NATIONAL CENTER FOR MISSING & EXPLOITED CHILDREN®

OJJDP Office of Juvenile Justice and Delinquency Prevention
Office of Justice Programs ◆ U.S. Department of Justice

For Healthcare Professionals:

Guidelines on Prevention of and Response to Infant Abductions

AWHONN
Association of Women's Health, Obstetric and Neonatal Nurses

INTERNATIONAL ASSOCIATION FOR HEALTHCARE SECURITY & SAFETY
IAHSS

For Healthcare Professionals:

Guidelines on Prevention of and Response to Infant Abductions

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Fourth Edition

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

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A Message to the Reader

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is a private, not-for-profit organization dedicated to improving the quality of care provided to the public. JCAHO is the nation's principal standard setter and evaluator for a variety of healthcare organizations. JCAHO believes that the environment in which medical care is rendered is an important element in the provision of quality treatment and care. The chapter of the standards titled "The Environment of Care" contains specific reference to elements required in a security management program. There is a requirement that security sensitive areas be identified within the healthcare organizations for which specific security measures must be undertaken. A commonly identified security sensitive area is the maternal-child care unit.

The guidelines presented in this document are intended to provide, in part, security strategies and protocols that support the JCAHO security standards and in no way should conflict with any of the standards promulgated by JCAHO.

In 1996 JCAHO published a book titled *Security in the Healthcare Environment* that provides basic information relative to this important subject. The book may be obtained by contacting JCAHO's Customer Service Division at One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181, 708-916-5800.

For a full treatment of hospital safety and security, *see* Russell L. Colling's 1992 book titled *Hospital Security* listed in the "Bibliography" on page 68.

Contents

1. The Problem

Case in Point On Father's Day a young mother sat in her room in a secure and well-managed private hospital in North Carolina feeding her newborn infant. A woman in a nurse's uniform came into the room and told the mother that she was taking the infant for tests and to have him weighed. The mother handed her infant over and, within minutes, the infant was out of the hospital, abducted by the woman impersonating a nurse. Happily, thanks to a speedy response by law enforcement and effective media coverage, the child was recovered two days later, unharmed. When questioned, the abductor, convicted for kidnapping, said, simply, "I wanted an infant for myself."

While **not** a crime of epidemic proportions, the abduction, by **nonfamily** members, of **infants (birth through 6 months)** from healthcare facilities has clearly become a subject of concern for parents, maternal-child care nurses, healthcare security and risk management administrators, law enforcement officials, and the National Center for Missing and Exploited Children (NCMEC). With the goal of preventing crimes against children, NCMEC—in cooperation with the Federal Bureau of Investigation (FBI), the International Association for Healthcare Security and Safety (IAHSS), and the University of Pennsylvania School of Nursing—has studied infant abductions from hospitals, homes, and other sites and considers them preventable in large part by "hardening the target" as described in this book.

Based on a study of cases from 1983 through 1995, the best estimate for the nationwide incidence of infant abductions, by nonfamily members, ranges between 12 and 18 per year. Because a number of cases may not be reported to NCMEC or other organizations, this estimate may be conservative. (As a point of comparison, there are approximately 4.2 million births yearly in the United States at more than 3,500 birthing facilities.) Eighty-eight (88) of the cases studied were abductions from hospital premises, and 49 were infant abductions from the home, following most of the same patterns as the hospital abductions. Fifteen (15) additional

infants were abducted from other places such as malls, offices, parking lots, etc. Of the facilities in which infants have been abducted, 8 percent of the abductions occurred in facilities with no more than 200 beds, 45 percent of the abductions occurred in facilities with between 201 and 400 beds, 21 percent of the abductions occurred in facilities with between 401 and 600 beds, and 26 percent of the abductions occurred in facilities with more than 600 beds. Of all the infants abducted from hospitals, 94 percent were located and safely returned, usually within a few days to two weeks. **Anecdotal evidence would suggest that there may be numerous abduction attempts at birthing facilities each year.**

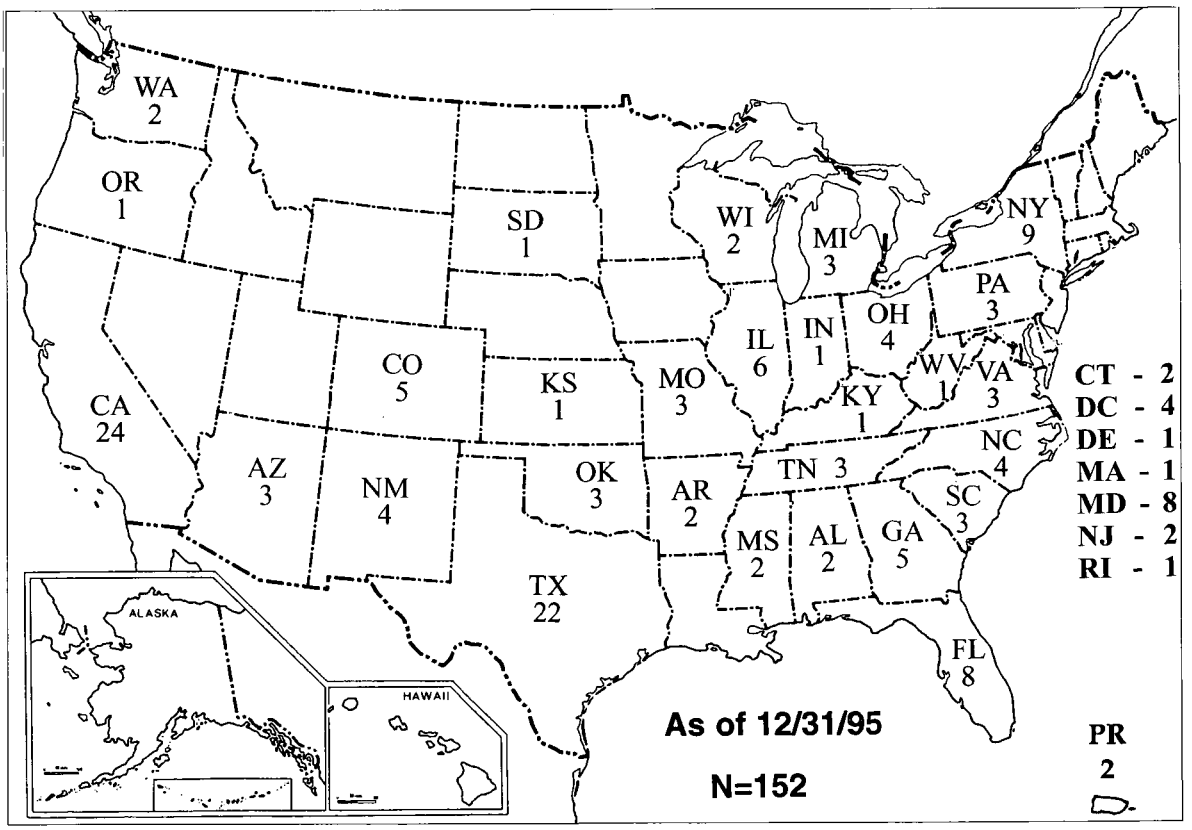
TOTAL - Abductions of Infants from *1983-1995: 152*
TOTAL - Still Missing: **9**

	1983-1995:	*Case Status:*
Abductions/HOSPITALS:	**88**	Located = 83 Still Missing = 5
From Mother's Room:	50 (57%)	
From Nursery:	13 (15%)	
From Pediatrics:	15 (17%)	
From "On premises" (outside hospital but still on hospital grounds)*:	10 (11%)	
With Violence to Mother: (both "On premises")	2 (2.3%)	
Abductions/HOMES:	**49**	Located = 46 Still Missing = 3
With Violence to Mother:	12 (30%)	
Abductions/ "OTHER PLACES":	**15**	Located = 14 Still Missing = 1
With Violence to Mother:	3 (22%)	

* To date there has been **NO** use of violence (or attempts) against the mothers or healthcare staff **within** the hospital; however, there is clear evidence of increasing violence by abductors when the abductions move outside of the healthcare setting.

The typical hospital abduction case involves an "unknown" abductor impersonating a nurse, hospital employee, volunteer, or relative in order to gain access to an infant. The obstetrics unit is an open and inviting one where patient's decreased length of stay gives them less time to know staff members. In addition it can be filled with medical and nursing staff, visitors, students, volunteers, and participants in parenting and newborn care classes. The number of new and changing faces on the unit is high, thus making the unit an area where 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 "con" the infant directly from the mother's arms.

NEWBORN/INFANT ABDUCTIONS IN THE UNITED STATES FROM 1983 - 1995



2. The Offender

The offender is almost always a female, frequently overweight, ranges in age from 14 to 45 years, and generally has no prior criminal record. Many of these women are gainfully employed. While she appears "normal," the woman is most likely compulsive, suffers from low self-esteem, often fakes one or more pregnancies, and relies on manipulation and lying as coping mechanisms in her interpersonal relationships. Sometimes she wishes either to "replace" an infant she has lost or to experience a "vicarious birthing" of a child she is for some reason unable to conceive or carry to term. The baby may be used in an attempt to maintain/save a relationship with her husband, boyfriend, or companion (hereinafter referred to as the significant other). On occasion an abductor may be involved in a fertility program at/near the hospital from which she attempts to abduct an infant. Of the 147 cases where the abductor's race is known, 65 are caucasian, 57 are black, and 25 are hispanic. The race/skin color of the abductor almost always matches the infant's or reflects that of the abductor's significant other. (*See* description of "The 'Typical' Abductor" on the inside backcover.)

