officer to the scene using only the standard crime code number over the radio without describing the incident.</p> <p>Call the local FBI office requesting assistance from the unit handling crimes committed against children.</p> <p>Assume control of the crime scene until law enforcement arrives.</p>	<p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Recommended</p> <p>Essential</p> <p>Essential</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>Assist nursing staff members in establishing and maintaining security in the unit.</p> <p>Notify public relations.</p> <p>Secure videotapes/ digital recordings for seven days prior to the date of the incident, and request the same from other health care facilities in the area and adjacent businesses.</p> <p>Provide law enforcement access to equipment, technical assistance and a private location to review electronic images and obtain copies.</p>	<p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Recommended</p>			
<p>3-4-11 Follow facility's media plan, which should mandate all information about the abduction be cleared by facility and law enforcement authorities involved before being released to staff members and the media.</p>	<p>Essential</p>			
<p>3-4-12 Brief the health care facility spokesperson who can inform and involve local media by requesting their assistance in accurately reporting the facts of the case and soliciting the support of the public.</p> <p>Apprise family of media plan and seek their cooperation in working through official spokespeople.</p>	<p>Essential</p> <p>Recommended</p>			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>3-4-17 Call NCMEC at 1-800-THE-LOST (1-800-843-5678), which can provide technical assistance, network with other agencies and organizations, assist in obtaining media coverage about the abduction, and coordinate dissemination of the infant's photograph.</p>	Essential			
<p>3-4-18 Call the local FBI office requesting the assistance of the crimes against children coordinator with technical and forensic resource coordination; computerized case management support; investigative, interview, and interrogation strategies; and information about behavioral characteristics of unknown offenders.</p>	Essential			
<p>3-4-19 Secure and review any available videotapes/digital recordings from the abduction scene and contact all other birthing facilities in the community and adjacent businesses to request the retrieval and secure storage of the previous seven days of videotapes/digital recordings for review.</p> <p>Ensure release of any and all video recordings is done with the concurrence of risk management and legal counsel.</p>	Essential			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
3-4-20 Set up one dedicated local telephone hotline for receipt of sightings/leads or coordinate this function with a local organization.	Recommended			
3-4-21 Polygraph infant's parents, female offender and male companion of offender.	Recommended			
3-4-22 Charge abductor appropriately. Make every effort to sustain a conviction.	Essential Essential			
3-4-23 Release of information concerning infant abduction should be well planned and agreed upon by the health care facility and law enforcement authorities involved. Keep family fully informed.	Essential Essential			
Public relations 3-4-24 Provide facts of case to media, ask for their assistance in releasing information to the public in hopes of generating leads about the infant and ask them to respect the privacy of the family. Limit information released to that which is approved by law enforcement and health care facility, minimizes information about security	Essential Recommended			

GUIDELINE	STATUS (Essential/ Recommended)	RESPONSIBLE PERSON/ TEAM	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>procedures and technology used within the facility, and refrains from blaming victim families for any aspect of the abduction.</p> <p>Prepare and jointly issue with law enforcement press release about the abduction.</p> <p>Place press release on facility's website.</p> <p>Designate/maintain separate areas for:</p> <p>Family members and friends of parents to gather for receipt of regular updates.</p> <p>Media to gather for receipt of regular updates.</p> <p>Provide media with escorted opportunities to film appropriate areas within facility and guard against attempts of unauthorized or unaccompanied media access.</p>	<p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p> <p>Recommended</p>			
<p>3-4-25 Provide written statement to address callers' concerns over the abduction, especially for anxious parents who are planning to deliver their infants at that facility, and instructions about how to handle tips or information received about the abduction.</p>	<p>Essential</p>			
<p>3-4-26 Activate the crisis communication plan.</p>	<p>Essential</p>			

8. Bibliography

The partial bibliography below outlines, in chronological order, the benchmark articles in journals and publications for health care professionals about this issue. For additional information about related articles from popular magazines and newspapers, contact the Missing Children Division of the National Center for Missing & Exploited Children® at 1-800-THE-LOST® (1-800-843-5678).

