

For Healthcare Professionals:


Guidelines on Prevention of and Response to Infant Abductions

Ninth Edition
2009



**National
Association of
Neonatal
Nurses**



NATIONAL
CENTER FOR 
**MISSING &
EXPLOITED**
CHILDREN®
THE "TYPICAL" ABDUCTOR

(Developed from an analysis of 256 cases occurring 1983-2008.)

1. Female of "childbearing" age (range now 12 to 53), often overweight.
2. Most likely compulsive; most often relies on manipulation, lying, and deception.
3. Frequently indicates she has lost a baby or is incapable of having one.
4. Often married or cohabitating; companion's desire for a child or the abductor's desire to provide her companion with "his" child may be the motivation for the abduction.
5. Usually lives in the community where the abduction takes place.
6. Frequently initially visits nursery and maternity units at more than one healthcare facility prior to the abduction; asks detailed questions about procedures and the maternity floor layout; frequently uses a fire-exit stairwell for her escape; and may also try to abduct from the home setting.
7. Usually plans the abduction, but does not necessarily target a specific infant; frequently seizes any opportunity present.
8. Frequently impersonates a nurse or other allied healthcare personnel.
9. Often becomes familiar with healthcare staff members, staff members work routines, and victim parents.
10. Demonstrates a capability to provide "good" care to the baby once the abduction occurs.

In addition an abductor who abducts from the home setting

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

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

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

To receive free technical assistance by telephone or on-site and a complimentary copy of

For Healthcare Professionals:
Guidelines on Prevention of and Response to Infant Abductions,
please call the National Center for Missing & Exploited Children at

1-800-THE-LOST®
(1-800-843-5678)

Please post this flier out of view of the public at the nurses' station,
nurses' lounge, medication room, security office, and risk-management unit.

For Healthcare Professionals:

Guidelines on Prevention of and Response to Infant Abductions

**Ninth Edition
2009**

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Executive Vice President and Chief Operating Officer
National Center for Missing & Exploited Children®**

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applicable to specific matters.**

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A Message to the Reader

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

Infant/pediatric abductions or discharge to the wrong family are reviewable sentinel events under the sentinel-event standards of TJC. A Sentinel Event Alert relative to infant abductions was issued by TJC on April 9, 1999, and is available on TJC’s website at www.jointcommission.org. In addition the TJC 2002 publication titled *Security Issues For Today’s Health Care Organizations* and the 2009 TJC *Comprehensive Accreditation Manual for Hospitals: The Official Handbook* should be consulted as important reference information. The primary TJC security requirements relative to infant security are found in the Environment of Care Section EC.02.01.01, which in 2009 combined the previously separated areas of security and safety. TJC publications may be obtained through Joint Commission Resources at www.jcrinc.com or 877-223-6866.

The International Association for Healthcare Security and Safety (IAHSS) publishes *Healthcare Security: Basic Industry Guidelines*. Guideline 09.02 addresses infant/pediatric security and is available in booklet form and on the Web at www.iahss.org or 1-888-353-0990.

The National Quality Forum (NQF) in 2002 published 28 serious reportable events. This was an effort of the NQF to address healthcare safety. The events are easily identifiable and measurable and are of a nature such that a risk of occurrence is influenced by policies and procedures of the healthcare facility. One of these 28 serious reportable events is abduction of a patient of any age. Centers for Medicare and Medicaid have linked payment to some of these events. Patient Safety — Obstetrical “never events” have listed infant abduction as one of these events.

The “guidelines” presented in this document are intended to provide, in part, security strategies and protocols that support and enhance TJC and IAHSS security guidelines. NCMEC encourages facilities that are not accredited by TJC to follow the intent of TJC requirements and IAHSS guidelines.

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

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

Nonfamily Abduction

KAMIYAH MOBLEY



DOB: Jul 10, 1998
Missing: Jul 10, 1998
Age Now: 10
Sex: Female
Race: Black
Hair: Black
Eyes: Brown
Height: 1'9" (53 cm)
Weight: 8 lbs (4 kg)
Missing From:
JACKSONVILLE
Florida
United States



Composite No Wig No Glasses

SUSPECT COMPOSITE



Suspect
DOB: Jan 1, 1968
Sex: Female
Race: Black
Hair: Black
Eyes: Brown
Height: 5'5" (165 cm)
Weight: 145 lbs (66 kg)

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

ANYONE HAVING INFORMATION SHOULD CONTACT



NATIONAL CENTER FOR MISSING & EXPLOITED CHILDREN
1-800-843-5678 (1-800-THE-LOST) or
Jacksonville Sheriff's Office (Florida) - 1-904-630-0500
FBI (Jacksonville, Florida) - 1-904-721-1211 Or Your Local FBI

**Photo composite
of Kamiyah Mobley
who was abducted from
her mother's hospital
room in July 1998.**

1. The Problem

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 & Exploited Children (NCMEC). With the goal of preventing crimes that are committed against children, NCMEC — in cooperation with the Federal Bureau of Investigation (FBI), International Association for Healthcare Security and Safety (IAHSS), and Boston College School of Nursing — has studied infant abductions from birthing/healthcare facilities, 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 2008, the best estimate for the nationwide incidence of infant abductions, by nonfamily members, ranges between 0 and 10 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, in 2007 there were more than 4 million births in the United States,¹ and there are nearly 3,000 birthing facilities.² In 124 of the cases studied the infants were abducted from the premises of healthcare facilities, and 99 were infant abductions from the home that followed most of the same patterns as the abductions from healthcare facilities but with the addition of violence committed against the mother or other present caregiver. Thirty-three (33) additional infants were abducted from other places such as malls, offices, and parking lots. The bed size of a facility, urban or rural, does not seem to be a factor as to whether or not they will experience an abduction. Of all the infants abducted from healthcare facilities, 95 percent were located and safely returned, usually within a few days to two weeks.

Because anecdotal evidence would suggest there may be numerous abduction attempts at birthing facilities each year, information regarding attempted abductions should be reported to NCMEC at 1-800-THE-LOST® (1-800-843-5678). When submitting information, the name of the healthcare facility may be excluded, but NCMEC would appreciate knowing the city in which the incident occurred and bed size of the healthcare facility reporting the incident. NCMEC wishes to collect this information in order to identify any possible changes in the profile or emerging trends in the abduction of infants.

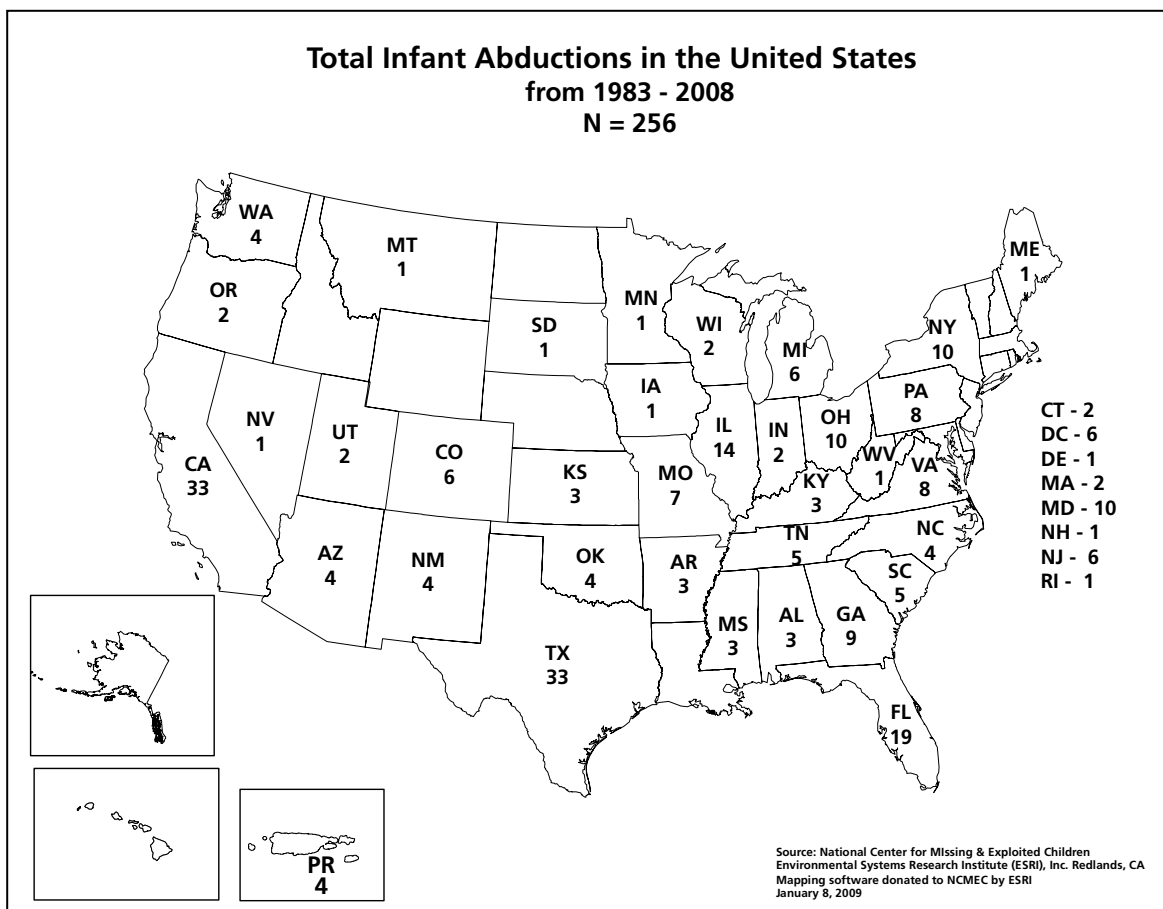
¹According to “Births, Marriages, Divorces, and Deaths: Provisional Data for 2007” in *National Vital Statistics Reports*, Vol. 56, No. 21, July 14, 2008, page 1, there were 4,315,000 live births in 2007, the most recent year of available data.

²According to the American Hospital Association 2,800 hospitals in the United States reported having obstetrics inpatient care units in 2007 (*AHA Hospital Statistics: The Comprehensive Reference Source for Analysis and Comparison of Hospital Trends*, 2009 Edition, page 156). On November 14, 2008, a representative of the National Association of Childbearing Centers stated there are approximately 190 free-standing birthing centers in the United States.

TOTAL - Abductions of Infants from 1983-2008: 256
TOTAL - Still Missing: 12

	1983-2008	Case Status
HEALTHCARE FACILITIES	124	Located = 118 Still Missing = 6
Mother's Room	71 (57%)	
Nursery	17 (14%)	
Pediatric Units	17 (14%)	
"On premises" (outside building but still on grounds)	19 (15%)	
With Violence to Mother "On Premises"	9 (7%)	
HOMES	99	Located = 95 Still Missing = 4
With Violence to Mother	29 (29%)	
"OTHER PLACES"	33	Located = 31 Still Missing = 2
With Violence to Mother	8 (24%)	
<p>*To date there has been <i>no</i> use of violence (or attempts) against the mothers <i>within</i> healthcare facilities; however, there have been several cases where assault and battery have occurred against nursing staff members during abduction attempts and abductions. In addition there is clear evidence of increasing violence by abductors when the abductions move outside of the healthcare setting.</p>		

The typical abduction from a healthcare facility involves an “unknown” abductor impersonating a nurse, healthcare employee, volunteer, or relative in order to gain access to an infant. The obstetrics unit is an open and inviting one where patients’ decreased length of stay, from one to three days, gives them less time to know staff members. In addition it can be filled with medical and nursing staff members, visitors, students, volunteers, and participants in 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.