More than half of the infants are 7 days old or younger when taken. The abducted infant is perceived by the abductor as "**her newborn** baby." Data do not reveal a strong gender preference in the abduction of these infants.

Although the crime may be precipitated by impulse and opportunity, the abductor has usually laid careful plans for finding another person's baby to take and call her own. In addition, prior to the abduction, the offender will often exhibit "nesting" instincts by "announcing her pregnancy" and by purchasing items for an infant in the same way an expectant mother prepares for the birth of her child. The positive attention she receives from family and friends "validates" her actions. Unfortunately, this "nesting" activity feeds the need for the woman to "produce" a baby 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 that 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 child.

The vast majority of these women take on the "role" of a nurse 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 baby for tests, to be weighed, photographed, etc. 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.

Most often the abductor has no prior criminal record; however, the pretense of being someone else has been seen in those abductors who have a past history of passing bad checks or forgery. These women demonstrate a capability to provide "good" care to the baby once the abduction occurs. 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 babies to be "their own." There is no indication that 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 stereotype of the "stranger." In most of these cases the offenders made themselves known and achieved some degree of familiarity with hospital 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 healthcare facility procedures and the layout of the maternity unit. In the case cited on page 1, the offender had taken the infant from a room with which she was highly familiar: Her daughter had given birth there just four months earlier. Moreover, these women usually impersonate nurses or other healthcare personnel, wearing uniforms or other staff attire. They have also impersonated lab technicians, social workers, photographers, and other professionals who may normally work in a hospital. They often visit or surveil more than one hospital in the community to assess security measures and explore infant populations, somewhat like window shopping.

The abductor may not target a specific infant for abduction. When an opportunity arises, she may immediately snatch an available victim, often be visible in the hallway for as little as four seconds with the baby in her arms, and escape via a fire exit stairwell. Since the abductor is compelled to show off her new infant to others, use of the media to publicize the abduction is critical in encouraging citizens 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 when the abductor is **not** portrayed in the media as a "hardened criminal."

For the first time in more than a decade the incidence of infant abductions from hospitals decreased. In 1992 infant abductions in healthcare facilities in the United States declined 55 percent and **by 1995 declined 82 percent overall**. This reduction seems directly attributable to the last five years of proactive education programs. The primary seminar, *Safeguard Their Tomorrows*, has been sponsored by AWHONN (the Association of Women's Health, Obstetric, and Neonatal Nurses—formerly NAACOG); the National Association of Neonatal Nurses (NANN); and NCMEC as underwritten by Mead Johnson Nutritionals and the Sensormatic Electronic Corporation. Education has greatly increased the awareness of nursing and security staffs in hospitals nationwide. In the last six years, the author has provided direct educational training to more than 42,000 healthcare professionals and informal on-site maternal-child care unit assessments for approximately 600 hospitals nationwide and in Canada and the United Kingdom. In addition NCMEC has distributed more than 150,000 copies of its award-winning publication *For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions* (formerly titled *For Healthcare Professionals: Guidelines on Preventing Infant Abductions* and *For Hospital Professionals: Guidelines on preventing abduction of infants from the hospital*).

Case in Point Susie was married, in an abusive/battering relationship with her spouse, participated in two support groups for battered women, and had three children who were removed from her care by Child Protective Services. Susie began "announcing" to people in January that she was pregnant and started to visit a local children's hospital where she informed the staff that her "baby" was going to be "born" with a "heart problem." She frequently showed staff members a sonogram of "her baby" despite the fact that she was not pregnant.

In November the women in her support groups asked about the impending "birth" of her child and, since she did not appear to be pregnant, accused her of faking the pregnancy. Apparently feeling pressured to "give birth to her baby" Susie went to the children's hospital, arrived on a floor where a

Code Blue was in progress, disconnected an infant from a cardiac monitor, put the infant under her sweater, and walked out of the hospital.

Susie's sister-in-law, learning of the abduction through the media and suspecting that Susie's "baby" was the child who was abducted from the hospital, called the police. Upon investigating, the police found the child, an altered birth certificate for the child, and a roll of film that contained pictures of a "pregnant looking" Susie. Although Susie did not harm the infant, she had placed raisins in the baby's naval to make it "look" as if the child were a newborn.

Note: The names of persons highlighted in the "Case in Point" sections throughout this book have been changed to protect the privacy of the families involved.

3. Guidelines for Healthcare Professionals

The guidelines highlighted in bold print are ***necessary*** *for the prevention and documentation that every facility should meet. Quality management team review processes should address each item at least quarterly. All other guidelines listed are highly recommended.*

3-1 General

To safeguard newborn infants requires a comprehensive program of healthcare policy; education of and teamwork by nursing, parents, security, and risk management; and 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** healthcare facilities.

A multidisciplinary approach to the development of specific healthcare policies and critical incident response plans is needed to effectively combat this infrequent and highly visible crime. Nurse managers/supervisors are 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 obstetric, nursery, and pediatric nurses, given the nature of maternal-child care, have close working relationships that would facilitate implementation of effective policies and process improvement measures. In the hospital, nurses are "surrogate parents" and the front line of defense in preventing abductions and documenting any incidents that occur.

Electronic security measures are simply modern tools used to back up hospital policy and nursing practices. Not only do these devices serve to further discourage or deter potential abductors, they may also serve as a physical basis for enhancing the ability of nursing, security, and risk management to work as a team. There are several technologies available for this purpose (infant bracelet tag alarms, closed-circuit television [CCTV], and access control) and each, or some combination, provides several benefits. First, these systems are reliable when properly installed. These systems are constantly vigilant, unaffected by distractions, breaks, shift changes, etc. Second, and more important, they serve to **document**

and **deter** (not simply prevent) an abduction. Infant tag alarms, coupled with CCTV, serve to document a potential abduction as it occurs. They may also help in resolving and documenting "false alarms" of systems (varying according to manufacturer) for supervisory follow-up and in support of total quality management. Additionally CCTV cameras and alarm panels, coupled with security signage, serve as a visual deterrent to the potential abductor. If taken, these precautions clearly increase the risk of being apprehended, the potential for immediately locating the abductor, and the recovery of the newborn. These policies and measures in no way diminish the empowerment of the parents in their responsibilities to their newborn infant. Together, they can "safeguard their tomorrows."

Each facility's chief executive officer (with the appropriate management staff members) should regularly review specific protocols and critical incident response plans to ensure that they effectively address all issues concerning security measures to help prevent and document such abductions and measures to be taken in case of an infant abduction at their facility. The guidelines enumerated in this chapter will aid facilities in this process. *See* "Self-Assessment for Healthcare Facilities" on page 47 which is a summary of all these guidelines.

Be alert to unusual behavior. Healthcare security, nursing, and risk management administrators should remind all personnel that the protection of infants is a proactive responsibility for everyone in the facility, not just for hospital security. One of the most effective means of thwarting, and later identifying, a potential abductor is to utilize phrases like, "May I help you?" while carefully observing behaviors and noting a physical description. All healthcare facility personnel should be alert to any unusual behavior they encounter from individuals such as

- repeated visiting "just to see" or "hold" the infants
- close questioning about healthcare facility procedures 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 mother's at **all** times?"
- taking uniforms or other means of hospital identification
- physically carrying an infant in the hospital corridor instead of using the bassinet to transport the child, or leaving the hospital with an infant while on foot rather than in a wheelchair
- carrying large packages off the maternity unit (*e.g.*, gym bags), particularly if the person carrying the bag is "cradling" or "talking" to it

Be aware that a disturbance may occur in another area of the healthcare facility creating a diversion that facilitates an infant abduction (*e.g.*, fire in a closet near the nursery or loud, threatening argument in the waiting area).

General Guidelines

3-1-1 Persons exhibiting the behaviors described above should be reported immediately (to the facility nurse manager/supervisor, security, and administration), positively identified, kept under close observation, and interviewed by the nursing supervisor along with hospital security.

3-1-2 Report and interview records on the incident should be preserved.

3-1-3 Each facility should designate a staff person who will have the responsibility to alert other birthing facilities in the area when there is an attempted abduction or when someone is identified who demonstrates the behaviors described above, but who has not yet made an attempt to abduct an infant.

Each facility should develop a concise, uniform reporting form to facilitate the timely recording and dissemination of this information. Care should be taken that this alert does not provide material for a libel or slander suit against the facility by the identified person. *See* sample notification form on page 30 that was 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 the police, then NCMEC at 1-800-THE-LOST (1-800-843-5678) of all attempted abductions.