The specific date of foreseeability of a particular infant abduction incident may vary; however, there is wide agreement foreseeability affixed to health care nationwide at least as early as January 1992.

1965

Wierschem, Joseph. "Know Them By Their Feet." *Medical Record News: Journal of the American Association of Medical Record Librarians* (June 1965), Pages 158-168.

1966

Gleason, Doris. "Tightening the Loopholes in Newborn Identification." *Hospitals: Journal of the American Hospital Association*, Vol. 40 (August 1, 1966, Part I), Pages 60-63.

"Footprinting of Infants." *FBI Law Enforcement Bulletin* (October 1966), Pages 8-11.

1982

Colling, Russell L. *Hospital Security*. Second edition. Stoneham, Massachusetts: Butterworth-Heinemann, 1982.

1987

Johnston, Jeffrey. "Several Infants Kidnapped at Hospitals." *Family Practice News*, Vol. 17, No. 18 (Sept. 15-30, 1987), Pages 2, 53.

Johnston, Jeffrey. "Preventing Infants' Abduction From Hospital." *Ob. Gyn News*, Vol. 22, No. 18 (Sept. 15-30, 1987), Pages 3, 18.

1988

See *Hospital Security and Safety Management*, various articles from August 1988 to present.

Rabun, John B., Jr., and Michelle P. Spring. "Newsbriefs: Infant Abductions." *Police: The Law Officer's Magazine* (December 1988), Pages 10-13.

1989

Rabun, John B., Jr. *For Hospital Professionals*. First edition. Alexandria, Virginia: National Center for Missing & Exploited Children, May 1989.

Lloyd, David W. "Abduction of Infants From Hospitals: Issues of Risk Management." Paper prepared as reference about topic, National Center for Missing & Exploited Children, October 1989.

Smock, Bruce K. "IAHSS Survey of Infant Abductions 1983-1989." *Journal of Healthcare Protection Management*, Vol. 6, No. 1 (Fall 1989), Pages 40-50.

1990

"Maternity Unit Openness Brings Rise in Baby Kidnappings." *Hospital Risk Management*, Vol. 12, No. 1 (January 1990), Pages 1-4.

Spadt, Susan Kellogg, and Kenneth D. Sensenig, Sr. "Infant Kidnapping: It Can Happen in Any Hospital." *MCN: The American Journal of Maternity/Child Nursing*, Vol. 15 (January/February 1990), Pages 52, 54.

Turner, James T. "Infant Abductions in Health Care: Critical Incident Response." *Journal of Police and Criminal Psychology* (March 1990), Pages 2-10.

Newborn Nursery: Security Audit Instrument. Lombard, Illinois: Communicorp, 1990.

Fiesta, Janine. "Security: Whose Liability, Infant Kidnapping." *Nursing Management*, Vol. 21, No. 5 (May 1990), Pages 16-17.

Eubanks, Paula. "Hospital Nursery Kidnappings Are Rare But Devastating." *Hospitals: The Magazine for Health Care Executives* (June 20, 1990), Pages 64, 66.

Smock, Bruce K. "How to Prevent Abductions of Infants from Hospitals." *Health Facilities Management*, Vol. 3, No. 7 (July 1990), Pages 18-24.

"Infant Kidnappings: Hospitals, Employees More Vigilant." *Healthwire*, Vol. 12, No. 6 (November/December 1990), Page 3.

1991

Rabun, John B., Jr. *For Hospital Professionals*. Second edition. Alexandria, Virginia: National Center for Missing & Exploited Children, March 1991.

Safeguard Their Tomorrows™ is a program consisting of educational materials for health care professionals and available at no charge through the National Center for Missing & Exploited Children. Nationwide distribution of this program began in June 1991.