2. The Offender and Modes of Operation

The offender

- Is *almost* always a female
- Is frequently overweight
- Ranges in age from 12 to 53 but, in general, is in her early 20s; and usually has no prior criminal record

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

- Shoplifting
- Passing bad checks
- Forgery

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
- Relies on manipulation and lying as coping mechanisms in her interpersonal relationships

The infant may be used in an attempt to maintain/save a relationship with her husband, boyfriend, or companion (hereinafter referred to as the significant other). Sometimes she wishes either to “replace” an infant she has lost or experience a “vicarious birthing” of an infant she is for some reason unable to conceive or carry to term. On occasion an abductor may be involved in a fertility program at/near the facility from which she attempts to abduct an infant. Of the 248 cases where the abductor’s race is known, 105 are Black, 94 are Caucasian, 48 are Hispanic, and 1 is Asian. The race/skin color of the abductor almost always matches the infant’s or reflects that of the abductor’s significant other.

Of the 124 infants who were abducted from healthcare facilities, 65 percent were 7 days old or younger. As a point of comparison, of the 99 infants who were abducted from homes, 21 percent were 7 days old or younger. Of the 33 infants who were abducted from other locations, 12 percent were 7 days old or younger. The abducted infant is perceived by the abductor as “*her newborn baby*.” A strong gender preference, in the abduction of these infants, is not revealed in the data.

Although the crime may be precipitated by impulse and opportunity, the abductor has usually laid careful plans for finding another person’s infant to take and call her own. In addition, prior to the abduction, the offender will often exhibit “nesting” behavior by “announcing her pregnancy” and purchasing items for an infant in the same way an expectant mother prepares for the birth of her baby. The positive attention she receives from family 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 very gullible in wanting to believe his wife/girlfriend/companion indeed gave birth to or adopted the infant now in her possession and may vehemently defend against law enforcement’s attempts to retrieve the baby.

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

The pretense of being someone else is most often seen in abductors who use interpersonal coping skills including manipulation, conning, lying, and ruses. These women demonstrate a capability to provide “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 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 healthcare 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 becoming familiar with the layout of the maternity unit. While the majority of the abductors visit the maternity unit in the days prior to the abduction, and pose as a nurse, some abductors are known to have been former employees, former patients, or have a friend or relative who was a patient at the facility where the crime is committed. Moreover, the women who impersonate nurses or other healthcare personnel usually wear uniforms or other healthcare-worker type of attire. They have also impersonated home-health nurses, staffers with financial-assistance programs, and other professionals who may normally work in a healthcare facility. They often visit more than one healthcare facility in the community to assess security measures and explore infant populations, somewhat like “window shopping.”

The abductor may also follow the mother to the home setting. As of the publication of this book in January 2009, there has been *no* use of violence against mothers *within* healthcare facilities; however, there have been several cases where assault and battery have occurred against nursing staff members during abduction attempts and abductions. In addition 29 percent of the abductions from homes involved some type of violent act committed against the mother including homicide. Clearly the location of abduction in the last few years seems to be changing from the healthcare to home setting as evidenced by the fact there was violence committed against the parent in a total 46 cases from 1983 to 2008, but, of those cases, 29 occurred from 1996 through 2008.

The abductor may not target a specific infant for abduction. When an opportunity arises, she may quickly “snatch” an available victim, often be visible in the hallway *for as little as four seconds* with the infant in her arms, and escape via a fire-exit stairwell. It is not uncommon for the abductor to focus on mothers’ rooms located closest to a stairwell exit to allow for immediate flight and minimize contact with others they might encounter in an elevator or public stairwells. Since the abductor is compelled to show off her new infant to others, use of the broadcast media to publicize the abduction is critical in encouraging people to report situations they find peculiar. Most often infants are recovered as a direct result of the leads generated by media coverage of the abduction when the abductor is *not* portrayed in the media as a “hardened criminal.”

For the first time since 1983, the incidence of nonfamily infant abductions from healthcare facilities decreased to ZERO in 1999. This reduction seems directly attributable to 17 years of proactive-education programs combined with “hardening the target” through the procedural and security measures discussed herein. 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, in part, by Mead Johnson Nutrition in association with IAHS. Education has greatly increased the awareness of nursing and security staffs in healthcare facilities nationwide. In the last 21 years the author has provided direct educational training to more than 64,000 healthcare professionals and informal on-site, maternal-child-care-unit assessments for more than 1,000 healthcare facilities nationwide, in Canada, and in the United Kingdom. In addition NCMEC and Mead Johnson Nutrition have published more than 527,000 copies of this 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*).

3. Guidelines for Healthcare Professionals

The guidelines highlighted in bold print are considered ESSENTIAL for the prevention and documentation every facility should strive to meet. All other guidelines listed are highly recommended.

3-1 General

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

- A comprehensive program of healthcare policy, procedures, and processes
- Education of and teamwork by nursing personnel, parents, physicians, security, and risk-management personnel
- Coordination of various elements of physical and electronic security if applicable

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, should an abduction occur, is needed to effectively combat this infrequent but highly visible crime. Nurse managers/supervisors may be well suited to take a lead role in this approach because of the holistic philosophy of nursing, the large amount of nursing time spent with parents and infants, the educational component of nursing care, and the ability of nurse managers/supervisors to incorporate teaching infant safety to parents and other staff members. Additionally, 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 healthcare facility, 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” a healthcare facility’s policies and procedures and nursing practices. These devices are designed to further discourage or deter potential abductors and augment the overall protection process. They may also serve as a physical basis for enhancing the ability of nursing, security, and risk-management personnel to work as a team. There are several technologies available for this purpose including video-surveillance systems (*i.e.*, closed-circuit television [CCTV]) backed up with recording, access control, and infant-bracelet-tag alarms. Each one, used singly or in some combination, provides several potential benefits. First these systems are reliable when properly designed, installed, tested, serviced, and maintained. These systems are constantly vigilant and unaffected by distractions, rest/lunch breaks, and shift

changes; however, these systems are not infallible and need to be tested. As such regular, scheduled testing of each system's operational elements, in accordance with the manufacturer's specifications, is required as is a post-alarm assessment in order to determine the cause of the alarm. Second, and more importantly, such systems serve to *document* and *help deter*, not simply prevent, an abduction. Digital recording, coupled with access control, serves to document a potential abduction as it unfolds. They may also help in resolving and documenting "false alarms" of systems, varying according to manufacturer, for supervisory and/or investigative follow-up. Additionally, CCTV cameras and alarm panels, coupled with security signage, serve as a visual deterrent to the potential abductor. If properly used by facilities, these precautions clearly add to the potential of deterring an abduction; identifying and locating the abductor more quickly when an abduction does occur; and, most importantly, aiding in recovering an abducted infant. Regardless of the safety controls selected and implemented, parents and staff members must always understand the security and surveillance systems described herein are *not a substitute* for continuous and personal vigilance toward infant security. These healthcare-organization policies and measures in no way diminish the empowerment of the parents in their responsibilities to their newborn infant, but together they can better "safeguard their tomorrows."

Each facility's chief executive officer, with the appropriate management-staff members, should regularly review specific protocols and critical-incident-response plans to see if all issues concerning security measures are addressed. Such a review should both help prevent abductions and document any that do occur. It should also allow a facility to review the prescribed measures to be taken in case an infant abduction occurs at their facility and help them document the fact that reasonable and appropriate measures are in place and/or identify areas needing to be improved. The guidelines enumerated in this chapter will aid facilities in this process. See Chapter "7. Self-Assessment for Healthcare Facilities" beginning on page 59 that is a summary of these guidelines. To create a justifiable and defensible posture, each facility should use a multidisciplinary team to conduct a self-assessment with this tool and note how they meet these guidelines or document what is not applicable to their facility and why. Once this assessment step is completed facilities should use the outline created to review and modify their policies and procedures as needed based on the format of these national guidelines.

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 security. One of the most effective means of thwarting, and later identifying, a potential abductor is to use phrases like, "May I help you?" and "Who are you here to visit?" emphasizing the need to obtain the name of the mother the person wishes to visit. When asking these questions, make eye contact, carefully observe the person's behavior, note a physical description, and follow-up as is appropriate for the situation. All healthcare-facility

personnel should be alert to any unusual behavior they encounter from individuals such as

- Repeated visiting or requests “just to see” or “hold” the infants.
- Close questioning about healthcare-facility procedures, security devices, and layout of the floor such as, “When is feeding time?” “When are the babies taken to the mothers?” “Where are the emergency exits?” “Where do the stairwells lead?” “How late are visitors allowed on the floor?” “Do babies stay with their mothers at *all* times?”
- Taking uniforms or other means of identification within that facility.
- Physically carrying an infant in the facility’s corridor instead of using the bassinet to transport the infant, or leaving the facility with an infant while on foot rather than in a wheelchair.
- Carrying large packages off the maternity unit (*e.g.*, gym bags, suitcases, backpacks), 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 to facilitate an infant abduction (*e.g.*, fire in a closet near the nursery or loud, threatening argument in the waiting area). Healthcare facilities need to be mindful of the fact that infants can stay in or need to be taken to many areas within the facility. Thus vigilance for infant safety must be maintained in all areas of the facility when infants are present.

General Guidelines

- 3-1-1** Persons exhibiting the behaviors described above should be immediately asked why they are in that area of the facility. Immediately report the person’s behavior and response to the nurse manager/supervisor, security, and administration. The person needs to be positively identified, kept under close observation, and interviewed by the nursing manager/supervisor and security. Remember, caution needs to be exercised when interacting with people who exhibit these behaviors.
- 3-1-2** Report and interview records on the incident should be preserved in accordance with the organization’s internal procedures. (Many suggest records should be kept from a minimum of seven years up to the child reaching adulthood.)
- 3-1-3** Each facility should designate a staff person in their critical-incident response plan who will have the responsibility to alert other birthing facilities in the area when there is an attempted abduction or someone is identified whom 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 to see that due diligence is used in sharing knowledge about a potential abduction or abductor. 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 the "Sample Notification Form" on page 35 adapted from a form designed by Jeff Karpovich when affiliated with the HCA Raleigh Community Hospital and reprinted with his permission.

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

3-2 Proactive Measures

The guidelines highlighted in bold print are considered ESSENTIAL for the prevention and documentation every facility should strive to meet. All other guidelines listed are highly recommended.

Proactive-Prevention Guidelines

- 3-2-1 As part of contingency planning, the backbone of prevention, every health-care facility must develop, test, and critique a written proactive-prevention plan for infant abductions that includes all of the elements listed in this section.** In addition measures must be taken to inform new or rotating (temporary) employees of these procedures as they join the staff. This plan needs to be tested, documented, and critiqued at least annually.
- 3-2-2 Immediately after the birth of the infant and before the mother and infant are separated, attach identically numbered ID bands to both the infant (2 bands) and mother (1 band) and 1 band to the father or mother's significant other when appropriate.** Inform parents of the reason or need for the bands.

If the fourth band is not used by the father/mother's significant other, that fact must be documented. This band may be stapled to the chart or cut and placed in the "sharps box." For information about the importance of bands in regard to transporting infants see 3-2-6(a) on page 16.

An infant's band needs to be verified with the mother when taking the infant for care as well as upon delivery of the infant to the mother after care has been rendered. The caregiver must examine and verify both the baby and the mother's (or significant other's) identification bands and have the mother (or significant other) do the same.

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

No matter what form of attachment bands (or clamps) are used with the electronic tagging of infants, healthcare facilities should be very careful to assure there is *never any delay* in activation of the alarm function upon separation and should perform frequent, ongoing testing in support of that guideline. Staff members should be trained to *immediately* respond so there is no delay between detection of the alarm condition and generation of the alarm notification. Staff members should never consider an alarm to be a "false alarm."

Case

Example

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

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

At approximately 9:00 P.M., after the mother's family had left, the "social worker" insisted the victim mother take a shower and get ready for bed. Around 9:20 P.M., the mother entered the bathroom and exited about 5 minutes later to discover her infant, the woman, and the suitcase were gone. The mother immediately contacted the nurses' station, and security and law enforcement were called. The local law-enforcement agency issued a be-on-the-lookout (BOLO) bulletin for the suspect.