3-2 Proactive Measures

The guidelines highlighted in bold print are ***necessary*** *for the prevention and documentation that every facility should meet. Quality management team review processes should address each item at least quarterly. All other guidelines listed are highly recommended.*

Proactive Measure Guidelines

3-2-1 As part of contingency planning, the backbone of prevention, every healthcare facility must develop a written proactive prevention plan per infant abductions.

3-2-2 Immediately after the birth of the infant 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.

If the fourth band is not used by the father/mother's significant other, that fact must be documented. That band may be stapled to the chart or cut and placed in the "sharps box." For information on the importance of bands in regards to transporting infants *see* 3-2-7(a).

3-2-3 Prior to the removal of a newborn from the birthing room (within two hours of the birth):

a. footprint the baby
b. take a color photograph of the baby
c. perform and record a full physical assessment of the baby

The footprints, photograph, physical assessment, and documentation of the placement of the ID bands, including their number, must be placed in the baby's medical chart.

Take footprints of each infant (at birth/admissions/readmissions to pediatrics). The infant's full foot should be sparingly inked and a complete impression made using light pressure. Take care to capture ridge-detail on the ball of the foot.

Occasionally footprints of the newborn are unreadable. Footprints are an excellent form of identification if an abducted infant is recovered many months later. Hospitals should take good, readable footprints of the infant. Consult your local FBI office or law enforcement agency for appropriate techniques, paper stock, and various inked and inkless products. (For further information on footprint techniques *see* Michael E. Stapleton's 1994 article on footprinting listed in the "Bibliography" on page 69.)

Like footprints, cord blood taken at the time of delivery is an excellent form of identification. (Note: Currently DNA testing is expensive and takes a minimum of six weeks for the results to be issued.) Healthcare facilities should store a sample of cord blood for future typing for identification purposes **until the day after the infant** is discharged from the hospital.

Another form of identification recently employed by some healthcare facilities is antibody profiling. Because a mother and her infant share the same antibody profile for the first year of the infant's life, a "biological barcode" can be created from one drop of blood from the infant and one drop of blood from the mother to look for a "match" in cases where there is a question concerning the infant's identity. *See* Thomas F. Unger's 1995 article on antibody profiling listed in the "Bibliography" on page 69.

Take clear, high-quality, color photographs of all infants (at birth and up to 6 months of age upon admissions), including a close-up of the face (taken "straight on").

When completing the physical assessment of the baby make sure to identify any marks or abnormalities such as skin tags, moles, birthmarks, etc. While the footprint, photograph, and assessment must be placed in the infant's medical records, parents may wish to keep a copy of this information for their own records.

3-2-4 Require all healthcare facility personnel to wear conspicuous, color photo ID badges. Personnel, including physicians, in direct contact with the infants should wear a form of unique identification used *only* by them and known to the parents (*e.g.*, a *distinctive* color or marking to designate personnel authorized to have direct contact with infants). *IDs should be worn above the waist on attire that will not be removed or hidden in any way.* ID systems should include provisions for all personnel in direct contact with infants including students, temporary staff, etc., such as the issuance of unique temporary badges that are controlled and assigned each shift (*e.g.*, control should be similar to narcotics key control).

Facilities need to address issues of assisting hearing, visually, physically, and mentally challenged patients with their special needs in this identification process.

3-2-5 The guidelines for parents in preventing hospital abductions (listed in "What Parents Need to Know" on page 41) must be distributed to parents in childbirth classes, on preadmission tours, upon admission, at postpartum instruction, and upon discharge. This same information needs to be distributed to all new/current staff members and physicians and their staff members who work with newborns and child patients.

3-2-6 Staff, at all levels, must receive instruction on protecting infants from abduction including, but not limited to, information on the offender profile and unusual behavior, prevention procedures, and critical incident response plan.

The videotape *Safeguard Their Tomorrows* provided by Mead Johnson Nutritionals is an excellent educational resource.

3-2-7 To safeguard the infant while being transported within the healthcare facility ensure that:

a. only an authorized staff member (or person with an authorized ID band for that baby) is allowed to transport the child.
b. a baby is never left in the hallway without direct supervision.
c. infants are taken to mothers one at a time. Hospital personnel never group babies while transporting them to the mother's room, nursery, or any other location.
d. babies are never carried, but always pushed in a bassinet.

Require anyone transporting the infant outside the mother's room (including the mother, father, or any other person designated by the mother) to wear an ID wristband. All wristbands should be coded alike numerically and readily recognizable.

3-2-8 Ensure that infants are always in line-of-sight supervision either by a responsible staff member, the mother, or other family member/close friend so designated by the mother.

3-2-9 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, or status boards. ***Do not leave charts, patient index cards, or any other medical information visible to anyone other than medical personnel.*** **Be aware that 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.***

Case in Point A new mother, with the help of the baby's maternal grandmother, was settling in on her first day back home after delivering a baby girl at the local hospital while a sign on the front window and balloons tied in front of the home announced the arrival of a new baby.

On that day a young woman who appeared to be pregnant knocked at the family's front door. She asked to use the telephone claiming that she was lost. While in the home the young woman asked to use the bathroom. Upon exiting the bathroom, with a gun in one hand and a knife in the other, she demanded the baby from the two women. When they refused to hand over the baby, the intruder shot and stabbed both women, fled with the baby, and discarded the gun along a roadside.

While the baby was located unharmed three days later and her grandmother recovered from the injuries sustained during the abduction, the baby's mother died.

During the course of the investigation, police found that the abductor had visited the hospital where the baby was born several days prior to the abduction. Investigators determined that the abductor—while looking through the hospital's nursery window—obtained a significant amount of personal information about the victim family from an information card located in the baby's bassinet.

3-2-10 Establish an access control policy for the nursing unit (nursery, maternity, neonatal intensive care, pediatrics) to maximize safety. At the front lobby or entrance to the maternity unit, instruct healthcare facility personnel to ask visitors which mother they are visiting and for how long. If no name is known or given, decline admission and alert hospital security, nurse manager/supervisor, facility administration, or the police. Especially after regular visiting hours, set up a system to positively identify visitors (preferably with a photo ID).

3-2-11 Require a show of the ID wristband for the person taking the infant home from the healthcare facility, matching the bands on the wrist and ankle of the infant with the bands worn by the mother and father/significant other.

3-2-12 Be aware that if the healthcare facility's public relations department still releases birth announcements to the news media, no home address or other unique information should be divulged that would put the infant and family at risk **after discharge**.

3-2-13 When providing home visitation services, personnel entering patients' homes need to wear a unique form of identification used only by them, strictly controlled by the facility, and known to the parents. (*See* 3-2-4 for a discussion of ID badges.) For additional information on this topic *see* "Outpatient Areas" on page 37.

Case in Point It was feeding time on the maternity floor of a hospital in Maryland. While in her room feeding her newborn infant, the mother was approached by a woman dressed in a hospital lab coat and uniform. The woman informed the mother that her son needed to be taken for routine tests and would be

returned to her in a few minutes. The mother relinquished her infant to "the nurse," who left the room. Minutes later "the nurse" was seen carrying the baby by a staff member of the oncology department on a different floor. This staff person suspected that something was wrong and called the nursery to check on the situation. Hospital security was notified by the nursery staff and as the abductor exited the building with the infant in her arms, she was stopped by security staff, who had surrounded the facility. Due to the actions of an alert nurse and the responsiveness of the security personnel, this abductor never left the hospital grounds and the infant was quickly reunited with his mother.

3-3 Physical Security Safeguards

The guidelines highlighted in bold print are ***necessary*** *for the prevention and documentation that every facility should meet. Quality management team review processes should address each item at least quarterly. All other guidelines listed are highly recommended.*

Guidelines for Physical Security

3-3-1 Every healthcare facility must develop a written assessment of the risk potential for an infant abduction.

In determining the physical security requirements for the prevention of infant abduction, each healthcare facility must conduct a physical security needs assessment. This assessment should be performed by a qualified professional (*e.g.*, Certified Protection Professional, Certified Healthcare Protection Administrator, Risk Manager) who identifies and classifies vulnerabilities within the healthcare facility. The application of safeguards (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 on infant abduction. This process should be considered ongoing as targets, risks, and methods change, particularly in the event of new construction. For assistance in this process, *see* "Self-Assessment for Healthcare Facilities" on page 47.

3-3-2 **Install alarms, preferably with time-delay locks, on all stairwell and exit doors on the perimeter of the maternity, nursery, neonatal intensive care, and pediatrics units that are exterior access doors. Establish a policy of responding to alarms and instruct responsible staff to silence and reset an activated alarm only after direct observation of the stairwell or exit and the person using it. The alarm system should never be disabled.**

Optimally, video recording should be tied to alarm activity. If the alarm is activated, the situation should be properly documented and a report on the incident submitted to the proper authority within that facility.

3-3-3 **All nursery doors must have self-closing hardware and remain locked at all times.**

3-3-4 If there is a lounge or locker room where staff members change/leave clothing, all doors to that room should have self-closing hardware and be under strict access control (locked) at all times.

3-3-5 **Document** a needs assessment for an electronic asset surveillance (EAS) detection system. (Optimally such a system would utilize an EAS infant bracelet tag tied to video recording of the incident and alarm activation.)