"NAACOG Safeguards Future of Infants with New Video." *NAACOG Newsletter*, Vol. 18, No. 8 (August 1991), Page 3.

Wilkie, Joy A. *A Sense of Security: A Hospital Guide to Infant Security in the Maternity Unit*. Columbus, Ohio: Ross Laboratories, 1991.

"Risk Analysis: Preventing Infant Abductions." *Hospital Risk Control* (September 1991), Pages 2-16.

"Infant Abductions from Hospitals." *Hospital Topics*, Vol. 69, No. 4 (Fall 1991), Page 43.

Westerbeck, Tim. "A Hospital's Worst Nightmare." *Public Relations Journal* (November 1991), Pages 8, 12.

Rabun, John B., Jr. "Preventing Abduction of Infants from Hospitals." *Plant, Technology & Safety Management Series* by The Joint Commission, No. 4 (1991 Series), Pages 7-13.

1992

Beachy, Patricia, and Jane Deacon. "Preventing Neonatal Kidnapping." *JOGNN*, Vol. 21, No. 1 (January/February 1992), Pages 12-16.

Dowdell, Elizabeth Burgess, and John B. Rabun, Jr. "Newborn Infant Abductions From Hospitals." *Child Trauma I: Issues and Research*. Ann Burgess, ed. New York & London: Garland Publishing, Inc., (1992), Pages 49-60.

Hospital Supervisor's Bulletin. Waterford, Connecticut: Bureau of Business Practice, Feb. 15, 1992.

LeCroy, Maura. "Should Birth Notices be Published?" *Public Relations Journal* (March 1992), Page 8.

Rabun, John B., Jr. *For Hospital Professionals*. Second edition, revised. Alexandria, Virginia: National Center for Missing & Exploited Children, March 1992.

Colling, Russell L. *Hospital Security*. Third edition. Stoneham, Massachusetts: Butterworth-Heinemann, 1992.

Martin, Sam. "Taking Care of Baby." *SECURITY*, Vol. 29, No. 5 (May 1992), Page 66.

"Birth Notices Link Hospitals to Infant Kidnapping, Liability." *Hospital Risk Management* (August 1992), Pages 101-104.

Rabun, John B., Jr. "Guidelines on Preventing Abduction of Infants from the Hospital." *Journal of Healthcare Protection Management*, Vol. 8, No. 2 (Summer 1992), Pages 36-49.

"Infant Kidnapping." *Key Hospital Security Issues*. Chicago, Illinois: American Hospital Association, 1992, Pages 17-19.

Beachy, Patricia. "Ask the Experts." *NAACOG Newsletter*, Vol. 19, No. 11 (November 1992), Page 9.

1993

Yutzy, Sean; James K. Wolfson; and Phillip J. Resnick. "Child Stealing by Cesarean Section: A Psychiatric Case Report and Review of the Child Stealing Literature." *Journal of Forensic Sciences*, Vol. 38, No. 1 (January 1993), Pages 192-196.

Butz, Arlene M.; Frank A. Oski; Jaque Repke; and Beryl J. Rosenstein. "Newborn Identification: Compliance with AAP Guidelines for Perinatal Care." *Clinical Pediatrics*, (February 1993), Pages 111-113.

"AWHONN Nurse Thwarts Potential Infant Abduction." *AWHONN Voice*, Vol. 1, No. 4 (April 1993), Pages 1, 3.

1994

Stapleton, Michael E. "Infant Footprints." *FBI Law Enforcement Bulletin*, Vol. 63, No. 11 (November 1994), Pages 14-17.

Rabun, John B., Jr., and Janet Lincoln. "Preventing Infant Abductions from Health Care Facilities." *NANN's Neonatal Network*, Vol. 13, No. 8 (December 1994), Pages 61-63.

1995

Burgess, Ann Wolbert, and Kenneth V. Lanning. *An Analysis of Infant Abductions*. Alexandria, Virginia: National Center for Missing & Exploited Children, 1995.