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

Key Factors Helping to Recover the Infant

Key factors that helped in recovering this infant included the

- Victim mother did not delay in notifying staff members her baby was missing

- Healthcare facility did not delay in contacting law enforcement, and law enforcement immediately issued a BOLO
- Arresting officer heard the BOLO and followed through when observing the suspect and her behavior at the restaurant

Teaching Points

Facilities need to conduct frequent, ongoing testing of infant-tagging security systems to ensure they are properly functioning. See 3-2-2 beginning on page 12 for additional information regarding these points.

Facilities also need to consider protecting nursery units in the same way behavioral units are protected, when possible with electronic card-in and card-out readers for authorized staff members and ask-in and ask-out for visitors to help eliminate confusion regarding who is a visitor and who is a staff member. See 3-2-11 on page 18 and 3-3-3 on page 21 for additional information regarding these points.

Facilities also need to take every opportunity to educate parents about the procedures used by the facility to identify staff members including ID badges worn by various personnel within and affiliated with the facility. See 3-2-4 and 3-2-5 beginning on page 15 for additional information regarding the use of ID badges.

- 3-2-3 Prior to the removal of a newborn from the birthing room or *within a maximum of two hours of the birth***
- a. **Footprint (with emphasis on the ball and heel of the foot) the infant making sure the print is clear.** Repeat if necessary.
 - b. **Take a color photograph or color video/digital image of the infant.**
 - c. **Perform a full, physical assessment of the infant, and record, in the medical chart, the assessment along with a description of the infant.**
 - d. **Store a sample of the infant's cord blood and any other blood specimens until at least the day after the infant's discharge.**
 - e. Place electronic security tags, if such a system is being used.

The footprints, photograph or video/digital image, physical assessment, and documentation of the placement of the ID bands, including their number, must be noted in the infant's medical chart.

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

Occasionally footprints of the newborn are unreadable or difficult to obtain, but footprints are an excellent form of identification if an abducted infant is recovered. Thus healthcare facilities should take good, readable footprints of each infant. Consult your local FBI office or law-enforcement agency for appropriate techniques, paper stock, various products, and methods to capture prints. For further information about footprint techniques *see* Michael E. Stapleton's 1994 article about footprinting listed in the "Bibliography" on page 80.

No matter which footprinting method is used — ink or “inkless” — care should always be taken to obtain clear, readable footprints with an emphasis on the ball and heel of the infant’s foot.

Like footprints, cord blood collected at the time of delivery is an excellent form of identification. Deoxyribonucleic acid (DNA) testing for identification purposes, “DNA Fingerprinting,” is considered the best current method of biological identification. There are two types of DNA tests because there are two types of DNA in human cells. They are mitochondrial DNA (mtDNA) and nuclear DNA. Nuclear DNA tests are based on short tandem repeat (STR) DNA sequences and have been used extensively in criminal cases and situations like identifying samples from the World Trade Center attack in 2001. While mtDNA analysis is strong circumstantial evidence for identification, using STRs as a match between a known infant reference sample and a “questioned” sample would be taken as conclusive, positive identification. Nuclear DNA testing has become routine. In fact, in an emergency situation, a definitive identification made from DNA can now be accomplished in less than 24 hours rather than the weeks it used to take, depending on specific laboratory requirements. If a healthcare facility chooses to use DNA rather than footprints, it should have a signed contract with a laboratory specifying 24 hour coverage, 365 days a year with a 4 to 6 hour turn around for infant ID tests. Although cord blood provides the best sample, even if cord blood is not available, a simple swab from the inside of the infant’s cheek will generate enough material to perform a DNA test. At a minimum the healthcare facility needs to store the sample of cord blood, dried onto a piece of sterile filter paper, or the dried mouth swab until the day after the infant is discharged from the facility or longer as a facility’s policy dictates.

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

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

- 3-2-4 Require all healthcare-facility personnel to wear, above the waist and “face-side” out, up-to-date, conspicuous, color-photo ID badges. The person’s name and title need to be easily identifiable, and the person’s**

photograph needs to be large enough so that he or she is recognizable. Update the photograph as the person's appearance changes. These badges need to be returned to Human Resources or the issuing department immediately upon termination of employment. All missing badges must be immediately reported and the appropriate security response enacted. Consider placing the staff member's photograph and identifying information on both sides of the badge to help ensure the photograph and all identifying information is fully readable no matter which side of the badge is facing the public. And, as recommended by the International Association for Healthcare Security and Safety in their *Healthcare Security: Basic Industry Guidelines* regarding access control and identification systems, healthcare facilities should "expire" and reissue previously issued badges at a minimum of five years from the date of issue (07.01(e)).

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

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

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

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

- 3-2-7** Distribute the guidelines for parents in preventing infant abductions, listed in "What Parents Need to Know" beginning on page 51, to parents during prenatal visits to their OBGYN, in childbirth classes, on preadmission tours, upon admission, at postpartum instruction, and upon discharge. Upon admission consider having the patient sign a document noting receipt of these guidelines with the patient retaining the guidelines and a copy of this signed document. Also consider permanently posting this information on patients' bathroom doors and/or in a prominent location within the mother's room, in the form of a poster, during their stay. **This same information needs to be distributed to all new/current staff members and physicians and their staff members who work with newborns, infants, and child patients.**
- 3-2-8** Provide staff members, at all levels, instruction, at least annually, about protecting infants from abduction including, but not limited to, information about the offender profile and unusual behavior, prevention procedures, their responsibilities, and critical-incident-response plan.

Consider the use of the DVD titled *Safeguard Their Tomorrows* provided by Mead Johnson Nutrition as an excellent educational resource in this instructional process. It can be obtained free-of-charge by contacting your local Mead Johnson Nutrition medical sales representative.

- 3-2-9** Always place infants in direct, line-of-sight supervision either by a responsible staff member, the mother, or other family member/close friend so designated by the mother, and address the procedure to be followed when the infant is with the mother and she needs to go to sleep/the bathroom and/or is sedated. If the mother is asleep when the infant is returned to the room, staff members should be careful to fully awaken her before leaving the room. In rooming-in situations, place the bassinet so the mother's bed is between the exit door(s) to the room and the bassinet.
- 3-2-10** Do not post the mother's or infant's full name where it will be visible to visitors. If necessary, use surnames only. Do not publish the mother's or infant's full name on bassinet cards, rooms, status or white boards. *Do not leave 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. Do not provide patient information via the telephone.*

3-2-11 **Establish an access-control policy for the nursing unit, nursery, maternity, neonatal-intensive care, and pediatrics to maximize safety.** At the front lobby or entrance to the maternity unit, instruct healthcare-facility personnel to ask visitors which mother they are visiting. If no name is known or given, decline admission and alert security, the nurse manager/supervisor, facility administration, or law enforcement. Especially after regular visiting hours, consider setting up a system to positively identify visitors, preferably with a photo ID.

Case

Example

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

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

The “relative” was apprehended by security and personnel in the parking lot after she exited the hospital and held until law enforcement arrived.

Key Factors Helping to Recover the Infant

Key factors that helped in recovering this infant included the

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

Teaching Points

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

Facilities also need to take every opportunity to provide staff members, at all levels, instruction about protecting infants from abduction including, but not limited to, information about the offender profile and unusual behavior, prevention procedures, their responsibilities, and critical-incident-response plan. See 3-2-8 on page 17 for additional information regarding this point.

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

3-2-13 For those healthcare facilities still providing birth announcements to the media, NCMEC strongly encourages these facilities to reconsider their role in that process. Many facilities no longer provide this service and simply share information with the parents about how they may personally do so, if they wish, after advising them of the potential risks of such public announcements. Such advice also urges parents to use only first initials and last names in the announcements they submit to newspapers. **Be aware, 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.** Also facilities should obtain parental consent before publishing an announcement in the newspaper or on the Internet. In addition, be aware, while giving yard signs away may be considered "good marketing," the use of these signs at parents' homes may put them at risk.

In mid-1996 some healthcare facilities began posting birth announcements on their Internet Web pages. These "online" announcements included photographs of the infant and in some cases of both the infant and parent(s). These birth announcements should never include the family's home address and be limited to the parents' surname(s) or first initial of the surname(s) (e.g., S. and D. Smith or Sam and Darlene S.). Additionally *the facility should not post this information on its Web page until after both mother and baby have been discharged from the facility and after the parents have signed a consent form for participating in this vendor service.* All postings need to be activated by a predetermined ID or password, with no default option to circumvent this precaution that would enable anyone other than individuals who are authorized by the parents, such as family members and friends, to access the announcement.

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

Consider using a system where the mother is called before the visit to inform her of the date and time of the visit; name of the staff person visiting; and requirement for that staff person to wear the current, unique photo ID badge. See 3-2-4 beginning on page 15 for a discussion of ID badges. For additional information about this topic see “Outpatient Areas” beginning on page 48.

3-3 Physical-Security Safeguards

The guidelines highlighted in bold print are considered ESSENTIAL for the prevention and documentation every facility should strive to meet. All other guidelines listed are highly recommended.

Guidelines for Physical Security

3-3-1 Every 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, Certified Healthcare Risk Manager) who identifies and classifies vulnerabilities within the healthcare facility. The application of safeguards, such as guidelines, systems, and hardware, developed by the facility to “harden the target” from infant abduction should be dependent upon the risk potential determined and reflect current professional literature about infant abduction. The needs assessment should include an evaluation of the facility and the existing policies and procedures, together with the possible appropriate application of any combination of physical controls or electronic systems such as closed-circuit television, locked and alarmed emergency-exit door controls, intercoms, remote door releases, and electronic-article-surveillance (EAS) systems, sometimes called infant-tagging systems. **This process must be considered ongoing as targets, risks, and methods change, particularly in the event of new construction, with the written risk assessment being conducted at least on a yearly basis and when significant changes are identified.** For assistance in this process, see “Self-Assessment for Healthcare Facilities” beginning on page 59.

Assessments of an organization’s infant-safety program often identify opportunities for improvements. Therefore it is important to perform such assessments under the auspices of the organization’s performance-improvement (PI) program, in order to lend possible protection from legal discovery to such information, if and when such statutory protections exist. Reports and/or corrective action plans relating to findings of such

assessments should also be treated as PI materials, with access limited to authorized persons. This is also sometimes referred to as “peer review,” “quality improvement,” or “quality assurance.”

- 3-3-2 Install alarms, preferably with time-delay locks, on all stairwell and exit doors leading to/from or in close proximity to the maternity, nursery, neonatal-intensive-care, and pediatrics units. Establish a policy of responding to all alarms and instruct responsible staff members to silence and reset an activated alarm only after direct observation of the stairwell or exit and the person using it. The alarm system should never be disabled without a defined countermeasure in place. A record of the alarms should be maintained and periodically analyzed for cause and potential opportunities for improvement to minimize “false” alarm activations.**

Optimally, video/digital recording should be integrated into the alarm activity. When an alarm is activated, the camera should automatically come to full-screen at the alarm enunciator location. This situation should be properly documented, a report about the incident needs to be submitted to the proper authority within that facility, and the recorded data needs to be retained and reviewed by security. A monthly report needs to be generated and reviewed with security and nursing. *See 3-4-3 on page 27 for a discussion regarding a head count of all infants.* Document each false alarm, ascertain what went wrong, and take any necessary corrective actions. If a video security monitor is located at a nurses’ station, policy should specify the purpose of that placement in such a way as to limit liability.

- 3-3-3 All doors to all nurseries must have self-closing hardware, remain locked at all times, and a staff member should be present at all times when an infant is in the nursery.** Consider protecting nursery units in the same way behavioral units are protected, when possible with electronic card-in and card-out readers for authorized staff members and ask-in and ask-out for visitors.
- 3-3-4 If there is a lounge, locker room, or storage area where staff members change, leave clothing, or store scrub suits, all doors to that room must be under strict access control (locked) at all times.**
- 3-3-5 Conduct and document a needs assessment for an electronic-article-surveillance (EAS) detection system.** Such a system would use an EAS infant-bracelet tag that is *always* activated and tied to video/digital recording of the incident and alarm activation and integrated with electronic locking devices to prevent exiting when a tagged infant is in close proximity to the exit. If a healthcare facility installs an infant EAS system, the system must always be operational. Staff members should never adopt a philosophy of

“only turning the system on if/when they suspect a problem.” Because such actions present major liability risks, documented records should be maintained on testing procedures and preventative-maintenance schedules.