3-3-6 **Install a security camera system (using time-lapse loop tape such as those employed in banks) to monitor activity in the halls of the maternity and pediatrics floors. When mounting the cameras ensure that they are placed in strategic spots at the entrance of the unit to cover the nursery, hallway, stairwells, and elevators, and that the camera is adjusted at an angle that is likely to capture an abductor's full face. Retain videotapes for a minimum of seven days before reusing.**

Take particular care to position one camera to capture the faces of all persons entering the main entrance of the maternal-child care unit.

Notes Since the lighting conditions in healthcare facilities are usually both good and stable, color cameras and accessory equipment are preferable for use. There are advantages from an identification standpoint.

It is important to have an audit trail on videotape with as much information as possible to aid in investigations. The abductor is likely acquainted with the facility and has probably evaluated the situation prior to acting. Ideally this would be done by having a dedicated videocassette recorder per camera running real-time recordings on a continual basis. It may be preferable to use video multiplexers and time-lapse videocassette recorders to change the tapes every twelve hours. The closer to real-time recording, the more information is on tape per camera. At a minimum keep at least seven days' worth of information on hand at all times.

Consider integrating the video system with alarms from devices such as electronic asset protection panels, magnetic door contacts on emergency exit doors, and motion detectors in stairwells. This can result in automated responses by the system.

Moveable cameras with high-resolution imagers and zoom lenses provide much more detailed images than fixed cameras and, if programmable, high-speed domes can "Pattern," and respond to alarms even if aimed in the opposite direction. Since many of the areas in the hospital, particularly corridors, look similar it is important to select programmable on-screen titling that varies with the pan and tilt position. Thus, when a tape is being presented for evidentiary purposes, there is no question which camera it was and where it was pointing since the information is overlaid on the video pictures.

In stairwells that contain videocameras and are not commonly traveled, these cameras should be equipped with video-motion detectors that are integrated with the system as outlined above.

Ian Chambers, Marketing Manager, Commercial/Industrial Division, of the Sensormatic Electronics Corporation contributed to this section.

3-4 Critical Incident Response Plan

The guidelines highlighted in bold print are ***necessary*** *for the prevention and documentation that every facility should meet. Quality management team review processes should address each item at least quarterly. All other guidelines listed are highly recommended.*

General

General Guidelines for Critical Incident Response Plans

3-4-1 As part of contingency planning, every facility must develop a written critical incident response plan in the event of an infant abduction.

All protocols and critical incident response plans with reference to abductions of infants from the healthcare facility must be in writing. In addition they must be communicated to and training signed off on by all staff members within the maternal-child care unit. Other departments including communications/switchboard, environmental services, accounting, and public relations should also have written action plans to follow in the event of an abduction.

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

- openness
- entrance/exit doors
- alarm systems
- staffing patterns including number of staff members who are visible on the unit

The plan must include a provision regarding the handling of the incident in relation to the time of day in which it occurs. 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 designated hospital authority).

The plan must include a provision to designate a staff person (usually the security director) to act as the liaison with law enforcement.

3-4-2 **Call NCMEC at 1-800-THE-LOST (1-800-843-5678).** It is in an excellent position to advise, provide technical assistance, network with other agencies and organizations, assist in obtaining media coverage of the abduction, and coordinate dissemination of the child's photograph as mandated by federal law (42 USC 5771 and 42 USC 5780).

A media or crisis communication plan should be developed to brief the media on the incident (with the approval of law enforcement), enlist their aid in publicizing the abduction, ensure accuracy of the description of the infant and abductor, coordinate photo dissemination, and provide appropriate access to victim parents while protecting their privacy.

Case in Point In 1995 the National Center for Missing and Exploited Children (NCMEC) received a telephone call from a law enforcement contact who indicated that they had received sketchy information about a possible infant abduction that had occurred four days earlier in a major metropolitan area located within a 50 mile radius of Washington, DC. NCMEC staff members proceeded to contact law enforcement officers in that community to obtain further information and offer assistance.

NCMEC provided technical assistance and distributed posters of the composite sketch of the abductor. Unfortunately no photographs of the infant were available. Media coverage of the incident was **limited to** local television stations and the newspaper in the city where the abduction occurred. Investigators **did not** elect to expand the media coverage to other media markets surrounding their city.

Nine days after the abduction a staff person at a Washington, DC, youth shelter called NCMEC's toll-free Hotline regarding a young woman with an infant. The shelter reported that the young woman was not properly caring for the infant and was being evasive about their identity. The shelter staffer asked whether the infant could be a missing child. Recognizing the potential for this infant to be the one abducted nine days earlier, staff in NCMEC's Case Enhancement and Information Analysis Unit instructed the shelter staffer to call the investigators in charge of the case. The information provided

by the shelter worker led to the recovery of the infant and the arrest of the abductor that same afternoon.

The suspect told law enforcement officials during an interview that she had no intention of ever returning the child and that she had planned to change the identity of the baby, obtain false documentation for herself and the child, and take the baby to a large metropolitan area to "hide."

Had NCMEC staff members **not** been aware of this abduction, it is likely that this child might not have been recovered.

Maternal-Child Care Nurses

Nursing Guidelines for Critical Incident Response Plans

3-4-3 *Immediately* **search the entire unit. Time is critical. (Do a head count of all infants.) Question the mother of the infant suspected to be missing as to other possible locations of the child within the facility.**

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

Where a facility has no security staff, immediately call the local police department and make a report. Then call the local FBI office.

3-4-5 **Protect the crime scene (area where the abduction occurred) in order to preserve the subsequent collection of any forensic evidence by law enforcement officials.**

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 child (but **not** their belongings) to a private room off the maternity floor and detail the nurse assigned to the mother and infant to accompany them at all times,

protecting them from stressful contact with the media and other interference. Secure all records/charts of the mother and infant. Notify lab and place STAT hold on infant's cord blood for follow-up testing. Consider designating a room for other family members to wait in that gives them easy access to any updates in the case while offering the parents some privacy.

3-4-7 The nurse manager/supervisor should brief all staff of the unit. In turn, nurses should then explain the situation to each mother while the mother and her infant are together. Mothers should never hear this news from the media or law enforcement.

3-4-8 A staff person (preferably the nurse assigned to the mother and infant) should be assigned to be the single liaison between the parents and hospital after the discharge of the mother from the hospital.

3-4-9 Nurse managers/supervisors should be sensitive to the fact that the nursing staff may suffer posttraumatic stress disorder (PTSD) as a result of the abduction and make arrangements to hold a group discussion session as soon as possible in which all personnel affected by the abduction are *required* to attend.

Such a session will allow healthcare facility personnel a forum for expressing their emotions and help them deal with the stress resulting from the abduction. Certain staff members may require further 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 the investigators of the law enforcement agencies handling the case.

3-4-10
- **call the local police department and make a report. Then call the local FBI office or you may call the FBI's Child Abduction and Serial Killer Unit at 540-720-4700.**
- ***immediately* and simultaneously activate a search of the entire healthcare facility, interior and exterior. Time is critical.**
- **assume control of crime scene (area where the abduction occurred) until law enforcement arrives.**
- **establish a security perimeter around the facility and assist the nursing staff in establishing and maintaining security within the unit (*i.e.*, access control to the unit).**

Ask the police to dispatch an officer to the scene using only the standard crime code number over the police radio without describing the incident. This will help ensure that media and citizens listening to police scanners will not be alerted of the incident before appropriate law enforcement procedures are initiated.

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 that all information about the abduction is 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 of the abduction when the abductor is **not** portrayed in the media as a "hardened criminal."

Consider limiting official spokespersons to **one** hospital staff, preferably from public relations, and **one** law enforcement representative, and these persons should always be on call throughout the crisis.

3-4-12 Brief the healthcare 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. 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 spokespersons.

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 rooms, and outpatient clinics for postpartum/pediatric care at other local healthcare facilities should be notified about the incident and provided a full description of the baby and the suspected or alleged abductor.

As part of her plan the abductor may take the infant to another facility, a private physician, or a public agency in an attempt to have the baby "checked out," obtain a birth certificate for "my child who was delivered at home," or secure public assistance.

Case in Point In 1994 an infant was abducted from the nursery of **Hospital A** located in a large metropolitan city. The infant was recovered several hours later the same day, and the abductor was arrested.

During the course of the post-abduction interview process law enforcement investigators determined that ten days prior to the abduction the abductor told her husband that she had given birth to their son at **Hospital B**, but was unable to bring the baby home immediately because the child required surgery and would be "hospitalized for **ten days.**" Ten days later, when the husband expected the baby to be discharged from **Hospital B**, the woman abducted the infant from **Hospital A**, took the baby to **Hospital B**, called her husband from the lobby of **Hospital B** asking him to come pick them up there, and waited in the lobby of **Hospital B** for him to arrive.

If authorities at **Hospital A** had notified all healthcare facilities in the city and surrounding area of the abduction from their facility, security personnel at **Hospital B** may have recognized the abductor as a suspect while she was still sitting in their lobby and the baby could have been recovered hours earlier.