Rabun, John B., Jr. "Ask the Experts." *AWHONN Voice*, Vol. 3, No. 6 (June/July 1995), Page 9.

Ankrom, Larry G., and Cynthia J. Lent. "Cradle Robbers: A Study of the Infant Abductor." *FBI Law Enforcement Bulletin*, Vol. 64, No. 9 (September 1995), Pages 12-17.

Burgess, Ann Wolbert; Allen G. Burgess; Elizabeth B. Dowdell; et al. "Infant Abductors." *Journal of Psychosocial Nursing*, Vol. 33, No. 9 (1995), Pages 30-37.

Burgess, Ann W.; Elizabeth B. Dowdell; Carol R. Hartman; et al. "Infant Abduction: A Family Crisis." *Crisis Intervention*, Vol. 2, No. 2 (1995), Pages 95-110.

Unger, Thomas F., and Arthur Strauss. "Individual-Specific Antibody Profiles as a Means of Newborn Infant Identification." *Journal of Perinatology*, Vol. 15, No. 2 (1995), Pages 152-155.

Aldridge, Geoffrey M. "Protecting Hospitals Against Infant Abductions." *Journal of Healthcare Protection Management*, Vol. 12, No. 1 (Winter 1995/1996), Pages 72-80.

1996

Colling, Russell L. *Security: Keeping The Health Care Environment Safe*. Oakbrook Terrace, Illinois: The Joint Commission, 1996.

Rabun, John B., Jr.; Ann W. Burgess; and Elizabeth B. Dowdell. "Infant Abduction in the Hospital." *Creating a Secure Workplace: Effective Policies and Practices in Health Care*. Editors John R. Lion, William R. Dubin and Donald E. Futrell. United States of America: American Hospital Publishing, Inc., 1996.

1997

Karpovich, Jeff. "Understanding National Guidelines for Infant Abduction Prevention and Response." *Journal of Healthcare Protection Management*, Vol. 13, No. 1 (Winter 1996/97), Pages 63-67.

Quayle, Catherine. "Robbing the Cradle: Hospitals Have Learned the Hard Way That One Stolen Baby Is One Too Many." *Health Facilities Management*, Vol. 10, No. 8 (August 1997), Pages 20-27.

1998

Provincial Ministry of Health. "Survey of Newborn Security in British Columbia Hospitals." *Journal of Healthcare Protection Management*, Vol. 14, No. 1 (Winter 1997/98), Pages 16-26.

American Society of Industrial Security or ASIS. *Security Business Practices Reference*. Alexandria, Virginia: ASIS, 1998.

1999

Sentinel Event Alert. Oakbrook Terrace, Illinois: The Joint Commission, April 9, 1999.

Roll, Fredrick G. "Nursery Crimes." *Health Facilities Management*, Vol. 12, No. 9 (September 1999), Pages 28-32.

Patient's Rights, 42 C.F.R. § 482.13 (1999).

2000

Rabun, John B., Jr. "NCMEC: clarification of statement on electronic bracelets." *Journal of Healthcare Protection Management*, Vol. 16, No. 1 (Winter 1999/2000), Pages 120-121.

American Society of Industrial Security or ASIS. *Security Business Practices Reference*. Vol. III. Alexandria, Virginia: ASIS, 2000.

Sells, David H., Jr. *Security in the Health Care Environment*. Gaithersburg, Maryland: Aspen Publishers, Inc., 2000.

Steiner, Paul J., Jr. "Abducting the Abductors." *Security Management*, Vol. 44, No. 3 (March 2000), Pages 48-56.

2001

American Society of Industrial Security or ASIS. *Security Business Practices Reference*. Vol. IV. Alexandria, Virginia: ASIS, 2001.

Colling, Russell L. *Hospital and Healthcare Security*. Fourth edition. Boston, Massachusetts: Butterworth-Heinemann, 2001.