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

- 3-3-6 Install a security-camera system using recording by digital technology to record activity in the hallways of the unit. Cameras should be placed in strategic spots to cover the entrance of the unit, the nursery, hallways, stairwells, and elevators. Cameras should be adjusted to capture a potential abductor’s full face, and care should be taken to avoid strong lighting behind the individuals on camera. Recorders must be functional at all times. The recording medium must be changed or backed up daily under the direction of an assigned and responsible individual. Retain daily back-up medium for a *minimum* of seven days before reusing or deleting it.**

Case	
Example	<p>As a new mother watched her 2-day-old daughter from her hospital bed, a woman portraying herself to be a nurse dressed in scrubs entered her room and asked if she needed any assistance. The mother stated she would like to take a shower. The “nurse” offered to take the infant back to the nursery and send another nurse to assist with the shower. The victim mother observed the “nurse” take the infant from the bassinet and walk out of the room. According to the mother, the “nurse” returned two to three minutes later with the infant and nervously claimed the other nurses were busy and she would return within 10 to 15 minutes. The “nurse” exited the room and did not return.</p>
	<p><i>Key Factors Helping to Thwart the Infant Abduction</i></p>
	<p>Key factors that helped in thwarting this infant abduction included</p>
	<ul style="list-style-type: none">■ The suspect did not know the infant had a security tag on her ankle, which prevented her from leaving the unit with the infant through an exit stairwell door.■ A nurse observed the suspect much earlier in the morning in the hospital solarium and then again observed the same individual lingering by a patient room on maternity a few hours later. This same nurse verbally challenged the suspect who told her she was looking for a patient and provided a specific name and room number.■ Another nurse observed the suspect arm-carrying the infant in the hallway in proximity to an exit stairwell door and made a comment to the suspect, who then returned the baby to the patient’s room.

- The detective assigned to the case advised staff members to alert other hospitals in the area about the incident. This action resulted in the receipt of information from two other hospitals days after the first incident that reported similar incidents at their facilities with a similar looking suspect.

Teaching Points

Facilities need to take every opportunity to educate parents about the procedures used to transport infants while in their care, especially in regard to the prohibition against “arm-carrying” infants, and the need to notify the nurses’ station when that procedure is violated. See 3-2-6 beginning on page 16 for additional information regarding this point.

Facilities also need to take every opportunity to remind staff members to immediately call facility security and/or other designated authority per their facility’s critical-incident-response plan when observing the behaviors exhibited by this suspect. See 3-4-4 on page 27 for additional information regarding this point.

Facilities also need to install and properly maintain a security-camera system. When images of a suspect or abductor are available, they greatly aid in the apprehension of suspects and the prevention of abductions or abduction attempts at other facilities. See 3-3-6 on page 22 for additional information regarding this point.

- 3-3-7 The camera(s) should be at/near real-time recording (versus time lapse) and remain functioning at all times. **It is further recommended (these) camera(s) be mounted in plain sight, at or near adult-head height, and a sign be prominently posted with each (all) camera(s) stating all persons entering the unit are being recorded for security purposes.** For example the sign could state, “Area under random video surveillance.” Some health-care facilities have found placing a live CCTV monitor at/near the camera showing the picture being recorded successfully replaces the signs. There are now integrated flat-panel monitors with built-in cameras called “Public View Monitors” which are excellent for this purpose. These monitors are now seen frequently in retail stores.
- 3-3-8 Install signage in the maternal-child-care unit; lobbies; obstetric, emergency room, and day-surgery waiting room areas instructing visitors they should not allow their children to be out of their line-of-sight.
- 3-3-9 Additional items to consider regarding electronic surveillance and access-control equipment include
- Color cameras make identification of subjects much easier than black-and-white cameras. There is virtually no cost difference in color cameras today so there is no reason to use black-and-white cameras.
 - Purchase and repair records should be maintained to include date of purchase, date of installation, date of any repairs performed, and description of work.

- Routine preventive maintenance should be performed as recommended by the manufacturer and documented.
- Alarms on stairwell doors should be adjusted to allow for the maximum delay in unlocking that is allowed by local fire regulations.
- As an aid to investigators, it is important to maintain an audit trail of recorded media. Tapes, if used, or digital recording should be retained as part of the facility's retention policy as long as possible but for a minimum of 10 days with a goal of 30 days. Information should be contained on the recorded media that provides the identification of the image being recorded to include location, date, and time it was recorded.
- Electronic systems should be fully integrated wherever possible. Alarms, door controls, motion detectors, elevator controls, and CCTV pictures can automatically be combined and presented on a single monitoring device that will greatly facilitate response and be supported by integrated, time-delay access alarms, monitored CCTV, intercoms, and remote release devices.
- Cameras covering emergency exits such as stairwells should be placed inside the stairwell, facing the emergency-exit door to view an adult-head height. To save recording space on cameras in seldom-traveled areas, it is recommended they be equipped with motion-detection, activation devices.

3-4 Critical-Incident-Response Plan

The guidelines highlighted in bold print are considered ESSENTIAL for the prevention and documentation every facility should strive to meet. All other guidelines listed are highly recommended.

General Guidelines

- 3-4-1 As part of contingency planning, every facility must develop a written, critical-incident-response plan to respond to 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 all staff members within the maternal-child-care areas and pediatrics. When these plans are part of staff training, records must be maintained verifying attendance. Training should be performance and competency based and documented. Other departments, including but not limited to security, communications/switchboard, environmental services, accounting, and public relations, should also have written action plans to follow in the event of an abduction. This training should begin at general orientation and be part of their departmental orientation competencies and annual refresher training similar to hazardous-material and fire training.

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

- Accessibility
- Entrance/exit doors (both vertical and horizontal)
- Alarm systems
- Staffing patterns including number of staff members who are visible on the unit
- Adjacent departments
- Proximity of unit and exits from the unit to parking areas, city streets, and other locations where vehicles can be positioned for escape
- Coordination with local law enforcement

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

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

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

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

Conduct at least one unannounced, facility-wide, infant-abduction drill each year involving all facility personnel taking into account more than one drill may need to be held in order to include personnel who work day, evening, weekend, and/or nontraditional shifts. In addition to the facility-wide drill, facilities should conduct quarterly unit-specific drills, “tabletop” exercises, or audit-type exercises. Critique each exercise to identify opportunities for improvement to enhance policy, procedure, or performance standards. Tabletop exercises take place “around the table” with the principle players acting out a specific scenario generally without simulated or actual patients involved. An audit-type exercise may be a formal review of a procedure by actually walking through the procedure or “testing” a procedure. An example of testing a policy/procedure would be sending a staff person, without the proper identification, into a mother’s room and advising the mom that her baby is being transported out of the room for a given purpose. If mom releases the infant to the caregiver, without asking for the proper badge identification, the caregiver should first reinstruct the mom supportively. The exercise itself should indicate the need for the facility to change or improve mother education.

Law enforcement should be advised, and/or invited to participate, in advance of all facility-wide drills to avert any unnecessary response should an employee, patient, or visitor take the initiative to call law enforcement during the drill.

For additional information about drills and the evaluation of them, *see Security Issues For Today’s Health Care Organization* listed in the “Bibliography” on page 82 in the 2002 entries. Also *see* “Drill Components” on page 38 and “Drill Critique Form” beginning on page 39. These items were adapted from information designed by Connie Blackburn Furrh of Cimarron Insurance Exchange and reprinted with her permission.

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

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

through the cooperation of the abductor's family members or associates. A concerted and well-thought-out media plan is critical in this process.

Nursing Guidelines

3-4-3 *Immediately 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 infant within the facility.* If the count is reconciled, the accountable person calls an "all clear." Records should be maintained reflecting how each infant-alarm activation was resolved or reconciled, by whom, at what time, and on what day.

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

This includes the announcement of the incident to all staff members using the predesignated code word (*see* the section of 3-4-1 addressing code words on page 25) and immediate notification of the local law-enforcement agency. Make sure the law-enforcement agencies that frequent your facility, for such things as assaults and car accidents, know this code word.

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

Case

Example

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

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

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

Key Factors Helping to Recover the Infant

Key factors that helped in recovering this infant included

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

Teaching Points

Facilities need to take a color photograph or color video/digital image of the infant and footprints of infants prior to the removal of a newborn from the birthing room or within a maximum of two hours of the birth. Such photos and footprints can be invaluable in recovering and identifying an abducted infant. See 3-2-3 beginning on page 14 for additional information regarding these points.

Facilities need to take every opportunity to educate parents about ways to prevent infant abductions. Such should include consideration of providing information about the services offered by the healthcare facilities and any affiliated organizations. See 3-2-7 on page 17 for additional information regarding this point.

Facilities also need to take every opportunity to provide staff members, at all levels, instruction about protecting infants from abduction including, but not limited to, being alert for unusual behavior. See the discussion about this concept beginning on page 10 of section 3-1 for additional information regarding this point.

Facilities also need to take every opportunity to remind staff members at all levels to immediately call facility security and/or other designated authority per their facility's critical-incident-response plan when observing such behaviors. See 3-4-4 on page 27 for additional information regarding this point.

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

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

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

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

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

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

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

- 3-4-7 The nurse manager/supervisor should brief all staff members of the unit. In turn, nurses should then explain the situation to each obstetric patient/mother while the mother and her infant are together. Mothers should never hear this news from the media or law enforcement. The nurse manager/supervisor should also be available to liaise with law enforcement. The nurse manager/supervisor should remind staff members not to discuss the incident with the media. The two other areas in the facility greatly affected are medical records and Human Resources because both departments are asked to produce a great deal of documentation.
- 3-4-8 A staff person, preferably the nurse assigned to the mother and infant, should be assigned to be the primary liaison between the parents and facility after the discharge of the mother from the facility.
- 3-4-9 **Nurse managers/supervisors must be sensitive to the fact nursing staff members may suffer posttraumatic-stress disorder (PTSD) as a result of the abduction, and make arrangements to hold a group discussion session led by a qualified professional as soon as possible in which all person-**

nel affected by the abduction are *required* to attend. Employee assistance programs, critical-incident stress debriefings, and/or spiritual/“pastoral” care should be available. Efforts should be made to provide ongoing counseling for individuals who need it.

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

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

Care should be taken *not* to discuss case details before any criminal/civil trials are concluded. Individual information-sharing-disclosure of case details should be limited to law-enforcement authorities and security, PI, and office of risk management authorities. 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 while emphasizing feelings, not details about the abduction, are the only things to be explored in these sessions.

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

(1-800-843-5678) for assistance with this healing process after an infant abduction in their facility.

Connie Blackburn Furrh, RN, Vice President, Risk Management, Cimarron Insurance Exchange.

Security Guidelines

3-4-10 Upon notification an infant is missing, security needs to

- ***Immediately and simultaneously* respond to perimeter points of the grounds or campus of the facility to observe persons leaving and record vehicle license-plate numbers. After securing the perimeter, proceed to the location of the incident, and activate a search of the entire healthcare facility, interior and exterior. Time is critical.**
- **Call the local law-enforcement agency, and make a report. Then call the local FBI office to report the incident to the squad handling crimes committed against children.**
- **Assume control of the crime scene, which is the area where the abduction occurred, until law enforcement arrives.**
- **Assist the nursing staff in establishing and maintaining security within the unit (*i.e.*, access control to the unit), and notify public relations.**
- **Secure videotapes/digital recordings for seven days prior to the incident, and request the same from other healthcare facilities in the area and adjacent business.**
- **Given the speed with which electronic technology changes, it is possible the electronic recording equipment in the healthcare facility will not be compatible with that of law enforcement. Facilities should provide access to equipment and a private location where law-enforcement officials may review the recorded electronic images.**

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

3-4-11 In order to safeguard against “panicking” the abductor into abandoning or harming the infant, follow the facility’s media plan, which should mandate all information about the abduction 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* healthcare-facility staff person, preferably from public relations, and one law-enforcement representative. These persons should be on the premises or on call throughout the crisis.

