

Patient Safety Tip of the Week

November 3, 2020

Reminder: Infant Abduction Risk

A recent infant abduction is a stark reminder that your organization can be vulnerable even when it thinks it has all appropriate preventive measures in place. A 35-year old man abducted a newborn infant in a back pack from a Louisiana hospital ([Segura 2020a](#), [Segura 2020b](#), [Cole 2020](#), [Onken 2020](#)). The baby was found safe a few hours later and the man was subsequently arrested.

The hospital had multiple measures in place for infant safety. Visitors are required to have a photo ID at arrival when check-in. The “Safe Place” infant security system was in place with sensors in place throughout the organization that track the baby as it moves from one place to the next. That system sends alerts and there are panels at the nurses' station as well as the security department that trigger alerts to the staff. Security bracelets are put on the babies until they're discharged. According to arrest records, an alarm did sound notifying the hospital staff that the security bracelet had been removed, but the baby was gone by the time staff arrived. Records state that the bracelet was found in the trashcan. The mother was not cooperative, according to authorities. Records said the suspected abductor entered the hospital room just after 11 p.m. He left the room with a book bag about 10 minutes later. The baby was taken from the hospital just after 11:20 PM and state police issued a Level II Endangered/ Missing Child Advisory and the baby was found safe a few hours later and the man, who was the father of the newborn, was subsequently arrested.

According to court records, the baby's mother had tested positive for THC and amphetamines and there was a possibility the baby would be taken by the Department of Children and Family Services ([Segura 2020b](#)).

The hospital had a similar newborn infant abduction four years earlier ([KNOE News 2016](#)). That led to implementation of the “Safe Place” infant security system. The hospital also provides ongoing education and training drills to all team members to ensure the safety of all patients.

[SAFE PLACE®](#) is an RFID-based infant security system (and can also be used for older patients who might be at risk for elopement). Patients wear small, lightweight transmitters that continuously “check-in” with the system. If a patient is too close to a

monitored exit, doors lock, an alarm sounds and staff members are instantly notified, all via their wireless devices. It is the type of tracking system we advocate, not only to protect against infant abductions, but also to identify wandering patients with dementia or delirium, or detect elopement in patients on behavioral health units (see our June 16, 2020 Patient Safety Tip of the Week “[Tracking Technologies](#)”).

But the current Louisiana case shows there are important considerations beyond just implementation of such systems. While removal of the bracelet triggers an alarm, the delay in responding to the alarm could allow enough time for the abductor to leave with the infant, as happened in this case. Fortunately, hospital video monitoring identified the perpetrator and staff was able to tell authorities who had been visiting the mother.

A second consideration is that such systems often rely upon Wi-Fi systems to broadcast the alarms and alerts to staff. Theoretically, an abductor could take advantage of malfunction of the Wi-Fi system to carry out an abduction. Hospitals doing a FMEA (failure mode and effects analysis) on risk of infant abduction or missing patient should ask what would happen if the Wi-Fi system happened to be down or whether someone could intentionally disable the Wi-Fi system.

Another question to ask is “What happens if a fire alarm has gone off?”. We’ve mentioned in several columns on patient elopements use of fire alarms to both serve as a distraction and to automatically unlock doors. For that reason, we recommend that hospitals occasionally perform drills where they tie a “Code Pink” (or whatever you call your infant abduction alert code) or “Code Yellow” (or whatever you call your alert for missing patients) to your fire drills.