2002

Burgess, Ann W.; Timothy Baker; Cathy Nahirny; and John B. Rabun, Jr. "Newborn Kidnapping by Cesarean Section." *Journal of Forensic Sciences*, Vol. 47, No. 4 (July 2002), Pages 827-830.

Nahirny, Cathy. "Trends in infant abduction." *Journal of Healthcare Protection Management*, Vol. 18, No. 2 (Summer 2002), Pages 30-34.

Security Issues For Today's Health Care Organization. Oakbrook Terrace, Illinois: The Joint Commission, 2002.

Sarratt, Walter G. *Hospital Security Professionals' Manual: An Assessment and Planning Guide*. Marblehead, Massachusetts: Opus Communication, 2002.

Baker, Timothy; Ann W. Burgess; John B. Rabun, Jr.; and Cathy Nahirny. "Abductor Violence in Nonfamily Infant Kidnapping." *Journal of Interpersonal Violence*, Vol. 17, No. 11 (November 2002), Pages 1218-1233.

Madden, Jeanne M.; Stephen B. Soumerai; Tracy A. Lieu; Kenneth D. Mandl; Fang Zhang; and Dennis Ross-Degnan. "Effects of a Law against Early Postpartum Discharge on Newborn Follow-up, Adverse Events, and HMO Expenditures." *The New England Journal of Medicine*, Vol. 347 (Dec. 19, 2002), Pages 2031-2038.

2003

Butler, Alan J. "Infant abduction: prevention through a multidisciplinary and multidimensional approach." *Journal of Healthcare Protection Management*, Vol. 19, No. 1 (Winter 2003), Pages 87-98.

Steiner, Paul J. "Planning for and preventing infant abductions in the healthcare environment." *Journal of Healthcare Protection Management*, Vol. 19, No. 2 (Summer 2003), Pages 92-97.

2004

Colling, Russell. "The 'body of knowledge' in healthcare security." *Journal of Healthcare Protection Management*, Vol. 20, No. 2 (Summer 2004), Pages 1-7.

2005

Comprehensive Accreditation Manual for Hospitals: The Official Handbook. Oakbrook Terrace, Illinois: The Joint Commission, 2005.

Nahirny, Cathy. "Trends in Infant Abductions." *Journal of Healthcare Protection Management*, Vol. 21, No. 2 (Summer 2005), Pages 95-99.

2006

Serious Reportable Events in Healthcare 2006 Update: A Consensus Report. Washington, D.C.: National Quality Forum.

2007

Wood, Debra Anscombe. "Keeping Baby Safe & Sound." *The Nursing Spectrum.* (July 2, 2007), <http://include.nurse.com/apps/pbcs.dll/article?AID=2007306250020>.

2008

Burgess, Ann Wolbert; Kathleen E. Carr; Cathy Nahirny; and John B. Rabun, Jr. "Nonfamily Infant Abductions, 1983-2006." *American Journal of Nursing*, Vol. 108, No. 9 (September 2008), Pages 32-38.

Glasson, Linda; Fay A. Rozovsky; and Meg Gaffney. "Security Challenges and Risk Management Strategies for Child Abduction." *Journal of Healthcare Protection Management*, Vol. 24, No. 1 (2008), Pages 78-86.

McKinnon, Joseph F. "Infant Abduction: Taking A New Look at 'False' Alarms." *Journal of Healthcare Protection Management*, Vol. 24, No. 1 (2008), Pages 87-90.

Weingaertner, Daniel; Olga Regina Pereira Bellon; Luciano Silva; and Mônica Nunes Lima Cat. "Newborn's Biometric Identification: Can it be done?" *International Conference on Computer Vision Theory and Applications*, 2008, Pages 200-205.

2009

"09. Areas of Higher Risk: 02. Infant/Pediatrics Security." *Healthcare Security: Basic Industry Guidelines.* Glendale Heights, Illinois: International Association for Healthcare Security & Safety, January 2009.