It was also learned that the abductor had told her husband two years prior to the abduction that she had given birth to a stillborn baby boy at **Hospital B**. A check of records at **Hospital B** indicated that the abductor **had not** given birth to a child two years earlier at that facility. Further investigation determined that the abductor had applied to **Hospital A** sometime within the year prior to the abduction to become a volunteer. She had specified on her application that she wanted to work in the nursery. It is common for such abductors to misrepresent facts about prior births and/or visit or try to somehow become "affiliated" with the healthcare facilities from which they eventually attempt to abduct an infant.

Law Enforcement Officers

Law enforcement should treat a case of infant abduction from a healthcare facility as a serious, felony crime requiring **immediate** response.

Law Enforcement Guidelines for Critical Incident Response Plans

3-4-15 Enter the child's name and description in the FBI's National Crime Information Center's Missing Person File (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.)

3-4-16 Call NCMEC at 1-800-THE-LOST (1-800-843-5678). It is in an excellent position to advise, provide technical assistance, network with other agencies and organizations, assist in obtaining media coverage of the abduction, and coordinate dissemination of the child's photograph as mandated by federal law (42 USC 5771 and 42 USC 5780).

Parents or law enforcement authorities may request age-progression of the infant's photograph as time elapses on the case. An infant's photograph may be "aged" using earlier photographs, computer technology and graphics, data on facial development, and the special skills of medical illustrators (*see* examples on pages 28 and 29).

3-4-17 Call the FBI's Child Abduction and Serial Killer Unit at 540-720-4700 for technical and forensic resource coordination; computerized case management support; investigative, interview, and interrogation strategies; and information on behavioral characteristics of unknown offenders.

3-4-18 Consider setting up one dedicated local telephone hotline for sightings/leads or coordinate this function with a local organization.

3-4-19 Polygraphs may be useful with female offenders and their male companions. While polygraphing the baby's father may be useful for eliminating him as a suspect, it should be done early in the investigation. Be aware that polygraphing the baby's mother within 24 hours of the delivery (or while medicated) is ill-advised.

3-4-20 To deter future crimes and document criminal behavior, the abductor should be charged and every effort made to sustain a conviction.

3-4-21 Any release of information concerning an infant abduction should be well planned and agreed upon by the healthcare 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.

Public Relations Officers

Public Relations Guidelines for Critical Incident Response Plans

3-4-22 As soon as possible after the abduction contact the local media and request that they come to a designated media room at the healthcare 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. **Most often infants**

are recovered as a direct result of the leads generated by media coverage of the abduction.

Be sure to designate a separate area where friends and family of the parents can gather to receive regular updates on the abduction in order to keep them informed about the case and shielded from the press.

3-4-23 Prepare the switchboard with a written response they may use for outside callers, including anxious parents who are planning to have their babies delivered at that facility.

3-4-24 Activate the crisis communication plan. It should list steps to be taken, people to be notified, resources available such as photo duplication and dissemination, etc.

For a full treatment of planning for, creating, and responding to a critical incident plan, *see* James T. Turner's 1990 article listed in the "Bibliography" on page 66.

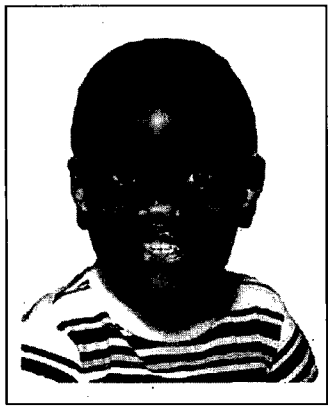
Photo composite of Tavish Sutton who was abducted from his hospital room in March 1993.

NATIONAL CENTER FOR MISSING & EXPLOITED CHILDREN

2101 Wilson Boulevard • Suite 550
Arlington, VA • 22201
(800) 843-5678 • (703) 235-3900

TAVISH SUTTON

Non-family abduction



Missing: 03/09/93 **Age Now:** 3 Yr
Missing From: ATLANTA, GA
Birth: 02/10/93 **Age Disap.:** 1 Mo
Sex: M **Race:** BLACK
Height: 2'0" **Weight:** 8 lbs
Hair: BLACK **Eyes:** BROWN

Id Info: The picture shown is a "PHOTO COMPOSITE" of what the child may look like at the age of 4 years.

Circum: 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.

ANYONE HAVING INFORMATION SHOULD CONTACT
The National Center for Missing and Exploited Children
1-800-843-5678
OR
ATLANTA POLICE DEPARTMENT (GEORGIA) - 1-404-853-3400 OR YOUR LOCAL FBI

Poster ver 2.0, Pegasus Imaging Corp

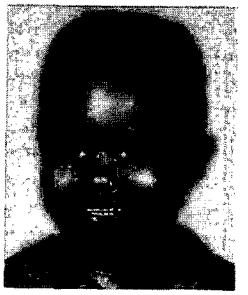
NATIONAL CENTER FOR MISSING & EXPLOITED CHILDREN

2101 Wilson Boulevard • Suite 550
Arlington, VA • 22201
(800) 843-5678 • (703) 235-3900

ANDRE TERRENCE BRYANT

Non-family abduction

ANDRE TERRENCE BRYANT



Age progression to 7 Yr

Age-Progression by NCMEC (4/96)

Missing: 03/29/89 **Age Now:** 7 Yr
Missing From: BROOKLYN, NY
Birth: 02/17/89 **Age Disap.:** 1 Mo
Sex: M **Race:** BLACK
Height: 17" **Weight:** 10 lbs
Hair: BLACK **Eyes:** BROWN

Id Info: Child last seen with his mother, who was later found deceased.

Circum: Mother and child left residence at about 2 p.m. to go shopping with two black female acquaintances. Seen in burgundy Pontiac Grand Am, poss. with MD tags.

ANYONE HAVING INFORMATION SHOULD CONTACT
The National Center for Missing and Exploited Children
1-800-843-5678
OR
NEW YORK CITY POLICE DEPARTMENT - 83RD PRECINCT (NEW YORK) MISSING PERSONS UNIT
1-718-574-1221

Poster ver 2.0, Pegasus Imaging Corp

Original and age-progressed photograph of Andre Terrence Bryant who was abducted from his home in March 1989.

Example of a Notification Form

TO: AREA BIRTHING FACILITIES
RE: Unusual/Suspicious Activity
FROM:
Following is a description of an unusual/suspicious incident that occurred at our facility. Please inform us if you experience any incidents of this nature.

Occurrence Date(s) Time(s)

Description of Subject
- Name/Alias(es)
- Sex
- Approximate Age
- Race
- Height
- Weight
- Hair
- Eyes
- Clothing
- Unusual Characteristics

Synopsis of Incident

For additional information contact at ( )

List facilities notified:

National Center for Missing and Exploited Children Notified? Y N
If not, please call at 1-800-THE-LOST (1-800-843-5678)

4. Liability

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

In the cases studied so far of hospitals that have been sued, as a result of infant abductions, a higher percentage of suits occurred in those cases where the infant was not recovered within one week of the abduction. The likelihood of litigation did not vary based upon the location of the abduction. That is, families sued their hospitals in equal proportions whether the infant was abducted from the nursery, the mother's room, or a pediatric room. The hospital was more likely to be sued in cases where the abductor impersonated a hospital employee than in those cases where the abductor did not impersonate an employee. Litigation was more common in the cases where the abduction occurred in the 1990s.

In cases of infant abduction, a healthcare 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 healthcare facility could be liable for any physical or psychological harm suffered by the abducted infant.

The second area of liability is based on the healthcare facility's contractual duty to use reasonable care to prevent the occurrence of foreseeable injury to third parties. Thus, the healthcare facility could be liable to the parents for the costs of any searches and for psychological harm.

Today's administrators, risk managers, and security directors have the responsibility for guiding not only the public trust in their facility but also the patient's safety and staff awareness for potential events. Though infant abductions do not occur with high frequency in any given area, they do occur. Ignoring the potential for infant abduction, given the statistics and known information from this publication and the other professional sources summarized in the "Bibliography" on page 65, negates the prudent due diligence of risk managers, nurse managers, and healthcare security that is necessary for them to perform their jobs. The specific date of 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, there is wide agreement that foreseeability affixed to the healthcare industry nationwide by January 1992. The "Bibliography" outlines, in chronological order, the benchmark articles in journals and publications for healthcare professionals.

5. After Discharge from the Maternal-Child Care Unit

After discharge from the 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 healthcare professionals on helping parents to safeguard infants from nonfamily abduction whether at home, at a healthcare facility in either a prolonged or short stay, or while at a regular check-up.

Special Care Nurseries and Pediatric Units

Neonatal and Pediatric Intensive Care Units (N/PICUs) normally 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 do **not** often utilize the same level of security as employed in well-newborn nurseries due to monitoring and increased nurse-to-patient staffing ratios.

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 the nursing staff. Consideration should be given to utilizing 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.

While there have been no reported cases of **nonfamily** member infant abductions from NICUs, infant abductions from these units have occurred involving **family** members of infants who are on "court hold" for such reasons as positive drug screens and custody issues. While these abductions may be reported to local authorities, no national figures have been tabulated on the incidence of this crime as committed by family members.