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

The family should be apprised of the media plan and their cooperation sought in working *through* the official 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, outpatient clinics for postpartum/pediatric care at other local healthcare facilities, and the health department’s bureau of vital statistics should be notified about the incident and provided a full description of the infant and suspected or alleged abductor.**

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

- 3-4-15 As part of the facility’s overall annual security program review, as required under TJC standards, document a specific review of the infant-security and safety program through use of the self-assessment tool beginning on page 59, or through the use of the certified individual as described in 3-3-1 on page 20.

Law-Enforcement Guidelines

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

- 3-4-16 Enter the infant’s name and description in the FBI’s National Crime Information Center’s Missing Person File (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.

- 3-4-17 Call NCMEC at 1-800-THE-LOST® (1-800-843-5678). NCMEC 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 infant's photograph as mandated by federal law (42 U.S.C. § 5773).**

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 about facial development, and the special skills of medical illustrators. (See examples on pages 36 and 37).

- 3-4-18 Call the local FBI office requesting the Crimes Against Children (CAC) Coordinator. The CAC Coordinator can request assistance from the FBI's National Center for the Analysis of Violent Crime. They can provide technical and forensic-resource coordination; computerized-case-management support; investigative, interview, and interrogation strategies; and information about behavioral characteristics of unknown offenders.**
- 3-4-19 Immediately secure and review any available videotapes/digital disks from the abduction scene and contact all other birthing facilities in the community and adjacent businesses to request the retrieval and secure storage of the previous seven days' worth of videotapes/digital disks for review. These videotapes/disks should be treated as photographic evidence.** Given the speed with which electronic technology changes, it is possible the electronic recording/viewing equipment within a law-enforcement agency may not be compatible with that of the healthcare facility. Law-enforcement officials should ask for access to the facility's equipment and review the recorded images in a private location within the facility.
- 3-4-20 Consider setting up one dedicated local telephone hotline for sightings/leads or coordinate this function with a local organization.
- 3-4-21 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.
- 3-4-22 To deter future crimes and document criminal behavior, the abductor should be charged and every effort made to sustain a conviction.**

3-4-23 Any release of information concerning an infant abduction should be well planned and agreed upon by the 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. All media releases should focus on the safe return of the infant, *not* the arrest/conviction of the abductor.

Public-Relations Guidelines

3-4-24 As soon as possible after the abduction, contact the local media and request they 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, limit sharing too much information about security procedures and technology in place within the facility, and refrain from blaming the victim parent in cases in which a parent may have handed their child to someone posing as a staff member within the facility. Press releases should be prepared and presented jointly by the law-enforcement, public-information officer, and the healthcare media liaison. *Most often infants are recovered as a direct result of the leads generated by media coverage of the abduction.*

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

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

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

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

For additional information about planning for, creating, and responding to a critical-incident plan, *see* James T. Turner's 1990 article listed in the "Bibliography" on page 78.

Sample 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 including specific contacts made and date and time of contact.	
National Center for Missing & Exploited Children notified? Y N	
If not, please contact at 1-800-THE-LOST® (1-800-843-5678).	

Congratulations!

My Name _____ Medical Record # _____




Sex _____ My Birthdate _____ Time _____ Rm _____

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

Mother's Doctor _____

My Doctor _____

Sample crib card as provided by Mead Johnson Nutrition.

<p>ANDRE BRYANT</p> 	<p>Nonfamily Abduction</p>	<p>Age Progressed</p> 
<p>DOB: Feb 17, 1989 Missing: Mar 29, 1989 Age Now: 19 Sex: Male Race: Black Hair: Black Eyes: Brown Height: 1'7" (48 cm) Weight: 10 lbs (5 kg) Missing From: BROOKLYN New York United States</p>		
<p>Andre's photograph is shown age progressed to 15 years. He was last seen with his mother, who was later found deceased. Andre and his mother had left their residence at about 2 P.M., to go shopping with two black female acquaintances in a burgundy Pontiac Grand AM, possibly with Maryland tags.</p>		
	<p>Anyone Having Information Should Contact NATIONAL CENTER FOR MISSING & EXPLOITED CHILDREN 1-800-THE-LOST (1-800-843-5678) or New York City Police Department (New York 1-212-694-7781)</p>	

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

Nonfamily Abduction

TAVISH SUTTON



DOB: Feb 10, 1993
Missing: Mar 9, 1993
Age Now: 15
Sex: Male
Race: Black
Hair: Black
Eyes: Brown
Height: 2'0" (61 cm)
Weight: 8 lbs (4 kg)
Missing From:
ATLANTA
Georgia
United States

Age Progressed



The pictures shown are "PHOTO COMPOSITES" of what Tavish may have looked like at age 4 and what he might look like at age 14. Tavish 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.

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



Anyone Having Information Should Contact
NATIONAL CENTER FOR MISSING & EXPLOITED CHILDREN
1-800-THE-LOST (1-800-843-5678) or
Atlanta Police Department (Georgia) -
Missing Person Unit 1-404-853-4235 Or Your Local FBI

Drill Components

- At least once a year an infant abduction drill should be conducted including the entire facility not just obstetrics
- Prior to the drill those who will observe and access the drill should attend a training class
- Training classes should include
 - Review of physical security features in place
 - Review of critical-incident-response plan
 - Planned scenario of abduction
- Drills should commence with an alarm sounding or by handing someone a note within the birthing center explaining a baby has been abducted
- Observers should be chosen from all job levels
- There should be standardized drill reports
- Law enforcement should be informed it is a drill only
- Observers should provide "real-time" instruction during the drill if needed
- At drill conclusion the evaluation form should be forwarded to the Security Director and/or other appropriate designee
- Evaluation meeting should include mid- and senior-level management
- During evaluation process, with observers and staff members involved in the drill in attendance, review step-by-step to identify areas needing improvement
- Final drill reports should include what did and did not work and a plan of action for improvements
- Final reports should be sent to Administration and the obstetric unit within two weeks of drill completion

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

4. Liability

Note: The information cited in this section is based on anecdotal information learned by NCMEC staff members and does not necessarily represent an analysis of all claims associated with infant abductions from healthcare settings. The comments herein should not be construed as or substituted for specific legal advice.

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

In the cases studied so far of the healthcare facilities 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 on the location of the abduction. That is, families sued those facilities in equal proportions whether the infant was abducted from the nursery, the mother's room, or a pediatric room. The facility was more likely to be sued in cases where the abductor impersonated facility staff members than in those cases where the abductor did not impersonate staff members.

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 psychological harm. And this liability could extend to abductions from settings other than the healthcare facility after the infant's discharge if the abductor obtained information about the victim family from the healthcare facility that aided in the abduction.

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

Today's administrators, risk managers, and security directors have the duty and responsibility for guiding not only the public trust in their facility but also the patient's safety and staff awareness for potential events. In addition, as noted on page 10 in section 3-1, to create a justifiable and defensible posture, each facility should use a multidisciplinary team to conduct a self-assessment, using the form beginning on page 59, and note how they meet these guidelines or document what is not applicable to their facility and why. Once this assessment step is completed facilities should use the outline created to review and modify their policies and

procedures as needed based on the format of these national guidelines. The liability to a facility regarding an infant encompasses many aspects that go beyond potential out-of-pocket expenses during an event and settlements awarded to family members from any resulting lawsuits. Facilities need to consider expenses such as potential loss of faith of patients within the area to continue using their facility for OBGYN or other services and the negative impact on staff members on duty during an incident up to and including loss of staff members and training of replacement staff members. Facilities also need to weigh the costs of those potential expenses against the cost of improving security and facility readiness in order to reduce the risk of an abduction incident in their facility. One tool that may assist in this process is a Hazard Vulnerability Analysis (HVA). Per TJC's Environment of Care Standard EC.4.11.2, hospitals conduct an HVA (emergency management and security management) to identify events that could affect demand for its services or its ability to provide those services, the likelihood of those events occurring, and the consequence of those events. *Before making changes if an abduction has occurred, please contact NCMEC at 1-800-THE-LOST® (1-800-843-5678) for guidance.*

Though infant abductions do not occur with high frequency in any given area, they do occur. Given the statistics and known information from this publication and the other professional sources summarized in the "Bibliography" beginning on page 77, ignoring the potential for infant abduction — especially with the special protections due to infants in adoption proceedings, "legal hold," and guardian-ad-litem situations — negates the prudent due diligence of risk managers, nurse managers, and healthcare security necessary for them to perform their jobs. The foreseeability of a particular infant-abduction incident may vary given the totality of circumstances. Considering the volume of material published in professional and popular literature, however, there is wide agreement foreseeability affixed to the healthcare industry nationwide beginning in January 1992. The "Bibliography" outlines, in chronological order, the benchmark articles in journals and publications for healthcare professionals.

5. After Discharge/Transfer from a Maternal-Child-Care Unit

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

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

When admitting and discharging infants and children to these areas of the healthcare facility

- *Footprint, photograph, and take a blood or saliva sample for DNA purposes of all infants aged birth to 3 months as well as a thumbprint of the infant’s mother.*
- *Perform and record a full, physical assessment noting any unique features. The footprints, photograph, and physical assessment must be placed in the infant’s or child’s medical chart. Over time refootprinting is advised, but certainly before discharge. For instance if children stay longer than one month, they should be photographed and refootprinted monthly. The blood sample must be saved until at least one day after the infant’s or child’s discharge.*
- *As discharge nears, parents may use a rooming-in service to prepare for meeting the infant’s or child’s special needs at home. It is imperative security procedures be followed that stress the importance of line-of-sight supervision by parents in these rooming-in 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 identification bands, require verification of identification with an official photo ID (e.g., driver’s license).*

To better safeguard the infant or child while being transported within the healthcare facility, personnel must see that

- *All healthcare-facility personnel authorized to transport infants and children should wear conspicuous, color-photo IDs as described in Guideline 3-2-4 beginning on page 15.*
- *Only personnel authorized to transport infants and children or a person with an authorized ID band for that infant or child is allowed to transport children as described*

in Guideline 3-2-5 on page 16. In cases where the infant or child needs to be taken for tests in other units of the facility (*i.e.*, X-ray, MRI) staff members should tell parents the transporter is an employee of the facility and parents should be encouraged to accompany their infant or child if and when possible. The facility should consider giving infants and children priority for testing to decrease their waiting time in the other unit. Transporters, who accompany infants and children, should receive education in abduction prevention and infant-security policies and procedures. Facilities with an electronic tagging system in maternity units should consider tagging all infants and toddlers, who are younger than 2, and any child on “police or child-protective-services hold.” For details about use of electronic tagging systems, *see 3-3-5 beginning on page 21.*

- *Infants and children are transported one at a time and never left out of direct, line-of-sight supervision.*
- *Infants and children are never carried, but always pushed in/on a bassinet, crib, stretcher, or wheelchair.*
- *Anyone visiting with or transporting the infant or child, 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 or child. Identification policies should clearly outline steps to be implemented for reapplying matching identification bands when the mother has been discharged from the facility but the infant is still in the facility.*
- *Infants and children who cannot be in direct, line-of-sight by staff members or parents, when possible, are placed in rooms physically located away from stairwells and elevators. Children involved with custody or abuse issues should receive greatest priority for this room placement, and security should be notified of their high-risk status. The person admitting an infant or child should be discreetly questioned regarding any custody issues and any positive history documented in the medical record.*
- *An access-control policy is established for these areas of the healthcare facility to maximize safety. All exterior doors to the unit where infants and children are staying must have self-closing hardware and be under strict access control (locked). Healthcare facilities should consider the use of alarms and security cameras on these doors. At the front lobby or entrance to the unit, instruct healthcare-facility personnel to ask visitors which infant or child they are visiting and their relationship to the patient. If no name is known or given, decline access and alert security, the nurse manager/supervisor, the facility administration, and/or law enforcement. Set up a sign-in log for visitors to the unit, specifying the infant or child to be visited, and requiring the visitor to show an official photo ID.*
- *If an infant or child is missing from one of these units, activate the critical-incident-response plan. That activation should include the use of a different or modified code word from the one used for infants taken from the maternal-child-care unit. See the text regarding code words on page 25.*

Special-Care Nurseries

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

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

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

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

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

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

- Environmental designs that divide the NICU 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.
- Use of temporary agency or 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 direct, line-of-sight observation.
- Discharge process that does *not* require parents to present an identification band matching 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 would not occur in such special-care units (*e.g.*, probable targets would be “feeder and 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). Facilities with electronic tagging systems should consider tagging infants as soon as they are moved into an open crib. For details about electronic tagging systems *see* 3-3-5 beginning on page 21.