Smith A.D. "Marketing and reputation aspects of neonatal safeguards and hospital-security systems." *Health Marketing Quarterly*, Vol. 26, No. 2 (April-June 2009) Pages 117-144.

Vincent J.L. "Infant hospital abduction: Security measures to aid in prevention." *The American Journal of Maternal Child Nursing*, Vol. 34, No. 3 (May-June 2009), Pages 179-183.

Tesini, D.A. "Development of a biometric infant identification tool: A new safeguard through innovation." *International Journal of Childbirth Education*, Vol. 24, No. 2 (June 2009), Pages 25-28.

2010

Tarasenko, M.A.; R.G Miltenberger; C. Brower-Breitwieser; and A. Bosch. "Evaluation of peer training for teaching abduction prevention skills." *Child & Family Behavior Therapy*, Vol. 32, No. 3 (July-September 2010), Pages 219-230.

Hiner, Jacqueline B., and Lily Pisegna. "How safe are our babies? A community hospital's innovative approach to hardwiring infant security." *Journal of Obstetric, Gynecologic & Neonatal Nursing*, Vol. 39, Sup. 1 (September 2010), Pages S43-S44.

Gregory I. "Ensuring baby safety in hospitals: Role of the MCA." *British Journal of Healthcare Assistants*, Vol. 4, No. 12 (December 2010), Pages 597-598.

Colling, Russell L., and Tony W. York. *Hospital and Healthcare Security*. Fifth edition. Burlington, Massachusetts: Elsevier Inc., 2010.

Wyld, D.C. "Preventing the worst case scenario: An analysis of RFID technology and infant protection in hospitals." *Internet Journal of Healthcare Administration*, Vol. 7, No. 1 (2010), Page 15.

2011

Benz, Jodeane. "Risk Management. Infant security: A hotel concept?" *Nursing Management*, Vol. 42, No. 3 (March 2011), Pages 10-11.

2012

Hiner, Jacqueline; Jeanine Pyka; Colleen Burks; Lily Pisegna; and Rachel Ann Gador. "Preventing infant abductions: An infant security program transitioned into an interdisciplinary model." *Journal of Perinatal & Neonatal Nursing*, Vol. 26, No. 1 (January-March 2012), Pages 47-56.

"Infant abductions: A violent trend emerges" September 2012, www.fbi.gov/news/stories/2012/september/infant-abductions-a-violent-trend-emerges/infant-abductions-a-violent-trend-emerges.

Bradwisch, Sarah A., and Claire Conti. "Code pink: Protecting our tiniest patients." *Nursing Made Incredibly Easy*, Vol. 10, No. 5 (September-October 2012), Pages 55-56.

Nahirny, Cathy; John Rabun; and Dan Yaross. "2 infant abductions show strengths of security systems, but also process failure." *Healthcare Risk Management*, Vol. 34, No. 10 (October 2012), Pages 109-111.

"287 infants abducted since '83 – Many are from mom's room." *Healthcare Risk Management*, Vol. 34, No. 10 (October 2012), Pages 111-112.

2013

"Tight access to unit is key to preventing infant abductions." *Healthcare Risk Management*, Vol. 35, No. 7 (July 2013), Page 78.

Newiss, Geoff. "Findings and implications from a study on UK child abduction." *British Journal of School Nursing*, Vol. 8, No. 6 (July-August 2013), Pages 287-289.

2014

Ramsey-Hamilton, Caroline. "Using risk-based security to stem the tide of violence in hospitals." Security InfoWatch.com, May 22, 2014.

Burgess, A.V.; A.G. Burgess; and C. Nahirny. *Fetal abduction by cesarean section*, publication pending.