The abductor in this case does not fit the profile of the “typical” infant abductor. The National Center for Missing & Exploited Children ([NCMEC 2018](#)) describes the characteristic of the “typical” infant abductor:

- Usually a female of childbearing age who appears pregnant.
- Most likely compulsive; most often relies on manipulation, lying and deception.
- Frequently indicates she has lost a baby or is incapable of having one.
- Often married or cohabitating; companion’s desire for a baby or the abductor’s desire to provide her companion with “his” baby may be the motivation for the abduction.
- Usually lives in the community where the abduction takes place.
- Frequently initially visits nursery and maternity units at more than one health care facility prior to the abduction; asks detailed questions about procedures and the maternity floor layout; frequently uses a fire exit stairwell for her escape; and may also try to abduct from the home setting.
- Usually plans the abduction but does not necessarily target a specific infant; frequently seizes any opportunity present to abduct a baby.
- Frequently impersonates a nurse or other allied health care personnel.
- Often becomes familiar with health care staff members, staff member work routines and victim parents.

- Often demonstrates a capability to provide care to the baby once the abduction occurs, within her emotional and physical abilities.

For those infants abducted from healthcare facilities, the abductor most often impersonates a nurse or other healthcare worker (72.53%), or a relative, friend or acquaintance (14.29%), someone involved in business-related interactions with the mother (i.e. advertising, selling, or purchasing) (4.40%), or someone from Social Services, INS or other government entity (2.20%).

But NCMEC notes that not all infant abductor fit that profile. Only 7 of 325 infant abductors in the NCMEC analysis were male. The unique circumstance in this case (threat of potentially losing the infant to the Department of Children and Family Services likely had a role in the motivation for the abduction by the infant's father.

The 2016 newborn infant abduction at that Louisiana hospital ([KNOE News 2016](#)) better fit with the "typical" pattern. A 24-year old woman entered a hospital room occupied by a mom and her three-day old infant. She told the mother a mutual friend sent her there with a baby bag. The two talked for a little while, and when the mother got up to use the bathroom, she returned to find the baby gone. Hospital staff, security, and police were notified, and began investigating. A hospital employee recalled dealing with a patient earlier in the day, talking about pregnancy issues. Police would later connect that person to that conversation, after finding out she had been treated in the hospital several hours prior to receiving the initial kidnapping call. Investigators contacted the suspect's mother at her home. Shortly after, an unknown woman came to the suspect's mother's home and surrendered the baby. Police say the child appeared in good health and unharmed, and afterwards, was reunited with his mom. Video footage from the hospital showed that suspect leaving with the child, which led to a warrant being issued for aggravated kidnapping.

A 2007 article ([Miller 2007](#)) still provides some very practical recommendations:

- Staff should learn to be suspicious of anyone who visits the unit repeatedly but isn't visiting a specific patient. A potential abductor may study the unit layout, learn when staff goes into patient rooms, and ask questions about feeding times or nursery location.
- Anyone carrying an infant in her arms (rather than in a bassinet) or carrying large bags or packages should raise a red flag.
- The abductor may target a patient room that's far away from the nurses' station or that's near an exit, stairway, or elevator.
- She may also create a diversion (or have an accomplice create one) so that she can escape unnoticed with the infant.

It also had recommendations to tell the parents:

- If they want to walk with their infant, he should be in the bassinet and not in a parent's arms.
- The infant's security band must remain attached to his wrist or ankle at all times.

- Call a nurse right away if the baby's band comes off. The nurse should replace it immediately in the presence of both parents, if possible.
- Know your name and the names of other unit staff who might take the baby to the nursery or to another department for tests. Familiarize them with unit ID badges.
- Ask to see identification of anyone who comes to look at the baby or take the baby to the nursery.
- Any time a parent feels uncomfortable with someone who's in the room, she should press the call bell to summon a staff member.
- The unit routine should be written on a whiteboard in the patient's room. When the parents know the unit's routines, they're more likely to notice when something isn't right.