Pediatric Units

Pediatric units also offer special challenges when trying to safeguard children from nonfamily abduction. While 14 percent of the infants abducted from healthcare facilities are from nurseries, 14 percent of the infants abducted are from pediatric units including children’s hospitals. It is recommended that similar and consistent security protocols be implemented in pediatric areas since they can also include infants. It is imperative that the facility’s assessment be used to identify any variations in security protocols for inpatient infant unit(s) to demonstrate reasonable and appropriate protection processes for pediatric patients.

As in special-care-nursery situations, parents may not be constantly present until the child’s discharge. The constant presence of family should be encouraged for those patients younger than 12 months. In addition nurses may not be ever-present in the baby’s room when family is absent, and infants are not usually placed in a centralized nursery when family members are absent. Pediatric units in a community-based hospital may be mixed with adults or on a multiservice unit with a pediatric population. Thus pediatric units often are less secure or “hardened” than maternal-child-care units and special-care nurseries, and special considerations are needed when employing items as noted in 3-4-1 beginning on page 24.

For instance if an electronic tagging system is to be used with patients in the pediatric unit, allowances need to be made for those patients who are permitted to leave the unit such as alarm activation once the child has been gone a specified period of time. When Code Pink is used in a facility to alert staff members that there is a missing infant, consider using a different code word, or the same code word with an age descriptor, for missing pediatric patients and older children visiting the facility. It is important for staff members to clearly understand the type of missing patient/child they are looking for from an infant being carried when a Code Pink is called to an older more ambulatory pediatric patient/visitor.

While nonfamily infant abductions grab the headlines, more common are family abductions involving custody disputes, child abuse, and Department of Family and Children Services (DFCS) intervention. While this problem is widespread and statistical information is available about the subject of family abduction, there is little systematic data available about such abductions from healthcare facilities. It is likely, however, 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 members should ask the parent/guardian if there is any personal circumstance the facility should be aware of, especially as it relates to a family situation that might place the parent/guardian or child at risk. Special concern should be placed on single persons who may be involved in a custody dispute or if the mother has a protective order against the baby's father. This line of questioning is best accomplished with a caring attitude because parents/guardians will often open up about past problems of abuse and even attempted abductions by the noncustodial parent in such situations.

Several factors to review when considering to establish "protection" for a patient include abduction risk, age of child, probability for violence, circumstances surrounding the risk, visitor-screening program, and coordination of security concerns with state and local agencies responsible for taking custody of children due to abuse and/or neglect. Protection strategies include

- "Red flagging" the child's name in the system to indicate no information is to be released
- Admitting the child under an assumed name
- Placing the child in an isolation room or the intensive-care unit
- Placing 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 or reception area
- Posting a security officer at the patient's room/floor/unit

Please use the self-assessment tool, beginning on page 59, when assessing needs in Pediatric Units.

Outpatient Areas

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

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

Visiting nurses, home-health aides, home-health-care workers, HMO workers, nurses in physicians' offices, and all nursing and medical students should be issued the same unique photo ID "to transport" badge referenced in Guidelines 3-2-4 and 3-2-5 beginning on page 15 and 3-2-14 beginning on page 19. *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 proliferation of identity-theft crimes demonstrates that fraudulent identification is readily made and easily obtained. As such patients need to be reminded they should always ask to see the visiting home nurse's photo ID, as issued by the appropriate facility, association, affiliation, and/or employer, and contact that issuing entity for verification. To facilitate this process, upon discharge, the facility should provide the parents with a list of telephone numbers parents may use to verify/confirm the identity of the visiting home nurse.

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

Homes

As stated previously, as of the publication of this book in January 2009, there has been *no* use of violence against mothers *within* healthcare facilities, and, of the 99 infant abductions from homes, 29 percent involved some form of violent act committed against the mother including homicide. Clearly the location of abduction in the last few years is moving primarily to the home; therefore, the importance of patient education before postpartum discharge is paramount. Consider using a signed release form indicating the parent has received the information titled "What Parents Need to Know" beginning on page 51. There have been several

cases where an abductor has made initial contact with a mother and infant in the healthcare setting and then subsequently abducted the infant from the family home. A high degree of diligence should, therefore, be exercised by the healthcare facility when releasing information about the birth of the infant. It is inappropriate for the healthcare facility to supply birth announcements to the press containing a family's complete home address or any other unique identifying data.

An important difference is evident in the abduction style and technique used in healthcare versus nonhealthcare-setting 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 stay in the birthing/healthcare facility or known only online such as in social networking sites, chatrooms, and forums. See "What Parents Need to Know" beginning on page 51 and the 1995 listing for *Analysis of Infant Abductions* by Ann Burgess and Kenneth Lanning in the "Bibliography" on page 80.

Additionally, with the trend toward reduced stays in facilities for mothers once they have given birth (see "Bibliography" on page 82 for the 2002 entry by Madden, et al., of their article in *The New England Journal of Medicine*), a reduced stay for a mother increases her recovery at home during a critical time when she needs to be vigilant about her infant's physical safety. Thus there could be an even greater increase in the infant's risk of being abducted from the home setting because typically fewer people are in the home to help the mother with line-of-sight supervision. As a result every effort should be made to have trusted family members and friends assist mom in the home with all child-care duties until she is fully recovered and able to take those over herself.

The most extreme cases of infant abduction from homes and other places outside of the healthcare setting involve a victim mother who is pregnant and her unborn child is cut from her womb by the abductor. NCMEC has documented 11 such cases from July 1987 through July 2008. Tragically, during that time period, 10 of these mothers and 3 of these infants died from their injuries. Miraculously 8 of the infants victimized in this way survived their traumatic abductions.

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

Case

Example

While her husband was at work a young mother of 2 sons took some time for herself and worked out while their infant son, a 1-month old, napped and his older brother, a 4-year-old, played in another room.

Just before 10:00 A.M., the 4-year-old noticed 2 adults peering in the front windows of the home. He did not answer the door and returned to playing as he thought they had left. Instead the pair apparently entered the home through an unlocked garage door.

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

Law enforcement was called, and by 10:30 A.M. a statewide AMBER Alert had been issued based on the detailed description provided by the 4-year-old including the fact that the woman was wearing a form of photo ID. Within 5 hours, in response to a lead generated by the AMBER Alert, the infant was located about 100 miles away, and the female suspect was taken into custody.

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

Key Factors Helping to Recover the Infant

Key factors that helped in recovering this infant included the

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

Teaching Point

Facilities need to take every opportunity to educate parents about any follow-up care in the home offered by the facility after discharge and the procedures surrounding that care. Such should include consideration of providing this information to the patient on the discharge instruction sheet he or she signs with the patient keeping a copy of the discharge sheet when leaving the facility. See 3-2-14 beginning on page 19 for additional information regarding this point.

6. What Parents Need to Know

Personnel in healthcare facilities and at prenatal visits 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 baby was born and once the parents take the baby home. They should be shared with expectant parents at prenatal visits, during the tour of the facility pre-delivery, and during the parents stay at the time of birth.

Please note in many cases of infant abduction, the abductor was bilingual while the victim mother was not. Healthcare facilities need to provide multilingual-educational information to these parents because infants' risk levels of abduction are substantially elevated when parents are not properly educated in their native language about the safety issues involved. *See* page 54 for the Spanish-language version of these prevention tips, and healthcare facilities should consider translating these tips into any other languages used by patients in their service area.

- | | |
|----------|---|
| FACILITY | 1. At some point <i>before</i> 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 about procedures for "special care" and security procedures in the maternity ward. Know all of the facility's procedures 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 restroom 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. When possible, keep the infant's bassinet on the side of your bed away from the door(s) leading out of the room. |
| FACILITY | 4. After admission to the facility, ask about the facility's protocols concerning the routine nursery procedures, feeding and visitation hours, and security measures. Do not hesitate to politely ask direct questions and settle for nothing less than an acceptable explanation. |
| FACILITY | 5. Do not give your infant to <i>anyone</i> without properly verified identification as issued by that facility. Find out what additional or special identification is being |

worn to further identify facility personnel who have authority to transport your infant. Speak to a person in authority (*e.g.*, unit director, charge nurse) if you have any questions or concerns. Be sure everyone who is helping you watch your infant while you are in the facility understands these safeguards and does not release your infant to any unauthorized person.

- FACILITY
6. Become familiar with the staff members who work in the maternity unit. During short stays in the facility, ask to be introduced to 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 the facility's attire or seem to have a reason for being there. Immediately alert the nurses' station.
- 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 infant or unable to clarify what testing is being done or why your infant is being taken from your room, it is appropriate to go with your infant to observe the procedure. Or if you are unable to accompany your infant, have a family member go along.
- FACILITY
9. For your records to take home, have at least one color photograph of your infant (full, front-face view) taken along with footprints and compile a complete written description of your infant including hair and eye color, length, weight, date of birth, and specific physical characteristics.
- FACILITY/HOME
10. At some point *after* the birth of your baby, but *before* discharge from the facility, request a set of written guidelines about 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 he or she is affiliated with the facility without properly verified identification as issued by that facility. Find out what additional or special identification is being worn to further identify those staff members who have authority to enter your home.
- FACILITY/HOME
11. Consider the risk you may be taking when permitting your infant's birth announcement to be published in the newspaper or online. Birth announcements should never include the family's home address and be limited

to the parents' surname(s). In general, birth announcements in newspapers are not endorsed by most experts.

Use caution in creating websites for your infant or posting photographs of your infant on websites. When doing so limit access to those you know personally and trust. To limit anyone else's potential misuse of a photograph of your infant, carefully consider anyone's request to take a picture of your infant and only share photographs of your infant with those you know personally and trust.

HOME

12. The use of outdoor announcements such as signs, balloons, large floral wreaths, and other lawn ornaments are not recommended to announce a birth because they call attention to the presence of a new infant in the home.

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 or recent acquaintance or known only online such as in social-networking websites, chatrooms, and forums, especially if met briefly since you became pregnant or gave birth to your infant. There have been several cases where an abductor has made initial contact with a mother and infant in the healthcare-facility setting and then subsequently abducted the infant from the family home. If anyone should arrive at the home claiming to be affiliated with the healthcare facility where the infant was born or other healthcare provider, remember to follow the procedures outlined in number 10 above. A high degree of diligence should be exercised by family members when home with the infant. The bottom line is, the infant's family *is* the domestic security team, and all family members should be sensitive to any suspicious visitors.

PUBLIC PLACES

14. If you must take your infant out, whenever possible, take a trusted friend or family member with you as an extra set of hands and eyes to protect and constantly observe the infant. *Never* leave a child alone in a motor vehicle. Always take the child with you. Never let someone you don't know pick up or hold your child. There have been cases in which initial contact with a mother and infant was made in other settings such as shopping malls or bus stations.