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

- infant care procedures that result in numerous infant identification band changes due to reinsertion of intravenous needles, edematous extremities, or infant weight gain
- environmental designs that divide the NICU and pediatric units into small, low census pods. These areas may be difficult for 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 that may not be consistent with the maternity department (*e.g.*, discharge of baby directly from unit where parents carry the baby out of the facility in their arms)
- large, busy units with multiple caregivers who may not be familiar with the parents
- utilization of registry personnel/traveling nurse service personnel who are not required to wear photo or unique identifying badges that are monitored each shift
- smaller units may experience, at times, lower census and lower staffing patterns that may increase vulnerability for line-of-sight observation
- discharge process that does **not** require parents to present an identification band that matches the infant's or require verification of identification with an official photo ID
- a false sense of security (on the part of staff members) that an infant abduction could not occur in such special care units (*e.g.*, probable targets would be "grower" babies, babies ready for discharge, "boarder" babies, or "adoption" babies who have yet to be placed with a family or picked up by the adoptive family)

Pediatric units also offer special challenges when trying to safeguard children from nonfamily abduction. While 15 percent of the infants abducted from healthcare facilities are from nurseries, 17 percent of the infants abducted are from pediatric units (including children's hospitals).

As in special care nursery situations, parents may not be constantly present until the child's discharge. In addition nurses may not be ever present in the baby's room when family is absent and infants are not usually placed in a nursery when family members are absent. Thus, pediatric units often are less secure or are less "hardened" than maternal-child care units and special care nurseries.

All items contained in Chapter 3, "Guidelines for Healthcare Professionals," should be carefully considered for adoption in special care nurseries and pediatric units. Thus all healthcare facility personnel should wear conspicuous color photo ID as described in Guideline 3-2-4. At admission, footprint and photograph the baby. In addition perform and record a full physical assessment of the baby. The footprints, photograph, and physical assessment must be placed in the baby's medical chart. Over time refootprinting the baby is advised, but certainly before discharge.

For instance if the child is hospitalized longer than one month, the child should be photographed and refootprinted monthly.

To safeguard the infant while being transported within the healthcare facility personnel must make sure that

- **only an authorized staff member or person with an authorized ID band for that infant is allowed to transport the child.** In cases where the infant needs to be taken for tests in other units of the facility (*i.e.*, X-ray, MRI) staff should assure parents that the transporter is an employee of the facility and parents should be encouraged to accompany their child if and when possible. The facility should consider giving pediatric patients a priority for testing to decrease the child's waiting time in the other unit.
- **infants are transported one at a time, never left in the hallway without direct supervision.**
- **infants are never carried, but always pushed in a bassinet.**
- **anyone visiting with or transporting the infant (who is 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 needs to be clearly documented, especially to facilitate discharge of the infant. Identification policies should clearly outline steps to be implemented for reapplying matching identification bands when the mother has been discharged from the facility while the infant is still in the facility.
- **infants are always in line-of-sight supervision by nurses or parents and/or near the nurses' station.** If possible, when not in a special care unit, infants should **not** be placed in rooms physically located next to 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.
- **an access control policy is established for the nursing unit to maximize safety.** All exterior doors to the unit must have self-closing hardware and be under strict access control (locked). At the front lobby or entrance to the unit, instruct healthcare facility personnel to ask visitors which infant they are visiting and their relationship to the child. If no name is known or given, decline admission and alert hospital security, nurse manager/supervisor, facility administration, or the police. Set up a sign-in log for visitors to the unit, specifying the infant to be visited and requiring the visitor to show an official photo ID.

In the NICU, infant maternity bands applied at birth may be removed due to patient care needs. The removed ID bands should be stapled to the medical record or cut and placed in the "sharps box" noting this in the medical record. NICU infants then need to be rebanded with another identification band.

As discharge nears, parents may utilize a rooming-in service to prepare for the infant's special needs. It is imperative that maternal-child care security procedures, as previously outlined, be followed in these situations.

Upon discharge require a show of the ID wristband for the person taking the infant home from the healthcare 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 an identification band that matches the infant's (the one on the infant or stapled in the medical record), require verification of identification with an official photo ID (*e.g.*, driver's license).

Ensure that infant security policy and procedures are consistent throughout the facility from the maternal-child care unit to special care nurseries and the pediatric unit. Consistency of policies and procedures will assist parents in decreasing confusion and increasing compliance.

Implement a policy and procedure that will meet the security needs of an infant who is on "court hold." For example, if the mother is in the well-newborn nursery to visit the infant she should be under direct supervision and observation.

Janet Lincoln, R.N.C., M.S.N., Former Director of Maternal-Child Health, Hoag Memorial Hospital-Presbyterian contributed to this section.

Notes While infant abductions grab the headlines, more common are family abductions involving custody disputes, child abuse, and Department of Family and Children Services (DFCS) intervention. While this problem is widespread and statistical information is available on the subject, it is likely that 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.

Upon admission of a child to a patient room and during the orientation process, nursing staff should ask the parent/guardian if there is any personal circumstance that 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 persons, who may be involved in a custody dispute. 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, and circumstances surrounding the risk. Protection strategies include

- "red flagging" the child's name in the system to indicate that 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 an assumed name on the child's door
- using a wireless CCTV 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 (reception area)
- posting a security officer at the patient's room/floor/unit

Jim Crumbley, Director of Protective Services, Scottish Rite Children's Hospital contributed to this section.

Outpatient Areas

Clinics or postpartum treatment facilities for mothers, pediatric clinics, health maintenance organizations (HMO), and hospital waiting rooms should post the policy that parents or guardians are not allowed to leave children unattended in the waiting room or relinquish that duty to others. Such facilities should enforce that rule by reminding parents when they violate it. Be sure to post that policy in all the languages spoken by patients in your service area.

Also such facilities need to establish a policy regarding the specific identification worn by staff who are authorized to transport and treat the infant and inform parents/guardians of that policy.

Visiting nurses, home health aides, home health care workers, HMO workers, nurses in physicians' offices, all nursing and medical students, etc., should be issued the same photo ID cards referenced in Guidelines 3-2-4 and 3-2-13 of "Proactive Measures." Whenever possible families

should be notified of planned visits to their home and families should be cautioned against allowing anyone to enter their home who does not have the approved form of identification issued by that service.

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

Case in Point Margaret had been home from the hospital only a few days after giving birth to her daughter when a woman came to her home announcing that she was a visiting nurse from the hospital assigned to offer "follow-up care for your newborn." The woman was dressed as a home nurse; appeared pregnant; carried medical equipment, including a blood pressure cuff and stethoscope; and had a notebook with the name of the hospital, where Margaret had given birth to her daughter, written on the front. Two days later the "nurse" visited Margaret a second time stating that she was being considered for a promotion and asked Margaret to write her a letter of recommendation. While Margaret went into the dining room to get a pen and paper, she heard the "nurse" going out the front door of the house. When Margaret asked where she was going the "nurse" said that she had forgotten her blood pressure cuff and would be right back. Margaret became suspicious when the "nurse" did not come back, found that her baby girl was no longer in the bedroom, and called the police.

Prior to going to Margaret's house on that second day, the "nurse" informed her husband that it was time for him to take her to the hospital. He waited in the hospital lobby while she told him that she was going to be examined. But, instead she exited the hospital and returned to Margaret's home. Upon abducting the child the "nurse" returned to the hospital, joined her husband in the lobby, and showed him the baby she had just "given birth to." Suspecting that something was wrong, the husband questioned her, and the couple began to argue. In the meantime the police began searching

for the missing baby and discovered the arguing couple in the parking lot as the abductor attempted to place the child in a car seat in their van. In addition to the car seat the abductor had purchased formula, baby clothes, and toys.

Homes

Although to date there has been **no** use of violence against mothers **within** the hospital, of the 49 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. There have been several cases where an abductor has made initial contact with a mother and baby in the hospital setting and then subsequently abducted the infant at the family home. Therefore, a high degree of diligence should be exercised by the healthcare facility when releasing information about the birth of the child. It is inappropriate for the healthcare facility to supply birth announcements to the press that contain 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 hospital versus nonhospital abductions. 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 hospital stay. *See* "What Parents Need to Know" on page 41 and the 1995 listing for *Analysis of Infant Abductions* by Ann Burgess and Ken Lanning in the "Bibliography" on page 69.

Case in Point While pregnant a mother took her older children to a shopping mall and stopped to observe a woman who was there painting clown faces on children. After a brief conversation the two women exchanged telephone numbers. Although initially the two women did not contact one another, the woman who was painting clown faces located the mother several months later after seeing the birth announcement of her new "friend's" baby in the newspaper. The woman gained entry to the mother's home, shot the mother in the head kill-

ing her, and abducted the baby. The abductor used the moment of the victim mother's death as the time and day of the "birth" of "her" baby. Upon announcing the "birth" to her husband and his coworkers, the coworkers became suspicious of the "arrival" of what appeared to be a 10-day-old baby in the household and contacted local law enforcement. The police found the infant, unharmed, at the home of the abductor.