The Miller article also had recommendations from a since-retired Joint Commission Sentinel Event Alert:

- Attach secure identically numbered bands to the infant (wrist and ankle bands), mother, and father or significant other immediately after birth.
- Footprint the infant, take a color photograph of him, and record his physical examination within 2 hours of birth.
- Implement an infant security tag or abduction alarm system, such as a bar-coding system or umbilical clamp, which triggers an alarm, locks doors, and freezes elevators if the infant comes within 4 feet of an exit or elevator.
- Transport infants only in bassinets; don't allow them to be carried or left in the hallway without direct supervision.
- Establish a tracking system to document where the infant is at all times.
- Require staff to wear up-to-date conspicuous, color-photograph ID badges and require staff in direct contact with infants to wear a second form of unique ID, such as a badge with a pink background.
- Don't publish birth announcements in local newspapers. Don't post the full names of mothers or infants where other patients or visitors can see them.
- Control access to the maternity unit; for instance, keep all unit exit doors locked and make sure they're monitored by video surveillance cameras with a date/time stamp.

Our December 20, 2011 Patient Safety Tip of the Week “[Infant Abduction](#)” also had examples of cases where infant abductions took place despite hospitals having in place similar bracelet-based alert systems. We hope you will go back to that column and also our September 4, 2012 Patient Safety Tip of the Week “[More Infant Abductions](#)” for our multiple recommendations on prevention of infant abductions.

But we also recommend you do a FMEA (failure mode and effects analysis) on infant abduction. A FMEA gets you to always consider “what if...?” scenarios to help you identify areas of vulnerability:

- What if...the bracelet security system failed?
- What if...the exit doors unlocked automatically during a fire alert?

- What if...staffing was low due to an unexpected absence and we now get an emergency C-section?
- What if...an infant has to go to radiology for a study?
- What if...a doctor tells us “it’s okay to let the father carry the infant to radiology”?
- What if...the Wi-Fi system went down?
- How many non-employees have access to your facilities, including “restricted” areas?
- Do you really have an access control system in place?
- How many of you thought that your infant security bands were “failsafe”?
- How difficult would it be to slide off an infant security band intact?
- What would the response be if a security band was removed?
- Do you have systems in place that ensure action items identified in reviews of your various drills actually get incorporated into your policies, procedures and practices?
- How do you deploy observers for your drills and what do you have them look for?
- When do you educate your moms (and dads) on security issues related to newborns?
- Are you sure that moms understand (i.e. that medications have not impaired their ability to understand)?
- Do you have some special means of identification of personnel who should have access to your restricted units?
- Do you have too many entrances and exits in your facility that could be accessed without an ID badge or other device?
- Would you allow a visitor to bring a big tote bag or duffle bag into any area of the hospital?

The whole point of a FMEA is to identify areas where unexpected circumstances might occur that could breach your safety processes.

As we said in our September 4, 2012 Patient Safety Tip of the Week “[More Infant Abductions](#)” “**First and foremost don’t get complacent!**” All too often we hear “that could never happen here” and people assume that the infant security bracelet system is failsafe. Well it’s not, as evidenced in this case and our prior columns.

Some of our prior columns related to newborn infant abductions:

- December 20, 2011 “[Infant Abduction](#)”
- September 4, 2012 “[More Infant Abductions](#)”
- June 16, 2020 “[Tracking Technologies](#)”

See our previous columns on wandering, eloping, and missing patients:

- July 28, 2009 “[Wandering, Elopements, and Missing Patients](#)”

- December 2012 “[Just Went to Have a Smoke](#)”
- April 2, 2013 “[Absconding from Behavioral Health Services](#)”
- October 15, 2013 “[Missing Patients](#)”
- December 2013 “[Lessons from the SFGH Missing Patient Incident](#)”
- April 7, 2015 “[Missing Patients and Death](#)”
- October 6, 2015 “[Suicide and Other Violent Inpatient Deaths](#)”
- April 12, 2016 “[Falls from Hospital Windows](#)”
- September 18, 2018 “[More on Hospital Suicides](#)”
- January 22, 2019 “[Wandering Patients](#)”
- June 16, 2020 “[Tracking Technologies](#)”
- July 7, 2020 “[Another Patient Found Dead in a Stairwell](#)”

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