Note The National Center for Missing & Exploited Children encourages the distribution of the English- and Spanish-language versions of "What Parents Need to Know" by health-care facilities to patients who will be giving birth to infants in their facility. To obtain these guidelines and NCMEC's Reprint Policy, please call NCMEC at 1-800-THE-LOST® (1-800-843-5678) or visit www.missingkids.com.

Proteja el futuro de su bebé
Medidas para prevenir el secuestro de bebés
Lo que los padres necesitan saber

El personal de los hospitales o centros de salud y en las visitas prenatales debe recordarles a los *padres*, de una manera amable y reconfortante, las medidas que deben tomar para proveer la máxima seguridad a su bebé. Las medidas enumeradas a continuación son técnicas que también pueden ayudar a los padres a prevenir el secuestro del bebé del centro hospitalario donde nació o de su propio hogar. Deberían ser explicadas a los futuros padres durante las visitas prenatales, durante la visita a las instalaciones antes del parto y durante la permanencia de los padres en el momento del nacimiento.

Debe tenerse en cuenta que en muchos casos de robo de infantes el secuestrador o la secuestradora era bilingüe mientras que la madre de la víctima no lo era. Es necesario que los centros de salud provean información educativa multilingüe a estos padres porque los niveles de riesgo de secuestro del infante aumentan sustancialmente cuando no se educa adecuadamente a los padres en su idioma nativo sobre las cuestiones de seguridad involucradas.

CENTRO
HOSPITALARIO

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. Conozca todos los procedimientos que se han adoptado para proteger a su bebé mientras esté en el establecimiento.

CENTRO
HOSPITALARIO

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

CENTRO
HOSPITALARIO

3. Nunca deje a su bebé fuera de su vista, incluso cuando vaya al baño o tome una siesta. Si sale de la habitación o tiene intenciones de dormir, avise a las enfermeras para que lleven a su bebé a la sala de recién nacidos o pida a un miembro de su familia que lo vigile. Siempre que sea posible mantenga la cuna del infante en el lado de su cama que está más alejado de la puerta de la habitación.

CENTRO
HOSPITALARIO

4. Después de entrar al hospital, infórmese sobre los protocolos de rutina del establecimiento, las horas de comidas y de visitas y las medidas de seguridad. No tenga miedo de hacer preguntas directas de una manera cortés y no acepte otra cosa que una explicación satisfactoria.

CENTRO
HOSPITALARIO

5. No entregue su bebé a *nadie* que no tenga identificación del hospital debidamente verificada. Averigüe cual es la identificación adicional o especial del personal autorizado del hospital para transportar a su bebé. Si tiene preguntas o alguna preocupación hable con una persona de autoridad (por ejemplo, el director de la unidad o la enfermera encargada). Asegúrese de que todos los que la ayudan a vigilar su bebé mientras se encuentra en el establecimiento comprenden estas salvaguardas y no le entregan su bebé a una persona que no esté autorizada.

CENTRO
HOSPITALARIO

6. Conozca al personal que trabaja en la sala de maternidad. Durante estancias breves en el hospital o centro de salud pida que le presenten a la enfermera encargada de usted y de su bebé en cada turno.

CENTRO
HOSPITALARIO

7. Interrogue a las personas desconocidas que entren a su habitación o que pregunten sobre su bebé, aunque estén vestidos con uniformes médicos del hospital o parezcan tener alguna razón para estar allí. Avise de inmediato a las enfermeras.

CENTRO
HOSPITALARIO

8. Averigüe donde estará su bebé cuando lo lleven a hacerle exámenes, y cuánto tiempo durarán dichos exámenes. Averigüe quién ha autorizado los exámenes. Si no se siente cómoda con alguna persona que quiera llevarse a su infante 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. O si usted no puede acompañar al infante haga que lo acompañe un miembro de su familia.

CENTRO
HOSPITALARIO

9. Para los archivos que llevará a su casa, tome por lo menos una fotografía en colores de su bebé (de frente), junto con impresiones de la planta del pie y escriba una descripción completa que incluya el color del cabello y de los ojos, tamaño, peso, fecha de nacimiento y las características físicas especiales.

CENTRO
HOSPITALARIO/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 ninguna persona que diga trabajar para el hospital sin verificar debidamente que su documento de identificación haya sido emitido por ese centro de salud. Averigüe cuál es la identificación adicional o especial del personal del hospital que tiene autorización para entrar a su casa.

CENTRO
HOSPITALARIO/CASA

11. Considere el riesgo que corre al permitir la publicación del anuncio del nacimiento de su bebé en el periódico o en línea. Los anuncios de nacimientos nunca deben incluir el domicilio de la familia y deberían limitarse a los apellidos de los padres. En general, los expertos no recomiendan anuncios de nacimiento en los periódicos.

Use cautela al crear sitios web para su bebé o al colocar fotos de su bebé en sitios web. Al hacerlo, limite el acceso sólo a personas a quienes conozca y en quienes tenga confianza. Para limitar el mal uso potencial de una fotografía de su bebé por alguien, considere cuidadosamente el pedido de toda persona que quiera tomar una foto del bebé y sólo comparta fotos de su bebé con personas a quienes conozca personalmente y en las que tenga confianza.

CASA

12. No se recomienda el uso de decoraciones en la parte de afuera de su casa para anunciar el nacimiento de su bebé, por ejemplo carteles,

globos, coronas de flores y otros adornos de jardín debido a que llaman la atención sobre la presencia de un nuevo infante en la casa.

CASA

13. Deje entrar a su casa sólo a personas a quienes conozca bien. No debe dejar entrar a nadie que acaba de conocer o a quién conoció sólo en línea como en sitios de redes sociales, salas de chateo o foros, especialmente si conoció a esa persona brevemente desde que estuvo embarazada o desde que dio a luz. Hubo varios casos en los que el secuestrador hizo contacto inicial con la madre y con el infante en el hospital y luego secuestró al bebé de su hogar. Si alguien se presenta al hogar diciendo estar afiliado al hospital donde nació el bebé u otro centro de salud, siga los procedimientos que se indican en el punto No. 10. Los miembros de la familia deben ser muy cuidadosos cuando se encuentran en el hogar con el infante. Es esencial recordar que la familia del infante *es* el equipo de seguridad en el hogar y todos los miembros de la familia deberían estar atentos a cualquier visitante sospechoso.

LUGARES PÚBLICOS

14. Si usted tiene que llevar a su infante a algún lado, cuando quiera que sea posible hágase acompañar por un amigo o un miembro de la familia para tener un par extra de manos y de ojos para protegerlo y observarlo constantemente. *Nunca* deje a un niño solo en un vehículo automotor. Siempre lleve al niño o a la niña con usted. Nunca permita que una persona a quien usted no conozca alce o sostenga a su bebé. Hubo casos en los cuales el contacto inicial con la madre y con el infante se hizo en otros lugares, como centros o galerías comerciales o estaciones de autobús.

Nota El Centro Nacional para Menores Desaparecidos y Explotados fomenta que los hospitales o centros de salud distribuyan las versiones en inglés y español de "Lo que los padres necesitan saber" a las pacientes que darán a luz en sus instalaciones. Para obtener estas pautas y la Política de Reimpresión del NCMEC llame al NCMEC al 1-800-THE-LOST® (1-800-843-5678) o visite www.missingkids.com.

7. Self-Assessment for Healthcare Facilities

Self-assessment guides are helpful tools for recommendable/advisable policies and/or protocols. Consider using a multidisciplinary task force to complete this self-assessment tool on an annual basis. Use the complete assessment to document areas of compliance, to develop new protocols, and as an outline to revise/write policies and procedures based on these national guidelines. Remember a reorganization of staff members or staff assignments or remodeling of a facility will require immediate reassessment of these policies and protocols to help ensure all measures are still adequate.