During their investigation the police also found five weeks' worth of birth announcements from the local daily newspaper in the assailant's home. They learned that she had posed as a child welfare worker and "checked up" on other mothers of infants that had been included in the published birth announcements.

6. What Parents Need to Know

Hospital personnel should remind **parents**, in a warm and comforting way, of the measures they should take to provide maximum child protection. The guidelines listed below provide good, sound parenting techniques that can also help prevent abduction of infants while in the healthcare facility where the child was born and once the parents take the child home.

FACILITY 1. At some point **before** the birth of your baby investigate security procedures at the facility where you plan to give birth to your baby and request a copy of the facility's written guidelines on procedures for "special care" and security procedures in the maternity ward. Make sure that you know all of the facility's procedures that are in place to safeguard your infant while staying in that facility.

FACILITY 2. While it is normal for new parents to be anxious, being deliberately watchful over the newborn infant is of paramount importance.

FACILITY 3. Never leave your infant out of your direct line-of-sight even when you go to the bathroom or take a nap. If you leave the room or plan to go to sleep, alert the nurses to take the infant back to the nursery or have a family member watch the baby.

FACILITY 4. After admission to the facility ask about hospital protocols concerning the routine nursery procedures, feeding and visitation hours, and security measures.

FACILITY 5. Do not give your infant to **anyone** without properly verified hospital identification. Find out what additional or special identification is being worn to further identify those hospital personnel who have authority to handle the infant.

FACILITY 6. Become familiar with the hospital staff who work in the maternity unit. During short stays in the hospital, be sure you know the nurse assigned to you and your infant.

FACILITY

7. Question unfamiliar persons entering your room or inquiring about your infant—even if they are in hospital attire or seem to have a reason for being there. Alert the nurses' station immediately.

FACILITY

8. Determine where your infant will be when taken for tests, and how long the tests will take. Find out who has authorized the tests. If you are uncomfortable with anyone who requests to take your baby or unable to clarify what testing is being done or why your baby is being taken from your room, it is appropriate to go with your baby to observe the procedure.

FACILITY

9. For your records to take home, have at least one color photograph of your infant (full, front-face view) taken and compile a complete written description of your infant, including hair and eye color, length, weight, date of birth, and specific physical attributes.

FACILITY/HOME

10. At some point **after** the birth of your baby, but **before** discharge from the facility, request a set of written guidelines on the procedures for any follow-up care extended by the facility that will be scheduled to take place in your home. Do not allow anyone into your home who says they are affiliated with the facility without properly verified hospital identification. Find out what additional or special identification is being worn to further identify those staff members who have authority to enter your home.

HOME

11. Consider the risk you may be taking when permiting your infant's birth announcement to be published in the newspaper. Birth announcements should never include the family's home address and should be limited to the parents' surname(s).

HOME

12. The use of outdoor decorations to announce the infant's arrival, such as mylar balloons, large floral wreaths, wooden storks, and other lawn ornaments are not recommended.

HOME

13. Only allow persons 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 acquaintance, especially if met briefly since you became pregnant or gave birth to your baby. There have been several cases where an abductor has made initial contact with a mother and baby in the hospital setting and then subsequently abducted the infant at the family home. If anyone should arrive at the home claiming to be affiliated with the healthcare facility where the infant was born, remember to follow the procedures outlined in number 10 above.

In addition there have been cases in which initial contact with a mother and baby was made in other settings such as shopping malls. A high degree of diligence should be exercised by family members when home with the baby.

PARA SU INFORMACIÓN
MEDIDAS PARA EVITAR EL SECUESTRO DE BEBÉS DE HOSPITALES O DEL HOGAR

Pese a que no es un delito de proporciones epidémicas, el secuestro de bebés (desde el nacimiento hasta los seis meses de edad) de hospitales y de hogares privados por personas ajenas a la familia, se ha convertido en motivo de preocupación para los padres, las enfermeras encargadas del cuidado materno-infantil, del personal de seguridad de los hospitales, los agentes del orden público y el Centro Nacional para Menores Desaparecidos y Explotados (National Center for Missing and Exploited Children—NCMEC).

Lo que los padres necesitan saber:

El personal del hospital debe recordar a los **padres** las medidas que deben tomar para proveer la máxima seguridad a su bebé. Las medidas enumeradas a continuación proveen técnicas para ayudar a los padres a prevenir el secuestro del bebés del lugar donde nació el bebé o de su propio hogar.

ESTABLECIMIENTO

1. **Antes** del nacimiento de su bebé debe investigar los procedimientos de seguridad del establecimiento donde piensa dar a luz y

pedir una copia de los procedimientos de "cuidado especial" y de seguridad de la sala de maternidad del hospital. Asegúrese de conocer todos los procedimientos para proteger a su bebé mientras esté en el establecimiento.

ESTABLECIMIENTO

2. Mientras que es normal que los padres se sientan ansiosos, es muy importante vigilar activamente a su bebé.

ESTABLECIMIENTO

3. Nunca deje a su bebé fuera de su vista—aún cuando vaya al baño o a tomar una siesta. Si sale de la habitación o tiene intenciones de dormirse, avise a las enfermeras para que lleven a su bebé a la guardería o pida a un miembro de su familia que lo vigile.

ESTABLECIMIENTO

4. Después de entrar al establecimiento, infórmese sobre los protocolos de rutina de la guardería, las horas de comidas y de visitas y las medidas de seguridad.

ESTABLECIMIENTO

5. No entregue su bebé a **nadie** que no tenga identificación debidamente verificada por el hospital. Averigüe cual es la identificación adicional o especial del personal autorizado para atender a su bebé.

ESTABLECIMIENTO

6. Debe conocer al personal que trabaja en la sala de maternidad. Durante estancias breves en el hospital, asegúrese de conocer a la enfermera encargada de usted y de su bebé en cada turno.

ESTABLECIMIENTO

7. Interrogue a las personas desconocidas que entran a su habitación o que preguntan sobre su bebé—aunque estén vestidos con ropa de hospital o parezcan tener alguna razón para estar allí. Avise de inmediato a la estación de enfemeras.

ESTABLECIMIENTO

8. Averigüe donde estará su bebé cuando lo lleven a hacerle exámenes, y cuánto tiempo durarán dichos exámenes. Averigüe quién ha autorizado dichos exámenes. Si no se siente cómoda con alguna persona que quiera llevarse a su bebé o si no puede averiguar qué exámenes quieren hacerle o por qué quieren sacarlo de su habitación, acompañe a su bebé para observar el procedimiento.

ESTABLECIMIENTO

9. Para sus archivos en casa, tome por lo menos una fotografía en colores de su bebé (de frente) y haga una descripción completa incluyendo el color del pelo y de los ojos, el tamaño, el peso, la fecha de nacimiento y las características físicas especiales.

ESTABLECIMIENTO/CASA

10. **Después** del nacimiento de su bebé, pero **antes** de salir del hospital, pida una copia escrita de los procedimientos para cualquier tratamiento de seguimiento que vaya a recibir en su casa. No permita entrar a su casa a nadie si no tiene identificación debidamente verificada del hospital. Averigüe cuál es la identificación adicional o especial del personal del hospital que tiene autorización para entrar a su casa.

CASA

11. Considere el riesgo que toma al permitir la publicación del anuncio del nacimiento de su bebé en el periódico. Los anuncios de nacimientos nunca deben incluir el domicilio de la familia ni los nombres completos de los padres.

CASA 12. No se recomienda uso de decoraciones fuera de su casa para anunciar la llegada de su bebé, por ejemplo globos, coronas de flores, cigüeñas de madera y el otros adornos para el jardín.

CASA 13. Deje entrar a su casa sólo a personas conocidas. No debe dejar entrar a nadie que acaba de conocer, especialmente si conoció a esa persona brevemente desde que estuvo embarazada o desde que dio a luz. Ha habido varios casos en que el secuestrador ha hecho contacto inicial con la madre y con el bebé en el hospital y luego ha secuestrado al bebé en el hogar de la familia. Si alguien se presenta al hogar diciendo estar afiliado al hospital donde nació el bebé, siga los procedimientos del No. 10.

Note The National Center for Missing and Exploited Children (NCMEC) considers written requests to reprint the English- and Spanish-language versions of "What Parents Need to Know" when healthcare facilities wish to distribute them to patients who will be giving birth to children in their facility. To obtain NCMEC's "Reprint Request Form," that enumerates the information needed to consider such a request, please call NCMEC at 703-235-3900.

Also, please consider requesting permission from NCMEC to translate these tips into any other languages spoken by patients within your service area.

7. Self-Assessment for Healthcare Facilities

Self-assessment guides are helpful tools for recommendable/advisable policies and/or protocols.