The National Center for Missing & Exploited Children® or NCMEC was established in 1984 as a private, nonprofit organization. Per 42 U.S.C. § 5773 and other federal statutes NCMEC is authorized by Congress to perform 22 core functions including the operation of a national, 24-hour, toll-free telephone line by which individuals may report information regarding the location of a missing child and request information about the procedures necessary to reunite a child with his or her legal custodian; operation of the national resource center and information clearinghouse for missing and sexually exploited children; provision of technical assistance and training in the prevention, investigation, prosecution and treatment of cases involving missing and sexually exploited children; and operation of a CyberTipline® for reporting Internet-related, child-sexual exploitation.

A 24-hour, toll-free telephone line, 1-800-THE-LOST® (1-800-843-5678), is available in Canada and the United States for those who have information regarding missing and sexually exploited children. The phone free number is 001-800-843-5678 when dialing from Mexico and 00-800-0843-5678 when dialing from many other countries. For a list of other toll-free numbers available when dialing from specific countries visit www.missingkids.com. The CyberTipline is available worldwide for online reporting of these crimes at www.cybertipline.com. The TDD line is 1-800-826-7653.

NCMEC offers free technical assistance by telephone or on-site **by calling toll-free 1-800-THE-LOST (1-800-843-5678)**. Below is a summary of the services NCMEC offers in regard to the prevention and resolution of infant abductions and as detailed throughout these guidelines. NCMEC:

- Studies infant abductions from birthing/health care facilities, homes and other sites, in conjunction with others, and considers them preventable in large part by hardening the target as described in these guidelines.
- Has trained, through June 2014, more than 72,550 health care professionals and conducted more than 1,170 on-site assessments of health care facilities to help harden the target and reduce infant abductions from these facilities.
- Provides technical assistance to health care facilities, law enforcement and families, when infants are abducted.
- Offers assistance to facilities when assessing and handling post-traumatic stress disorder among staff members impacted by an abduction.
- Encourages distribution of “What parents need to know,” found beginning on Page 57, by health care facilities to patients who will be giving birth to children in their facility.
- Provides additional information about related articles from popular magazines and newspapers regarding infant abductions.

In addition a number of publications are available free of charge in single copies by visiting online at www.missingkids.com.

Note: *Safeguard Their Tomorrows™*, an educational DVD for health care professionals, has been produced by Mead Johnson Nutrition™ at the request of and in cooperation with NCMEC. For more information about this free resource and to arrange an educational program with a speaker at your facility contact your local Mead Johnson Nutrition medical sales representative. The educational program is also available online at www.pediatricnutritionce.org. To obtain the DVD at no charge contact NCMEC at 1-800-THE-LOST® (1-800-843-5678).

This project was supported by Grant No. 2014-MC-FX-K001 awarded by the Office of Juvenile Justice and Delinquency Prevention, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions in this document are those of the author and do not necessarily represent the official position or policies of the U.S. Department of Justice.

For health care professionals: Guidelines on prevention of and response to infant abductions was previously published as *For Healthcare Professionals: Guidelines on Preventing Infant Abductions* and *For Hospital Professionals: Guidelines on preventing abduction of infants from the hospital*. The second edition of this guide received the 1991 Russell L. Colling Literary Award from the International Association for Healthcare Security & Safety.

First Edition, Issued May 1989
Second Edition, Issued March 1991
Second Edition, Revised, Issued March 1992
Third Edition, Issued June 1993
Fourth Edition, Issued June 1996
Fifth Edition, Issued June 1998
Sixth Edition, Issued March 2000
Seventh Edition, Issued January 2003
Eighth Edition, Issued April 2005
Ninth Edition, Issued January 2009
10th Edition, Issued August 2014

For health care professionals:

Guidelines on prevention of and response to infant abductions

- 1. The problem**
- 2. The offender and modes of operation**
- 3. Guidelines for health care professionals**
- 4. Liability**
- 5. After discharge/transfer from a maternal child care unit**
- 6. What parents need to know**
- 7. Self-assessment for health care facilities**
- 8. Bibliography**

**Official sponsors of the National Center for
Missing & Exploited Children**