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
3-1 General 3-1-1 Immediately report to the nurse manager/supervisor, security, and administration persons exhibiting behaviors of potential abductor. Positively identify suspect. Interview suspect.	Essential Essential Essential		
3-1-2 Preserve report and interview records about incident, many suggest from a minimum of seven years up to the child reaching adulthood.	Essential		
3-1-3 Alert other birthing facilities in the area of attempted abductions/when person identified who demonstrates behaviors of potential abductor.	Essential		
3-1-4 For all attempted abductions Notify law enforcement. Notify NCMEC.	Essential Essential		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
3-2 Proactive Measures 3-2-1 Develop, annually test, and annually critique written proactive-prevention plan.	Essential		
3-2-2 Immediately after birth of infant, attach identically numbered ID bands to infant, mother, father/ significant other. The infant's band needs to be examined and verified with the mother's band when taking the infant for care as well as upon delivery of the infant to the mother after care has been rendered. No matter what form of attachment bands or clamps are used with the electronic tagging of infants, assure <i>no delay</i> in activation of alarm function upon separation of the tag from the infant. Frequent, ongoing testing of the system is needed. Staff members should be trained to immediately respond so there is no delay between detection of the alarm condition and generation of the alarm notification. Staff members should never consider an alarm to be a "false alarm."	Essential Essential Essential Essential Essential		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>3-2-3 Prior to removal of newborn from birthing room or <i>within a maximum of two hours of the birth</i></p> <p>Footprint infant.</p> <p>Take color photograph/video/digital image of infant.</p> <p>Perform and record full, physical assessment and description of infant.</p> <p>Note all these items in infant's medical chart.</p> <p>Store sample of infant's cord blood and any other blood specimens until at least day after infant's discharge.</p> <p>Place electronic security tag, if used by facility.</p>	<p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Recommended</p>		
<p>3-2-4 Require all healthcare personnel to wear, above-the-waist, up-to-date, conspicuous, color-photo ID badges.</p>	<p>Essential</p>		
<p>3-2-5 Personnel allowed to <i>transport</i> infants should wear a unique identification such as a <i>distinctive</i> and prominent color or marking to designate personnel authorized to transport infants that is clearly different than the general healthcare ID badge.</p>	<p>Essential</p>		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>3-2-6 While infants are transported within the healthcare facility, see that</p> <p>Only authorized staff members and the mother/father/significant other with identically numbered ID band to that of the infant's are allowed to transport that infant.</p> <p>Educate mother/father/significant other about the importance of this precaution.</p> <p>An infant is never left without direct, line-of-sight supervision.</p> <p>Infants are taken to mothers one at a time.</p> <p>Infants are always pushed in a bassinet and never carried in anyone's arms.</p> <p>Require family members transporting the infant outside of the mother's room, including mother, father, significant other, to wear an ID wristband matching that of the infant's ID wristband.</p>	<p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p>		
<p>3-2-7 Distribute guidelines, for parents in preventing infant abductions, during prenatal visits, in childbirth classes, on pre-admissions tours, upon admission, at postpartum instruction, and upon discharge.</p>	<p>Essential</p>		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
Upon admission consider having the patient sign a document noting receipt of these guidelines with the patient retaining the guidelines and a copy of the signed document.	Recommended		
3-2-8 Train staff members, at all levels, on protecting infants from abduction.	Essential		
3-2-9 Always place infants in direct, line-of-sight supervision.	Essential		
3-2-10 Do not post mother's or infant's full name where it will be visible to visitors especially on items such as bassinet cards or white boards.	Essential		
3-2-11 Establish an access-control policy for the nursing unit, nursery, maternity, neonatal-intensive care, and pediatrics. At the front lobby or entrance to those units, instruct healthcare-facility personnel to ask visitors which mother they are visiting.	Essential Recommended		
3-2-12 Require a show of the ID wristband for the person taking the infant home from the	Essential		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
healthcare facility and be sure to match the number on the infant's band, as worn on the wrist and ankle, with number on the band worn by the mother/ father/significant other.			
3-2-13 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 <i>after discharge</i> .	Essential		
3-2-14 When providing home visitation services, personnel entering patients' homes need to wear an authorized and unique form of identification strictly controlled by the issuing organization and explained to parents at the time of discharge. Consider providing this information in the discharge instruction sheet the patient signs and takes home.	Essential Recommended		
3-3 Physical-Security Safeguards			
3-3-1 Develop written assessment of risk potential for infant abduction.	Essential		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>Conduct written assessment on a yearly basis or more often as targets, risks, and methods change such as new construction.</p>	<p>Essential</p>		
<p>3-3-2 Install alarms on all stairwell and exit doors on the perimeter of the maternity, nursery, neonatal-intensive-care, and pediatrics units.</p> <p>Respond to all alarms and instruct responsible staff members to silence and reset an activated alarm only after direct observation of the stairwell or exit and person using it.</p> <p>When an alarm is activated properly document it, submit documentation to proper facility authority, and generate monthly reports to be reviewed with security and nursing.</p>	<p>Essential</p> <p>Essential</p> <p>Recommended</p>		
<p>3-3-3 All doors to all nurseries must have self-closing hardware, remain locked at all times, and a staff member should be present at all times when the nursery is in use.</p>	<p>Essential</p>		
<p>3-3-4 All doors to lounges, locker rooms, and storage areas where staff members change/leave clothing or scrub suits must be under</p>	<p>Essential</p>		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>manager, and proper authority within facility.</p> <p>When using the system in pediatric units with patients who are permitted to leave the unit, allow for alarm activation after a specified period of time.</p>	Recommended		
3-3-6 Install and properly maintain a security-camera system.	Essential		
3-3-7 Position camera so it will fully capture the face of all persons using any public entrances, including elevators, to the infant/pediatrics units.	Essential		
3-3-8 Install signage in the maternal-child-care unit; lobbies; obstetric, emergency room, and day-surgery waiting areas instructing visitors not to leave their children out of their line-of-sight.	Recommended		
3-3-9 Consider electronic surveillance and access-control equipment that includes color cameras with video/digital recording, alarms on all stairwell and exit doors on the perimeter of the unit, testing and maintenance of that equipment per manufacturer's recommendations,	Recommended		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
and retention of tapes/ digital recordings for at least seven days.			
3-4 Critical-Incident-Response Plan General 3-4-1 Develop written, critical-incident-response plan in the event of an infant abduction. Conduct full-house response drill at least annually. Conduct quarterly unit-specific drills, "tabletop" exercises, or audit-type exercises.	Essential Essential Recommended		
3-4-2 Call NCMEC at 1-800-THE-LOST® (1-800-843-5678) for advice and technical assistance.	Essential		
Nursing 3-4-3 <i>Immediately</i> search the entire unit.	Essential		
3-4-4 <i>Immediately and simultaneously</i> call facility security and/or other designated authority.	Essential		
3-4-5 Secure and protect the crime scene, and allow no entrance until law enforcement releases it.	Essential		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
3-4-6 Move the parents of the abducted infant, but <i>not</i> their belongings, to a private room off the maternity floor.	Recommended		
Have the nurse assigned to the mother and infant continue to accompany the parents at all times.	Recommended		
Coordinate services to meet the emotional, social, and spiritual needs of the family.	Recommended		
Provide regular, ongoing, information updates to the family in collaboration with other entities such as law enforcement.	Recommended		
Secure all records/charts of the mother and infant.	Recommended		
Notify lab and place STAT hold on infant's cord blood and any other blood specimens.	Recommended		
Designate a room for other family members to wait in giving them easy access to any updates in the case while offering the parents some privacy.	Recommended		
Designate a room for media and another one for law enforcement.	Recommended		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>3-4-7 Nurse manager/supervisor brief all staff members of the unit.</p> <p>Nurses should then explain the situation to each obstetric patient/mother while the mother and her infant are together.</p>	<p>Recommended</p> <p>Recommended</p>		
<p>3-4-8 Assign one staff person to be the primary liaison between the parents and facility after the discharge of the mother from the facility.</p>	<p>Recommended</p>		
<p>3-4-9 Hold a group discussion session as soon as possible in which all personnel affected by the abduction are <i>required</i> to attend.</p>	<p>Essential</p>		
<p>Security Personnel</p> <p>3-4-10 <i>Immediately and simultaneously</i> respond to perimeter points of the grounds to observe persons leaving, and record vehicle license-plate numbers.</p> <p>Call local law enforcement, and make a report.</p> <p>Then call the local FBI office requesting assistance from</p>	<p>Essential</p> <p>Essential</p> <p>Essential</p>		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
<p>the squad handling crimes committed against children.</p> <p>After securing the perimeter, proceed to the location of the incident and activate a search of the entire healthcare facility, interior and exterior.</p> <p>Assume control of the crime scene until law enforcement arrives.</p> <p>Assist nursing staff members in establishing and maintaining security in the unit.</p> <p>Notify public relations.</p> <p>Secure videotapes/ digital recordings for seven days prior to the date of the incident, and request the same from other healthcare facilities in the area and adjacent businesses.</p>	<p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p> <p>Essential</p>		
<p>3-4-11 Facility's media plan should mandate all information about the abduction be cleared by facility <i>and</i> law-enforcement authorities involved before being released to staff members and the media.</p>	<p>Essential</p>		
<p>3-4-12 Brief the healthcare-facility spokesperson who can</p>	<p>Essential</p>		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
inform and involve local media by requesting their assistance in accurately reporting the facts of the case and soliciting the support of the public.			
3-4-13 Call NCMEC at 1-800-THE-LOST (1-800-843-5678) for technical assistance in handling ongoing crisis management.	Essential		
3-4-14 Notify newborn nurseries, pediatric units, emergency rooms, outpatient clinics for postpartum/pediatric care at other local healthcare facilities, and the health department's bureau of vital statistics about the incident, and provide a full description of the infant and suspected or alleged abductor.	Essential		
3-4-15 Document specific review of facility's infant-security and safety program.	Recommended		
Law Enforcement 3-4-16 Enter the infant's name and description in the FBI's National Crime Information Center's Missing Person File (NCIC-MPF).	Essential		
3-4-17 Call NCMEC at 1-800-THE-LOST	Essential		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
(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 infant's photograph.			
3-4-18 Call the local FBI office requesting the assistance of the Crimes Against Children Coordinator with technical and forensic-resource coordination; computerized-case-management support; investigative, interview, and interrogation strategies; and information about behavioral characteristics of unknown offenders.	Essential		
3-4-19 Immediately secure and review any available videotapes/digital recordings from the abduction scene and contact all other birthing facilities in the community and adjacent businesses to request the retrieval and secure storage of the previous seven days' worth of videotapes/digital disks for review.	Essential		
3-4-20 Set up one dedicated local telephone hotline for sightings/leads or	Recommended		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
coordinate this function with a local organization.			
3-4-21 Polygraph infant's parents, female offender, and male companion of offender.	Recommended		
3-4-22 Charge abductor. Make every effort to sustain a conviction.	Essential Essential		
3-4-23 Release of information concerning infant abduction should be well planned and agreed upon by the healthcare-facility and law-enforcement authorities involved. Keep family fully informed.	Essential Essential		
<p>Public Relations</p> <p>3-4-24 Provide facts of case to media and ask for their assistance in releasing information to the public in hopes of generating leads about the infant.</p> <p>Limit information released to that which is approved by law enforcement and healthcare facility, minimizes information about security procedures and technology used within the facility, and refrains from blaming victim families for any aspect of the abduction.</p>	Essential Recommended		

GUIDELINE	STATUS (Essential/ Recommended)	FACILITY COMPLIES (Yes/No)	COMMENTS
Place a news release about the abduction on the facility's website.	Recommended		
3-4-25 Provide written statement to address callers' concerns over the abduction, especially for anxious parents who are planning to deliver their infants at that facility, and instructions about how to handle tips or information about the abduction.	Essential		
3-4-26 Activate the crisis communication plan.	Essential		

8. Bibliography

The partial bibliography below outlines, in chronological order, the benchmark articles in journals and publications for healthcare professionals about this issue. For further information about related articles from popular magazines and newspapers, contact the National Center for Missing & Exploited Children's Jimmy Ryce Law Enforcement Training Center.

The specific date of foreseeability of a particular infant-abduction incident may vary; however, there is wide agreement foreseeability affixed to healthcare nationwide by January 1992.

1965

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

1966

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

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

1982

Colling, Russell L. *Hospital Security*. 2nd edition. Stoneham, Massachusetts: Butterworth-Heinemann, 1982.

1987

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

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

1988

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

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

1989

Rabun, John B., Jr. *For Hospital Professionals*. 1st edition. Alexandria, Virginia: National Center for Missing & Exploited Children, May 1989.

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

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

1990

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

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

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

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

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

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

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

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

1991

Rabun, John B., Jr. *For Hospital Professionals*. 2nd edition. Alexandria, Virginia: National Center for Missing & Exploited Children, March 1991.

Safeguard Their Tomorrows is a program consisting of educational materials for healthcare professionals and distributed by Mead Johnson Nutrition. Nationwide distribution of this program began in June 1991.

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

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

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

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

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

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

1992

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

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

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

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

Rabun, John B., Jr. *For Hospital Professionals*. 2nd edition, revised. Alexandria, Virginia: National Center for Missing & Exploited Children, March 1992.

Colling, Russell L. *Hospital Security*. 3rd edition. Stoneham, Massachusetts: Butterworth-Heinemann, 1992.

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

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

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

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

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

1993

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

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

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

1994

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

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

1995

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

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

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

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

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

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

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

1996

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

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

1997

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

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

1998

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

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

1999

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

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

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

2000

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

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

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

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

2001

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

Colling, Russell L. *Hospital and Healthcare Security*. 4th edition. Boston, Massachusetts: Butterworth-Heinemann, 2001.

2002

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

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

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

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

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

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

2003

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

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

2004

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

2005

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

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

2006

Serious Reportable Events in Healthcare 2006 Update: A Consensus Report. Washington, DC: National Quality Forum, 2007

2007

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

2008

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

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

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

2009

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

The National Center for Missing & Exploited Children® (NCMEC) was established in 1984 as a private, nonprofit organization. Per 42 U.S.C. § 5773 NCMEC fulfills 19 core federal mandates including the operation of a national, 24-hour, toll-free telephone line by which individuals may report information regarding the location of a missing child and request information about the procedures necessary to reunite a child with his or her legal custodian; operation of the national resource center and information clearinghouse for missing and sexually exploited children; coordination of programs to locate, recover, or reunite missing children with their families; provision of technical assistance and training in the prevention, investigation, prosecution, and treatment of cases involving missing and sexually exploited children; and operation of a CyberTipline® for reporting Internet-related, child-sexual exploitation.

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

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

- Studies infant abductions from birthing/healthcare facilities, homes, and other sites, in conjunction with others, and considers them preventable in large part by “hardening the target” as described in these guidelines
- Has trained more than 64,000 healthcare professionals and conducted more than 1,000 on-site assessments of healthcare facilities to help “harden the target” and reduce infant abductions from these facilities
- Provides technical assistance to healthcare facilities, law enforcement, and families, when infants are abducted
- Offers assistance to facilities when assessing and handling posttraumatic-stress disorder (PTSD) among staff members impacted by an abduction
- Encourages distribution of “What Parents Need to Know,” found beginning on page 51, by healthcare facilities to patients who will be giving birth to children in their facility
- Provides additional information about related articles from popular magazines and newspapers regarding infant abductions

In addition a number of publications are available free-of-charge in single copies by writing to Administrative Services, National Center for Missing & Exploited Children, Charles B. Wang International Children's Building, 699 Prince Street, Alexandria, Virginia 22314-3175.

Note: Safeguard Their Tomorrows, an educational DVD for healthcare professionals, has been produced by Mead Johnson Nutrition in cooperation with NCMEC. For more information about this free resource contact your local Mead Johnson Nutrition medical sales representative.

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For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions was previously published as *For Healthcare Professionals: Guidelines on Preventing Infant Abductions* and *For Hospital Professionals: Guidelines on preventing abduction of infants from the hospital*. The second edition of this publication received the 1991 Russell L. Colling Literary Award from the International Association for Healthcare Security and Safety.

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