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
3-1 General					
3-1-1 Immediately report persons exhibiting behaviors of potential abductor.	X				
Positively identify suspect.	X				
Interview suspect.	X				
3-1-2 Preserve report and interview records on incident.	X				
3-1-3 Alert other birthing facilities in the area of attempted abductions/ when person identified who demonstrates behaviors of potential abductor.	X				

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
3-1-4 For all attempted abductions:					
Notify the police.	X				
Notify NCMEC.	X				
3-2 Proactive Measures					
3-2-1 Develop written proactive prevention plan.	X				
3-2-2 Immediately after birth of infant attach identically numbered ID bands to infant, mother, father/significant other.	X				
3-2-3 Prior to removal of newborn from birthing room:					
Footprint baby.	X				

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
Take color photograph of baby.	X				
Perform and record full physical assessment of baby.	X				
Place all these items in baby's medical chart.	X				
3-2-4 Require all healthcare personnel to wear conspicuous, color photo ID badges.	X				
Personnel in direct contact with the infants should wear a second form of unique identification.	X				
3-2-5 Distribute guidelines for parents in preventing hospital abductions in childbirth classes, on preadmission tours, upon admission, at postpartum instruction.	X				

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
3-2-6 Train staff on protecting infants from abduction.	X				
3-2-7 While infants are transported within the healthcare facility ensure that:					
Only authorized staff members are allowed to transport the child.	X				
A baby is never left in the hallway without direct supervision.	X				
Infants are taken to mothers one at a time.	X				
Babies are never carried, always pushed in bassinet.	X				
3-2-8 Ensure that infants are always in line-of-sight supervision.	X				

GUIDELINE Number/Referencing		NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
3-2-9	Do not post mother's or infant's full name where it will be visible to visitors.	X				
3-2-10	Establish an access control policy for the nursing unit (nursery, maternity, neonatal intensive care, pediatrics).		X			
	At the front lobby or entrance to those units, instruct healthcare facility personnel to ask visitors which mother they are visiting and for how long.		X			
3-2-11	Require a show of the ID wristband for the person taking the infant home from the healthcare facility, matching the bands on the wrist and ankle of the infant with the bands worn by the mother and father.		X			

GUIDELINE Number/Referencing		NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
3-2-12	No home address or other unique information should be divulged to the public in birth announcements that would put the infant and family at risk **after discharge**.		X			
3-2-13	When providing home visitation services, personnel entering patients' homes need to wear a unique form of identification used only by them, strictly controlled by the facility, and known to the parents.		X			
3-3 Physical Security Safeguards						
3-3-1	Develop written assessment of risk potential for infant abduction.	X				

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
3-3-2 Install alarms on all stairwell and exit doors on the perimeter of the maternity, nursery, neonatal intensive care, and pediatrics units that are exterior access doors.	X				
Respond to alarms and instruct responsible staff to silence and reset an activated alarm only after direct observation of the stairwell or exit and the person using it.	X				
3-3-3 Ensure all nursery doors have self-closing hardware and remain locked at all times.	X				
3-3-4 All doors to lounges or locker rooms where staff members change/ leave clothing, must have self-closing hard-ware and be under strict access control.		X			

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
3-3-5 **Document** a needs assessment for an electronic asset surveillance (EAS) detection system, utilizing an EAS infant bracelet tag tied to video recording of the incident and alarm activation.		X			
3-3-6 Install a security camera system.	X				
3-4 Critical Incident Response Plan *General* 3-4-1 Develop written critical incident response plan in the event of an infant abduction.	X				
3-4-2 Call NCMEC at 1-800-THE-LOST (1-800-843-5678) for advice and technical assistance.	X				

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
Maternal/Child-Care Nurses					
3-4-3 **Immediately** search the entire unit.	X				
3-4-4 **Immediately** call facility security and/or other designated authority.	X				
3-4-5 Protect the crime scene.	X				
3-4-6 Move the parents of the abducted child (but **not** their belongings) to a private room off the maternity floor.		X			
Detail the nurse assigned to the mother and infant to accompany them at all times.		X			
Secure all records/charts of the mother and infant.		X			
Notify lab and place STAT hold on infant's cord blood.		X			

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
Consider designating a room for other family members to wait in which gives them easy access to any updates in the case while offering the parents some privacy.		X			
3-4-7 Nurse manager/ supervisor brief all staff of the unit.		X			
Nurses should then explain the situation to each mother while the mother and her infant are together.		X			
3-4-8 Assign one staff person to be the single liaison between the parents and hospital after the discharge of the mother from the hospital.		X			

GUIDELINE Number/Referencing		NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
3-4-9	Hold a group discussion session as soon as possible in which all personnel affected by the abduction are **required** to attend.	X				
Security Personnel						
3-4-10	Call the local police department and make a report.	X				
	Then call the local FBI office or the FBI's Child Abduction and Serial Killer Unit at 540-720-4700.	X				
	Immediately and simultaneously activate a search of the entire healthcare facility, interior and exterior.	X				
	Assume control of crime scene until law enforcement arrives.	X				

GUIDELINE Number/Referencing		NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
	Assist nursing staff in establishing and maintaining security in the unit.	X				
	Establish a security perimeter around the facility and assist the nursing staff in establishing and maintaining security within the unit.	X				
3-4-11	Facility's media plan should mandate that all information about the abduction be cleared by facility **and** law enforcement authorities involved before being released to staff members and the media.	X				

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
3-4-12 Brief the healthcare 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.		X			
3-4-13 Call NCMEC at 1-800-THE-LOST (1-800-843-5678) for technical assistance in handling ongoing crisis management.	X				
3-4-14 Notify newborn nurseries, pediatric units, emergency rooms, and outpatient clinics for postpartum/ pediatric care at other local healthcare facilities about the incident and provide a full description of the baby and the suspected abductor.	X				

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
Law Enforcement Officers					
3-4-15 Enter the child's name and description in the FBI's National Crime Information Center's Missing Person File (NCIC-MPF).	X				
3-4-16 Call NCMEC at 1-800-THE-LOST (1-800-843-5678) to request technical assistance, network with other agencies and organizations, assist in obtaining media coverage of the abduction, and coordinate dissemination of the child's photograph.	X				

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
3-4-17 Call the FBI's Child Abduction and Serial Killer Unit at 540-720-4700 for technical and forensic resource coordination; computerized case management support; investigative, interview, and interrogation strategies; and information on behavioral characteristics of unknown offenders.	X				
3-4-18 Consider setting up one dedicated local telephone hotline for sightings/leads or coordinate this function with a local organization.		X			

GUIDELINE Number/Referencing		NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
3-4-19	Consider polygraphing infants' parents, female offender, and her male companion.		X			
3-4-20	Charge abductor.	X				
	Make every effort to sustain a conviction.	X				
3-4-21	Release of information concerning infant abduction should be well planned and agreed upon by the healthcare facility and law enforcement authorities involved.		X			
	Keep family fully informed.		X			

GUIDELINE Number/Referencing	NCMEC Necessary	NCMEC Recommended	FACILITY Complies (Yes/No)	FACILITY Responsible Department	COMMENTS
Public Relations Officers					
3-4-22 Provide facts of case to media and ask for their assistance in releasing that information to the public in hopes of generating leads on the child.		X			
3-4-23 Provide written statement to address callers' concerns over the abduction, especially anxious parents who are planning to have their babies delivered at that facility.		X			
3-4-24 Activate the crisis communication plan.		X			

8. Bibliography

The following partial bibliography outlines, in chronological order, the benchmark articles in journals and publications for healthcare professionals on this issue. For further information on related articles from popular magazines and newsprint contact the Case Enhancement and Information Analysis Unit of the National Center for Missing and Exploited Children.

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The National Center for Missing and Exploited Children (NCMEC) serves as a clearinghouse of information on missing and exploited children. A 24-hour, toll-free telephone line (available throughout the United States, Canada, and Mexico) is open for those who have information on missing and exploited children: **1-800-THE-LOST** (1-800-843-5678). The TDD hotline is 1-800-826-7653. The business number is 703-235-3900. The facsimile number is 703-235-4067. The homepage is http:/www.missingkids.org.

NCMEC offers free technical assistance and a complimentary copy of **For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions** by calling toll-free **1-800-THE-LOST**.

A number of publications are available free of charge in single copies by writing the Publications Department, National Center for Missing and Exploited Children, 2101 Wilson Boulevard, Suite 550, Arlington, VA 22201-3052.

Note: *Safeguard Their Tomorrows*, a 35-minute educational videotape for healthcare professionals, has been produced by **Mead Johnson Nutritionals** in cooperation with AWHONN (the Association of Women's Health, Obstetric, and Neonatal Nurses—formerly NAACOG); NANN (the National Association of Neonatal Nurses); and NCMEC. For more information contact your local Mead Johnson Nutritionals Representatives.

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3. Frequently indicates that she has lost a baby or is incapable of having one
4. Often married or cohabitating; companion's desire for a child may be the motivation for the abduction
5. Usually lives in the community where the abduction takes place
6. Frequently visits nursery and maternity units prior to the abduction; asks detailed questions about hospital procedures and the maternity floor layout; frequently uses a fire exit stairwell for her escape
7. Usually plans the abduction, but does not necessarily target a specific infant; frequently seizes on any opportunity present
8. Frequently impersonates a nurse or other hospital personnel
9. Often becomes familiar with hospital personnel and even with the victim parents
10. Demonstrates a capability to provide "good" care to the baby once the abduction occurs

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